S T A T E O F N E W Y O R K

S. 2809--D A. 4009--D

S E N A T E - A S S E M B L Y

February 1, 2011

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

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee -- again reported from said committee with amendments, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the elder law, in relation to Medicare part D; to amend the public health law, in relation to early intervention services; to amend the public health law, in relation to tobacco control and insurance initiatives pool distributions; to amend the public health law, in relation to clinical laboratories; to amend the public health law, in relation to distribution of HEAL NY capital grants; to amend section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, in relation to the effectiveness thereof; to amend section 4 of part X2 of 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 the effectiveness thereof; to amend paragraph b of subdivision 1 of section 76 of chapter 731 of the laws of 1993, amending the public health law and other laws relating to reimbursement, delivery and capital costs of ambulatory health care

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

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services and inpatient hospital services, in relation to the effectiveness thereof; to amend section 4 of chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to the effectiveness thereof; to amend section 3 of chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to repeal subdivision 2, and paragraphs (c), (d) and (g) of subdivision 3 of section 242 of the elder law, relating to eligibility for comprehensive coverage for elderly pharmaceutical insurance; to repeal section 244 of the elder law, relating to the elderly pharmaceutical insurance coverage panel; to repeal subdivisions 1, 2 and 4 of section 247 of the elder law, relating to cost-sharing responsibilities of participants in the elderly pharmaceutical insurance coverage program; and to repeal section 248 of the elder law, relating to cost-sharing responsibilities of participants in the elderly catastrophic insurance program (Part A); to amend the public health law, in relation to rates of payment and medical assistance (Part B); to amend the New York Health Care Reform Act of 1996, in relation to extending certain provisions relating thereto; to amend the New York Health Care Reform Act of 2000, in relation to extending the effectiveness of provisions thereof; to amend the public health law, in relation to the distribution of pool allocations and graduate medical education; to amend chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, in relation to the deposit of certain funds; to amend the public health law, in relation to health care initiative pool distributions; to amend the public authorities law, in relation to the transfer of certain funds; to amend the social services law, in relation to extending payment provisions for general hospitals; to amend chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, in relation to the effectiveness of such chapter; to amend chapter 520 of the laws of 1978 relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, in relation to extending the effectiveness of portions thereof; to amend the public health law, in relation to extending access to community health care services in rural areas; to amend the public health law, in relation to continuing the priority restoration adjustment; 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 extending the applicability of certain provisions thereof; to amend the insurance law, in relation to liquidation of domestic insurers; to amend chapter 63 of the laws of 2001 amending chapter 20 of the laws of 2001 amending the military law and other laws relating to making appropriations for the support of government, in relation to extending the applicability of certain provisions thereof; 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 the social services law and the public health law, in relation to rates of payment for personal care service providers, residential health care facilities and diagnostic and treatment centers; and to amend chapter 495 of the laws of 2004 amending the

insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness of such provisions (Part C); to amend the public health law, in relation to payments to residential health care facilities; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to reimbursements; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend the public health law, in relation to capital related inpatient expenses; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to rates of payment by state governmental agencies; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to extending the effectiveness of certain provisions thereof; to amend the public health law, in relation to rates of payment for long term home health care programs; to amend chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, in relation to the effectiveness of certain provisions thereof; to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof; to 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 the effectiveness of certain provisions thereof; to amend chapter 535 of the laws of 1983, amending the social services law relating to eligibility of certain enrollees for medical assistance, 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 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; 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 repeal certain provisions of the public health law relating to capital related inpatient expenses; and to repeal certain provisions of chapter 41 of the laws of 1992, amending the public health law and other laws relating to health care providers relating to the effectiveness of certain provisions thereof (Part D); to amend the social services law, in relation to suspension of eligibility for medical assistance (Part E); to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to foregoing such adjustment during the 2011-2012 state fiscal year (Part F); to amend the mental hygiene law, in relation to

the closure and the reduction in size of certain facilities serving persons with mental illness; and providing for the repeal of certain provisions upon expiration thereof (Part G); and to amend the public health law, in relation to general hospital inpatient reimbursement for annual rates; to amend the public health law, in relation to establishing ceiling limitations for certain rates of payment; to repeal certain provisions of the social services law relating to prescription drug payments; to amend the social services law, in relation to a study to determine costs incurred by public school districts for certain medical care, services and supplies; to amend the public health law, in relation to calculation of capital costs and to repeal certain provisions of such law relating thereto; to amend chapter 58 of the laws of 2010 amending the public health law and other laws relating to Medicaid payments, in relation to the HIV special needs plan; to amend the public health law, in relation to the pharmacy and therapeutics committee and the preferred drug program; and to repeal certain provisions of such law relating thereto; to amend the social services law and the public health law, in relation to covered part D drugs, limited coverage for formula therapy, prescription footwear, speech therapy, physical therapy and occupational therapy, payment for home health care nursing services, and coverage for smoking cessation counseling services, the furnishing of medical assistance to applicants with responsible relatives, mail order prescriptions, and the commissioner of health's authority to negotiate agreements resolving multiple pending rate appeals; to repeal subdivision 12 of section 272 of the public health law relating to authorization under the preferred drug program for anti-psychotics, anti-depressants, anti-rejection drugs for transplants and anti-retrovirals used in the treatment of HIV and AIDS; to amend the public health law, in relation to diagnostic care centers; to amend the public health law, in relation to temporary operator certificates for general hospitals or diagnostic and treatment centers; to amend the social services law, in relation to health home services; to amend the public health law, in relation to statewide planning and research cooperative systems; to amend the public health law, in relation to managed long term care plans and residential health care facilities; to amend the social services law, in relation to insurance co-payments; to amend the public health law, in relation to providing palliative care support for patients with advanced life limiting conditions and illnesses; to amend the social services law, in relation to provisions of home health care services, to establish a workgroup to develop a plan and draft legislation for the purpose of operating and managing public nursing homes; to amend the public health law, in relation to encouraging cooperative, collaborative and integrative arrangements between health care providers, payers, and others; to amend the social services law, in relation to definition of estate; to amend the public health law, in relation to the New York state medical indemnity fund and the New York state hospital quality initiative; to amend the mental hygiene law, in relation to compliance with operational standards by hospitals and providers of services in hospitals; to amend the public health law, in relation to serious event reporting; to amend the public health law in relation to creating an accountable care organization demonstration program; to amend the social services law, in relation to limiting the reporting of death by the operator of an adult home or residence, to define certain terms as used in the social services law, and to require preclaim review for

participating providers of medical assistance program items and services; to amend the public health law, and part B of chapter 58 of the laws of 2010, amending chapter 474 of the laws of 1996 amending the education law and other laws relating to rates for residential healthcare facilities and other laws relating to Medicaid payments, in relation to seeking federal approvals to establish payment methodologies with accountable care organizations, to amend the social services law, in relation to medical assistance for needy persons and to repeal certain provisions of such law relating thereto; to amend the social services law, in relation to the character and adequacy of assistance; to amend the public health law, in relation to operating costs and rates of payment and repealing certain provisions of such law relating thereto; to amend chapter 58 of the laws of 2009, amending the public health law and other laws relating to Medicaid reimbursements to residential health care facilities, in relation to such reimbursements; and to amend the public health law, in relation to residential health care facility supplemental payments, non-capital components of rates, temporary nursing home stability contributions, authorizes commissioner of health to enter into contracts for purposes of the Early Innovator federal grant award; to amend chapter 385 of the laws of 2008 amending the insurance law relating to an exemption to certain provisions of law relating to risk-based capital for property/casualty insurance companies, in relation to the effectiveness thereof; and to amend the insurance law, in relation to applications for orders of rehabilitation or liquidation; 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 extending the effectiveness thereof and providing for the repeal of certain provisions upon expiration thereof (Part H)

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2011-2012 state fiscal year. Each component is wholly contained within a Part identified as Parts A through H. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph (f) of subdivision 3 of section 242 of the elder law, as added by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(f) As a condition of [continued] eligibility for benefits under this title, if a program participant is eligible for Medicare part D drug coverage under section 1860D of the federal social security act, the participant is required to enroll in Medicare part D at the first avail-

able enrollment period and to maintain such enrollment. [This requirement shall be waived if such enrollment would result in significant additional financial liability by the participant, including, but not limited to, individuals in a Medicare advantage plan whose cost sharing would be increased, or if such enrollment would result in the loss of any health coverage through a union or employer plan for the participant, the participant's spouse or other dependent. The elderly pharmaceutical insurance coverage program shall provide premium assistance for all participants enrolled in Medicare part D as follows:

(i) for participants with comprehensive coverage under section two hundred forty-seven of this title] FOR UNMARRIED PARTICIPANTS WITH INDIVIDUAL ANNUAL INCOME LESS THAN OR EQUAL TO TWENTY-THREE THOUSAND DOLLARS AND MARRIED PARTICIPANTS WITH JOINT ANNUAL INCOME LESS THAN OR EQUAL TO TWENTY-NINE THOUSAND DOLLARS, the elderly pharmaceutical insurance coverage program shall pay for the portion of the part D monthly premium that is the responsibility of the participant. Such payment shall be limited to the low-income benchmark premium amount established by the federal centers for Medicare and Medicaid services and any other amount which such agency establishes under its de minimus premium policy, except that such payments made on behalf of participants enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

[(ii) for participants with catastrophic coverage under section two hundred forty-eight of this title, the elderly pharmaceutical insurance coverage program shall credit the participant's annual personal covered drug expenditure amount required under this title by an amount equal to the annual low-income benchmark premium amount established by the centers for Medicare and Medicaid services, prorated for the remaining portion of the participant's elderly pharmaceutical insurance coverage program coverage period. The elderly pharmaceutical insurance coverage program shall, at appropriate times, notify participants with catastrophic coverage under section two hundred forty-seven of this title of their right to coordinate the annual coverage period with that of Medicare part D, along with the possible advantages and disadvantages of doing so.]

S 2. Subdivision 6 of section 241 of the elder law is amended and two new subdivisions 8 and 9 are added to read as follows:

6. "Annual coverage period" shall mean the period of twelve consecutive calendar months for which an eligible program participant has met the [application fee or deductible requirements, as the case may be, of sections two hundred forty-seven and two hundred forty-eight] REQUIREMENTS OF SECTION TWO HUNDRED FORTY-TWO of this title.

8. "COVERAGE GAP PERIOD" SHALL MEAN THE PERIOD BETWEEN THE END OF THE MEDICARE PART D INITIAL COVERAGE PHASE AND THE START OF MEDICARE PART D CATASTROPHIC COVERAGE.

9. "MEDICARE PART D EXCLUDED DRUG CLASSES" SHALL MEAN ANY DRUGS OR CLASSES OF DRUGS, OR THEIR MEDICAL USES, WHICH ARE DESCRIBED IN SECTION 1927(D)(2) OR 1927(D)(3) OF THE FEDERAL SOCIAL SECURITY ACT, WITH THE EXCEPTION OF SMOKING CESSATION AGENTS.

S 3. Subdivision 1 of section 242 of the elder law, paragraph (b) as amended by section 14 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

1. Persons eligible for [comprehensive] coverage under [section two hundred forty-seven of] this title shall include:

(a) any unmarried resident who is at least sixty-five years of age, WHO IS ENROLLED IN MEDICARE PART D, and whose income for the calendar

year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand five, is less than or equal to [twenty] THIRTY-FIVE thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

(b) any married resident who is at least sixty-five years of age, WHO IS ENROLLED IN MEDICARE PART D, and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person's spouse beginning on or after January first, two thousand one, is less than or equal to [twenty-six] FIFTY thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

S 3-a. Subdivision 2 of section 242 of the elder law is REPEALED.

S 3-b. Paragraph (c) of subdivision 3 of section 242 of the elder law is REPEALED and a new paragraph (c) is added to read as follows:

(C) FOR PERSONS WHO MEET THE ELIGIBILITY REQUIREMENTS TO PARTICIPATE IN THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM, THE PROGRAM WILL PAY FOR A DRUG COVERED BY THE PERSON'S MEDICARE PART D PLAN OR A DRUG IN A MEDICARE PART D EXCLUDED DRUG CLASS, AS DEFINED IN SUBDIVISION NINE OF SECTION TWO HUNDRED FORTY-ONE OF THIS TITLE, DURING THE COVERAGE GAP, AS DEFINED IN SUBDIVISION EIGHT OF SECTION TWO HUNDRED FORTY-ONE OF THIS TITLE, PROVIDED THAT SUCH DRUG IS A COVERED DRUG, AS DEFINED IN SUBDIVISION ONE OF SECTION TWO HUNDRED FORTY-ONE OF THIS TITLE, AND THAT THE PARTICIPANT COMPLIES WITH THE POINT OF SALE CO-PAYMENT REQUIREMENTS SET FORTH IN SECTION TWO HUNDRED FORTY-SEVEN OF THIS TITLE.

S 3-c. Paragraph (d) of subdivision 3 of section 242 of the elder law is REPEALED.

S 3-d. Paragraphs (e) and (f) of subdivision 3 of section 242 of the elder law, paragraph (e) as amended by section 112 of part C of chapter 58 of the laws of 2009, paragraph (f) as amended by section one of this act, are amended to read as follows:

(e) As a condition of [continued] eligibility for benefits under this title, if a program participant's income indicates that the participant could be eligible for an income-related subsidy under section 1860D-14 of the federal social security act by either applying for such subsidy or by enrolling in a medicare savings program as a qualified medicare beneficiary (QMB), a specified low-income medicare beneficiary (SLMB), or a qualifying individual (QI), a program participant is required to provide, and to authorize the elderly pharmaceutical insurance coverage program to obtain, any information or documentation required to establish the participant's eligibility for such subsidy, and to authorize the elderly pharmaceutical insurance coverage program to apply on behalf of the participant for the subsidy or the medicare savings program. The elderly pharmaceutical insurance coverage program shall make a reasonable effort to notify the program participant of his or her need to provide any of the above required information. After a reasonable effort has been made to contact the participant, a participant shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the participant's coverage may be terminated.

(f) As a condition of [continued] eligibility for benefits under this title, [if] a program participant is [eligible for Medicare part D drug coverage under section 1860D of the federal social security act, the participant is] required to [enroll] BE ENROLLED in Medicare part D [at the first available enrollment period] and to maintain such enrollment.

[This requirement shall be waived if such enrollment would result in significant additional financial liability by the participant, including, but not limited to, individuals in a Medicare advantage plan whose cost sharing would be increased, or if such enrollment would result in the loss of any health coverage through a union or employer plan for the participant, the participant's spouse or other dependent.]

S 3-e. Paragraph (g) of subdivision 3 of section 242 of the elder law is REPEALED.

S 3-f. Paragraph (h) of subdivision 3 of section 242 of the elder law, as added by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(h) [In order to maximize prescription drug coverage under Medicare part D, the] THE elderly pharmaceutical insurance coverage program is authorized to represent program participants under this title [in the pursuit of such] WITH RESPECT TO THEIR MEDICARE PART D coverage. [Such representation shall not result in any additional financial liability on behalf of such program participants and shall include, but not be limited to, the following actions:

(i) application for the premium and cost-sharing subsidies on behalf of eligible program participants;

(ii) enrollment in a prescription drug plan or MA-PD plan; the elderly pharmaceutical insurance coverage program shall provide program participants with prior written notice of, and the opportunity to decline such facilitated enrollment subject, however, to the provisions of paragraph (f) of this subdivision;

(iii) pursuit of appeals, grievances, or coverage determinations.]

S 3-g. Section 243 of the elder law is amended to read as follows:

S 243. Pharmaceutical insurance contract. 1. The [elderly pharmaceutical insurance coverage panel, established pursuant to section two hundred forty-four of this title] COMMISSIONER OF HEALTH shall, subject to the approval of the director of the budget, enter into a contract with one or more contractors to assist in carrying out the provisions of this title. Such contractual arrangements shall be made subject to a competitive process pursuant to the state finance law and shall ensure that state payments for the contractor's necessary and legitimate expenses for the administration of this program are limited to the amount specified in advance, and that such payments shall not exceed the amount appropriated therefor in any fiscal year. The [panel] COMMISSIONER shall[, at each of its regularly scheduled meetings,] review the contract pricing provisions to assure that the level of contract payments are in the best interest of the state, giving consideration to the total level of participant enrollment achieved, the volume of claims processed, and such other factors as may be relevant in order to contain state expenditures. In the event that the [panel] COMMISSIONER determines that the contract payment provisions do not protect the interest of the state, the [executive director] COMMISSIONER shall initiate contract negotiations for the purpose of modifying contract payments and/or scope requirements.

2. The responsibilities of the contractor or contractors shall include, but need not be limited to:

(a) providing for a method of determining, on an annual basis and upon their application therefor, the eligibility of persons pursuant to section two hundred forty-two of this title within a reasonable period of time, including alternative methods for such determination of eligibility, such as through the mail or home visits, where reasonable and/or

necessary, and for notifying applicants of such eligibility determinations;

(b) notifying each eligible program participant in writing upon the commencement of the annual coverage period of such participant's cost-sharing responsibilities pursuant to [sections] SECTION two hundred forty-seven [and two hundred forty-eight] of this title. The contractor shall also notify each eligible program participant of any adjustment of the co-payment schedule by mail no less than thirty days prior to the effective date of such adjustments and shall inform such eligible program participants of the date such adjustments shall take effect;

(c) issuing an identification card to each ELIGIBLE program participant [who is eligible to purchase prescribed covered drugs for an amount specified pursuant to subdivision three of section two hundred forty-seven or subdivision three of section two hundred forty-eight of this title. The dates of the annual coverage period shall be imprinted on the card. When an eligible program participant meets the annual limits on point of sale co-payments set forth in subdivision four of section two hundred forty-seven or subdivision four of section two hundred forty-eight of this title, either new identification cards shall be issued to such participant indicating waiver of such co-payment requirements for the remainder of the annual coverage period or the contractor shall develop and implement an alternative method to permit the purchase of covered drugs without a co-payment requirement];

(d) [developing and implementing the system for those individuals electing the deductible option to record their personal covered drug expenditures in accordance with subdivision three of section two hundred forty-eight of this title. Such recordkeeping system shall be provided to each such participant at a nominal charge which shall be subject to the approval of the panel. The contractor shall also reimburse participants for personal covered drug expenditures made in excess of their deductible requirements, less the co-payments required by subdivision four of section two hundred forty-eight of this title, made prior to their receipt of an identification card issued in accordance with paragraph (c) of this subdivision;

(e)] processing of claims for reimbursement to participating provider pharmacies pursuant to section two hundred fifty of this title;

[(f)] (E) performing or causing to be performed utilization reviews for such purposes as may be required by the [elderly pharmaceutical insurance coverage panel] COMMISSIONER OF HEALTH;

[(g)] (F) conducting audits and surveys of participating provider pharmacies as specified pursuant to the terms and conditions of the contract; and

[(h)] (G) coordinating coverage with insurance companies and other public and private organizations offering such coverage for those eligible program participants having partial coverage for covered drugs through third-party sources, and providing for recoupment of any duplicate reimbursement paid by the state on behalf of such eligible program participants.

3. The contractor or contractors shall be required to provide such reports as may be deemed necessary by the [elderly pharmaceutical insurance coverage panel] COMMISSIONER OF HEALTH and shall maintain files in a manner and format approved by the [executive director] COMMISSIONER.

4. The contractor or contractors may contract with private not-for-profit or proprietary corporations, or with entities of local government within the state of New York, to perform such obligations of the

contractor or contractors as the [elderly pharmaceutical insurance coverage panel] COMMISSIONER OF HEALTH shall permit.

S 3-h. Section 244 of the elder law is REPEALED and a new section 244 is added to read as follows:

S 244. POWERS OF THE COMMISSIONER OF HEALTH. THE POWERS OF THE COMMISSIONER OF HEALTH IN ADMINISTERING THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING:

1. SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET, PROMULGATING PROGRAM REGULATIONS PURSUANT TO SECTION TWO HUNDRED FORTY-SIX OF THIS TITLE;

2. DETERMINING THE ANNUAL SCHEDULE OF COST-SHARING RESPONSIBILITIES OF ELIGIBLE PROGRAM PARTICIPANTS PURSUANT TO SECTION TWO HUNDRED FORTY-SEVEN OF THIS TITLE;

3. ENTERING INTO CONTRACTS PURSUANT TO SECTION TWO HUNDRED FORTY-THREE OF THIS TITLE;

4. IMPLEMENTING ALTERNATIVE PROGRAM IMPROVEMENTS FOR THE EFFICIENT AND EFFECTIVE OPERATION OF THE PROGRAM IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE;

5. ESTABLISHING OR CONTRACTING FOR A THERAPEUTIC DRUG MONITORING PROGRAM, FOR THE PURPOSE OF MONITORING THERAPEUTIC DRUG USE BY ELIGIBLE PROGRAM PARTICIPANTS IN AN EFFORT TO PREVENT THE INCORRECT OR UNNECESSARY CONSUMPTION OF SUCH THERAPEUTIC DRUGS.

S 3-i. The section heading of section 247 of the elder law is amended to read as follows:

Cost-sharing responsibilities of eligible program participants [for comprehensive coverage].

S 3-j. Subdivision 1 of section 247 of the elder law is REPEALED and a new subdivision 1 is added to read as follows:

1. AS A CONDITION OF ELIGIBILITY FOR BENEFITS UNDER THIS TITLE, PARTICIPANTS MUST MAINTAIN MEDICARE PART D COVERAGE AND PAY MONTHLY PREMIUMS TO THEIR MEDICARE PART D DRUG PLAN.

S 3-k. Subdivisions 2 and 4 of section 247 of the elder law are REPEALED and subdivision 3 is renumbered subdivision 2 and paragraph (a) is amended to read as follows:

(a) [Upon satisfaction of the registration fee pursuant to this section an eligible] A program participant must pay a point of sale co-payment as set forth in paragraph (b) of this subdivision at the time of each purchase of a [covered] drug prescribed for such individual THAT IS DESCRIBED IN PARAGRAPH (C) OF SUBDIVISION THREE OF SECTION TWO HUNDRED FORTY-TWO OF THIS TITLE. [Such co-payment shall not be waived or reduced in whole or in part, subject to the limits provided by subdivision four of this section.]

S 3-l. Section 248 of the elder law is REPEALED.

S 3-m. Section 250 of the elder law, paragraph (a) of subdivision 1 as amended by section 6-a and subparagraph l of paragraph (b) of subdivision 1 as amended by section 1 of part A of chapter 58 of the laws of 2008, paragraph (b) of subdivision 1 as amended by section 17 of part A of chapter 58 of the laws of 2004, subparagraph 1 of paragraph (a) of subdivision 3 and subdivision 5 as amended by section 19 of part B of chapter 57 of the laws of 2006, subdivision 6 as amended by section 19-a of part A of chapter 109 of the laws of 2010, is amended to read as follows:

S 250. Reimbursement to participating provider pharmacies. 1. The amount of reimbursement which shall be paid by the state to a participating provider pharmacy [for any covered drug filled or refilled for

any eligible program participant] FILLING OR REFILLING A PRESCRIPTION FOR A DRUG THAT IS DESCRIBED IN PARAGRAPH (C) OF SUBDIVISION THREE OF SECTION TWO HUNDRED FORTY-TWO OF THIS TITLE shall be equal to the allowed amount defined as follows, minus the point of sale co-payment as required by [sections] SECTION two hundred forty-seven [and two hundred forty-eight] of this title:

(a) Multiple source covered drugs. Except for brand name drugs that are required by the prescriber to be dispensed as written, the allowed amount for a multiple source covered drug shall equal the lower of:

(1) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase, or

(2) The upper limit, if any, set by the centers for medicare and medicaid services for such multiple source drug, or

(3) Average wholesale price discounted by twenty-five percent, or

(4) The maximum allowable cost, if any, established by the commissioner of health pursuant to paragraph (e) of subdivision nine of section three hundred sixty-seven-a of the social services law.

Plus a dispensing fee for drugs reimbursed pursuant to subparagraphs two, three, and four of this paragraph, as defined in paragraph (c) of this subdivision.

(b) Other covered drugs. The allowed amount for brand name drugs required by the prescriber to be dispensed as written and for covered drugs other than multiple source drugs shall be determined by applying the lower of:

(1) Average wholesale price discounted by sixteen and twenty-five one hundredths percent, plus a dispensing fee as defined in paragraph (c) of this subdivision, or

(2) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase.

(c) As required by paragraphs (a) and (b) of this subdivision, a dispensing fee of four dollars fifty cents will apply to generic drugs and a dispensing fee of three dollars fifty cents will apply to brand name drugs.

2. For purposes of determining the amount of reimbursement which shall be paid to a participating provider pharmacy, the [panel] COMMISSIONER OF HEALTH shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug that participating provider pharmacies buy most frequently. Using the result of this survey, the contractor shall update every thirty days the list of average wholesale prices upon which such reimbursement is determined using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is dispensed.

3. [(a) Notwithstanding any inconsistent provision of law, the program for elderly pharmaceutical insurance coverage shall reimburse for covered drugs which are dispensed under the program by a provider pharmacy only pursuant to the terms of a rebate agreement between the program and the manufacturer (as defined under section 1927 of the federal social security act) of such covered drugs; provided, however, that:

(1) any agreement between the program and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and

provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one; and

(2) the program may reimburse for any covered drugs pursuant to subdivisions one and two of this section, for which a rebate agreement does not exist and which are determined by the elderly pharmaceutical insurance coverage panel to be essential to the health of persons participating in the program; and likely to provide effective therapy or diagnosis for a disease not adequately treated or diagnosed by any other covered drug; and which are recommended for reimbursement by the panel and approved by the commissioner of health.

(b) The rebate agreement between such manufacturer and the program for elderly pharmaceutical insurance coverage shall utilize for covered drugs the identical formula used to determine the rebate for federal financial participation for drugs, pursuant to section 1927(c) of the federal social security act, to determine the amount of the rebate pursuant to this subdivision.

(c) The amount of rebate pursuant to paragraph (b) of this subdivision shall be calculated by multiplying the required rebate formulas by the total number of units of each dosage form and strength dispensed. The rebate agreement shall also provide for periodic payment of the rebate, provision of information to the program, audits, verification of data, damages to the program for any delay or non-production of necessary data by the manufacturer and for the confidentiality of information.

(d) The program in providing utilization data to a manufacturer (as provided for under section 1927 (b) of the federal social security act) shall provide such data by zip code, if requested, for the top three hundred most commonly used drugs by volume covered under a rebate agreement.

(e) Any funds collected pursuant to any rebate agreements entered into with a manufacturer pursuant to this subdivision, shall be deposited into the elderly pharmaceutical insurance coverage program premium account.

4.] Notwithstanding any other provision of law, entities which offer insurance coverage for provision of and/or reimbursement for pharmaceutical expenses, including but not limited to, entities licensed/certified pursuant to article thirty-two, forty-two, forty-three or forty-four of the insurance law (employees welfare funds) or article forty-four of the public health law, shall participate in a benefit recovery program with the elderly pharmaceutical insurance coverage (EPIC) program which includes, but is not limited to, a semi-annual match of EPIC's file of enrollees against the entity's file of insured to identify individuals enrolled in both plans with claims paid within the twenty-four months preceding the date the entity receives the match request information from EPIC. Such entity shall indicate if pharmaceutical coverage is available from the entity for the insured persons, list the copayment or other payment obligations of the insured persons applicable to the pharmaceutical coverage, and (after receiving necessary claim information from EPIC) list the amounts which the entity would have paid for the pharmaceutical claims for those identified individuals and the entity shall reimburse EPIC for pharmaceutical expenses paid by EPIC that are covered under the contract between the entity and its insured in only those instances where the entity has not already

made payment of the claim. Reimbursement of the net amount payable (after rebates and discounts) that would have been paid under the coverage issued by the entity will be made by the entity to EPIC within sixty days of receipt from EPIC of the standard data in electronic format necessary for the entity to adjudicate the claim and if the standard data is provided to the entity by EPIC in paper format payment by the entity shall be made within one hundred eighty days. After completing at least one match process with EPIC in electronic format, an entity shall be entitled to elect a monthly or bi-monthly match process rather than a semi-annual match process.

[5.] 4. Notwithstanding any other provision of law, the [panel] COMMISSIONER OF HEALTH shall maximize the coordination of benefits for persons enrolled under Title XVIII of the federal social security act (medicare) and enrolled under this title in order to facilitate medicare payment of claims. The [panel] COMMISSIONER OF HEALTH may select an independent contractor, through a request-for-proposal process, to implement a centralized coordination of benefits system under this subdivision for individuals qualified in both the elderly pharmaceutical insurance coverage (EPIC) program and medicare programs who receive medications or other covered products from a pharmacy provider currently enrolled in the elderly pharmaceutical insurance coverage (EPIC) program.

[6. (a)] 5. The EPIC program shall be the payor of last resort for individuals qualified in both the EPIC program and title XVIII of the federal social security act (Medicare). [For such individuals, no reimbursement shall be available under EPIC for covered drug expenses except:

(i) where a prescription drug plan authorized by Part D of the federal social security act (referred to in this subdivision as a Medicare Part D plan) has approved coverage and EPIC has an obligation under this title to pay a portion of the participant's cost-sharing responsibility under Medicare Part D; or

(ii) where the provider pharmacy has certified that a Medicare Part D plan has denied coverage.

(b) If the provider pharmacy certifies as set forth in subparagraph (ii) of paragraph (a) of this subdivision, the EPIC program shall pay for the drug as the primary payor upon a showing of compliance with the notification and appeal provisions of subparagraph two of paragraph (c) of subdivision three of section two hundred forty-two of this title.]

S 3-n. Section 254 of the elder law is amended to read as follows:

S 254. Cost of living adjustment. [1.] Within amounts appropriated, the [panel] COMMISSIONER OF HEALTH shall adjust the program eligibility standards set forth in subdivision [two] ONE of section two hundred forty-two of this title to account for increases in the cost of living.

[2. The panel shall further adjust individual and joint income categories set forth in subdivisions two and four of section two hundred forty-eight of this title to conform to the adjustments made pursuant to subdivision one of this section.]

S 4. Notwithstanding any contrary provision of law, rates established pursuant to section 69-4.30 of Title 10 of the New York Codes, Rules and Regulations for approved services rendered on and after April 1, 2011 shall be reduced by five percent.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. Intentionally omitted.

S 9. Intentionally omitted.
S 10. Intentionally omitted.
S 11. Intentionally omitted.
S 12. Subdivisions 4 and 5 of section 2545 of the public health law, as added by section 2 of chapter 428 of the laws of 1992, are amended to read as follows:
4. If the IFSP TEAM MEMBERS, INCLUDING THE early intervention official and the parent agree on the IFSP, the IFSP shall be deemed final and the service coordinator shall be authorized to implement the plan.
5. If the IFSP TEAM MEMBERS, INCLUDING THE early intervention official and the parent do not agree on an IFSP, the service coordinator shall implement the sections of the proposed IFSP that are not in dispute, and the parent shall have the due process rights set forth in section twenty-five hundred forty-nine of this title.
S 13. Subdivision 2 of section 605 of the public health law, as amended by section 7 of part B of chapter 57 of the laws of 2006, is amended to read as follows:
2. State aid reimbursement for public health services provided by a municipality under this title, shall be made [as follows:
(a)] if the municipality is providing some or all of the basic public health services identified in paragraph (b) of subdivision three of section six hundred two of this title, pursuant to an approved plan, at a rate of no less than thirty-six per centum of the difference between the amount of moneys expended by the municipality for public health services required by paragraph (b) of subdivision three of section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services if they are not approved in a plan or if no plan is submitted for such services.
[(b) if the municipality is providing other public health services within limits to be prescribed by regulation by the commissioner in addition to some or all of the public health services required in paragraph (b) of subdivision three of section six hundred two of this title, pursuant to an approved plan, at a rate of not less than thirty-six per centum of the moneys expended by the municipality for such other services. No such reimbursement shall be provided for services if they are not approved in a plan or if no plan is submitted for such services.]
S 14. Intentionally omitted.
S 15. Intentionally omitted.
S 16. Paragraph (fff) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:
(fff) Funds shall be made available to the empire state stem cell fund established by section ninety-nine-p of the state finance law [from the public asset as defined in section four thousand three hundred one of the insurance law and accumulated from the conversion of one or more article forty-three corporations and its or their not-for-profit subsidiaries occurring on or after January first, two thousand seven. Such funds shall be made available] within amounts appropriated up to fifty million dollars annually and shall not exceed five hundred million dollars in total.
S 17. Subdivision 2 of section 2407 of the public health law, as amended by chapter 430 of the laws of 2005, is amended to read as follows:

2. The advisory council shall be responsible for advising the commissioner with respect to the implementation of this article and shall make recommendations as to [the selection of approved organizations and] the standards to be established by the commissioner pursuant to section twenty-four hundred six of this title. [The commissioner shall consult with the advisory council prior to developing standards for approved organizations, selecting approved organizations, making grants to such organizations and implementing the breast and cervical cancer detection and education program.]

S 18. Subdivision 3 of section 571 of the public health law, as amended by chapter 436 of the laws of 1993, is amended to read as follows:

3. "Reference system" means a system of [periodic testing] ASSESSMENT of methods, procedures and materials of clinical laboratories and blood banks, including, but not limited to, ONGOING VALIDATION WHICH MAY INCLUDE DIRECT TESTING AND EXPERIMENTATION BY THE DEPARTMENT OF SUCH METHODS, PROCEDURES AND MATERIALS, the distribution of [manuals of approved methods] STANDARDS AND GUIDELINES, inspection of facilities, [cooperative research, and] periodic submission of test specimens for examination, AND RESEARCH CONDUCTED BY THE DEPARTMENT THAT INVOLVES THE STUDY OF NEW OR EXISTING METHODS, PROCEDURES AND MATERIALS RELATED TO THE QUALITY OF CLINICAL LABORATORY MEDICINE.

S 19. Subdivisions 1, 2 and 6 of section 575 of the public health law, as amended by chapter 436 of the laws of 1993, are amended to read as follows:

1. Application for a permit shall be made by the owner and the director of the clinical laboratory or blood bank [upon forms provided by the department] IN A MANNER AND FORMAT PRESCRIBED BY THE DEPARTMENT. The application shall contain the name of the owner, the name of the director, the procedures or categories of procedures or services for which the permit is sought, the location or locations and physical description of the facility or location or locations at which tests are to be performed or at which a blood bank is to be operated, and such other information as the department may require.

2. A permit OR PERMIT CATEGORY shall not be issued unless a valid certificate of qualification in the category of procedures for which the permit is sought has been issued to the director pursuant to the provisions of section five hundred seventy-three of this title, [and] unless ALL FEES AND OUTSTANDING PENALTIES, IF ANY, HAVE BEEN PAID, AND the department finds that the clinical laboratory or blood bank is competently staffed and properly equipped, and will be operated in the manner required by this title.

6. A permit shall become void by a change in the director, owner, or location. A CATEGORY ON A PERMIT SHALL BECOME VOID BY A CHANGE IN THE DIRECTOR FOR THAT CATEGORY. The department may, pursuant to regulations adopted under this title, extend the date on which a permit OR CATEGORY ON A PERMIT shall become void for a period not to exceed sixty days from the date of a change of the director, owner or location. An application for a NEW permit [may] MUST be made [at any time,] in the manner provided by this section.

S 20. Subdivision 3 and paragraphs (a), (b), (c) and (e) of subdivision 4 of section 576 of the public health law, as amended by chapter 436 of the laws of 1993, are amended to read as follows:

3. The department shall operate a reference system and shall prescribe standards for the PROPER OPERATION OF CLINICAL LABORATORIES AND BLOOD BANKS AND FOR THE examination of specimens. As part of such reference

system, the department may REVIEW AND APPROVE TESTING METHODS DEVELOPED OR MODIFIED BY CLINICAL LABORATORIES AND BLOOD BANKS PRIOR TO THE TESTING METHODS BEING OFFERED IN THIS STATE, AND MAY require clinical laboratories and blood banks to analyze test samples submitted by the department and to report on the results of such analyses. The rules and regulations of the department shall prescribe the REQUIREMENTS FOR THE PROPER OPERATION OF A CLINICAL LABORATORY OR BLOOD BANK, FOR THE APPROVAL OF METHODS AND THE manner in which proficiency testing or analyses of samples shall be performed and reports submitted. Failure to meet department standards FOR THE PROPER OPERATION OF A CLINICAL LABORATORY OR BLOOD BANK, INCLUDING THE CRITERIA FOR APPROVAL OF METHODS, OR FAILURE TO MAINTAIN SATISFACTORY PERFORMANCE in proficiency testing shall result in termination of the permit in the category or categories of testing established by the department in regulation until remediation is achieved. Such standards shall be at least as stringent as federal standards promulgated under the federal clinical laboratory improvement [act] AMENDMENTS of nineteen hundred eighty-eight. Such failure and termination shall be subject to review in accordance with regulations adopted by the department.

(a) The department may adopt and amend rules and regulations to effectuate the provisions and purposes of this title. Such rules and regulations shall establish [inspection and reference] fees for clinical laboratories and blood banks in amounts not exceeding the cost of the [inspection and] reference [program] SYSTEM for clinical laboratories and blood banks and shall be subject to the approval of the director of the budget. FOR THE PURPOSES OF THIS SUBDIVISION, STANDARD FEDERALLY ESTABLISHED GOVERNMENTAL COST ALLOCATION PRACTICES SHALL BE USED BY THE COMMISSIONER TO DETERMINE THE COST OF THE REFERENCE SYSTEM. THE DEPARTMENT SHALL MAKE AVAILABLE, ON THE DEPARTMENT'S WEBSITE, INFORMATION ON THE COSTS INCLUDED IN DETERMINING THE PERMITTED LABORATORIES' FEES. THE DEPARTMENT SHALL NOT DEEM AS COSTS OF THE REFERENCE SYSTEM, COSTS ASSOCIATED WITH FEDERAL GRANTS AND PATENTS WHICH ARE NOT RELATED TO THE REFERENCE SYSTEM. THE FEE PAID BY THE DEPARTMENT TO MAINTAIN AN EXEMPTION FOR CLINICAL LABORATORIES AND BLOOD BANKS FROM THE REQUIREMENTS OF THE FEDERAL CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF NINETEEN HUNDRED EIGHTY-EIGHT SHALL BE DEEMED A COST OF THE REFERENCE SYSTEM.

(b) In determining the fee charges to be assessed, the department shall, on or before May first of each year, compute the [total actual] costs for the preceding state fiscal year which were expended to operate and administer the duties of the department pursuant to this title. The department shall, at such time or times and pursuant to such procedure as it shall determine by regulation, bill and collect from each clinical laboratory and blood bank an amount computed by multiplying such total computed operating expenses of the department by a fraction the numerator of which is the gross annual receipts of such clinical laboratory or blood bank during such twelve month period preceding the date of computation as the department shall designate by regulation, and the denominator of which is the total gross annual receipts of all clinical laboratories or blood banks operating in the state during such period.

(c) Each such clinical laboratory and blood bank shall submit to the department, in such form and at such times as the department may require, a report containing information regarding its gross annual receipts [from the performance of tests or examination of specimens] FOR ALL ACTIVITIES PERFORMED pursuant to a permit issued by the department in accordance with the provisions of section five hundred seventy-five

of this title. The department may require additional information and audit and review such information to verify its accuracy.

(e) On or before September fifteenth of each year, the department shall [recompute the actual] RECONCILE ITS costs and expenses [of the department] FOR THE REFERENCE SYSTEM for the preceding state fiscal year and shall, on or before October fifteenth send to each clinical laboratory and blood bank, a statement setting forth the amount due and payable by, or the amount computed to the credit of, such clinical laboratory or blood bank, computed on the basis of the above stated formula, except that for the purposes of such computation the fraction shall be multiplied against the total recomputed [actual] expenses of the department for such fiscal year. Any amount due shall be payable not later than thirty days following the date of such statement. Any credit shall be applied against any succeeding payment due.

S 21. Subdivision 1 of section 577 of the public health law is amended by adding a new paragraph (i) to read as follows:

(I) HAS BEEN FOUND UPON INSPECTION BY THE DEPARTMENT TO BE IN NONCOMPLIANCE WITH A PROVISION OR PROVISIONS OF THIS TITLE OR THE RULES AND REGULATIONS PROMULGATED HEREUNDER, AND HAS FAILED TO ADDRESS SUCH FINDINGS AS REQUIRED BY THE DEPARTMENT.

S 22. Intentionally Omitted.

S 23. Intentionally Omitted.

S 24. Intentionally Omitted.

S 25. Intentionally Omitted.

S 25-a. Section 2818 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. 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, SUBJECT TO AVAILABLE APPROPRIATIONS, FUNDS AVAILABLE FOR EXPENDITURE PURSUANT TO THIS SECTION MAY BE DISTRIBUTED BY THE COMMISSIONER WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS FOR GRANTS TO GENERAL HOSPITALS AND RESIDENTIAL HEALTH CARE FACILITIES FOR THE PURPOSE OF FACILITATING CLOSURES, MERGERS AND RESTRUCTURING OF SUCH FACILITIES IN ORDER TO STRENGTHEN AND PROTECT CONTINUED ACCESS TO ESSENTIAL HEALTH CARE RESOURCES. PRIOR TO AN AWARDED BEING GRANTED TO AN ELIGIBLE APPLICANT WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, THE COMMISSIONER SHALL NOTIFY THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE AND THE DIRECTOR OF THE DIVISION OF BUDGET OF THE INTENT TO GRANT SUCH AN AWARD. SUCH NOTICE SHALL INCLUDE INFORMATION REGARDING HOW THE ELIGIBLE APPLICANT MEETS CRITERIA ESTABLISHED PURSUANT TO THIS SECTION.

S 26. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, as amended by section 20 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

S 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2008; provided however, that sections one, six-a, nineteen, twenty, twenty-four, and twenty-five of this act shall take effect July 1, 2008; provided however that sections sixteen, seventeen and eighteen of this act shall expire April 1, [2011] 2014; provided, however, that the amendments made by section twenty-eight of this act shall take effect on the same date as section 1 of chapter 281 of the laws of 2007 takes effect; provided further, that sections twenty-nine, thirty, and thirty-one of this act

shall take effect October 1, 2008; provided further, that section twenty-seven of this act shall take effect January 1, 2009; and provided further, that section twenty-seven of this act shall expire and be deemed repealed March 31, [2011] 2014; and provided, further, however, that the amendments to subdivision 1 of section 241 of the education law made by section twenty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided that the amendments to section 272 of the public health law made by section thirty of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

S 27. Section 4 of part X2 of 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, as amended by chapter 21 of the laws of 2010, is amended to read as follows:

S 4. This act shall take effect immediately; provided that the provisions of section one of this act shall be deemed to have been in full force and effect on and after April 1, 2003, and shall expire March 31, [2011] 2013 when upon such date the provisions of such section shall be deemed repealed.

S 28. Paragraph (b) of subdivision 1 of section 76 of chapter 731 of the laws of 1993, amending the public health law and other laws relating to reimbursement, delivery and capital cost of ambulatory health care services and inpatient hospital services, as amended by section 14 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(b) sections fifteen through nineteen and subdivision 3 of section 2807-e of the public health law as added by section twenty of this act shall expire on [July 1, 2011] JULY 1, 2014, and section seventy-four of this act shall expire on July 1, 2007;

S 29. Section 4 of chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, as amended by chapter 609 of the laws of 2007, is amended to read as follows:

S 4. This act shall take effect immediately; provided, however, that the provisions of paragraph (b) of subdivision 4 of section 409-c of the public health law, as added by section three of this act, shall take effect January 1, 1996 and shall expire and be deemed repealed [sixteen] TWENTY years from the effective date thereof.

S 30. Section 3 of chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, as amended by chapter 607 of the laws of 2007, is amended to read as follows:

S 3. This act shall take effect immediately, provided, however, that subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of 1973, as added by section one of this act, shall expire and be deemed repealed June 30, [2011] 2015; and provided further, however, that the expiration and repeal of such subdivision 15-a shall not affect or impair in any manner any health facilities bonds issued, or any lease or purchase of a health facility executed, pursuant to such subdivision 15-a prior to its expiration and repeal and that, with respect to any such bonds issued and outstanding as of June 30, [2011] 2015, the provisions of such subdivision 15-a as they existed immediately prior to such expiration and repeal shall continue to apply through the latest maturity date of any such bonds, or their earlier retirement or redemption, for the sole purpose of authorizing the issuance of refunding bonds to refund bonds previously issued pursuant thereto.

S 31. This act shall take effect April 1, 2011, provided, however that:

(a) section one of this act shall take effect July 1, 2011;

(b) sections two through three-n of this act shall take effect January 1, 2012;

(c) section thirteen of this act shall take effect July 1, 2011; and

(d) related to sections eighteen, nineteen, twenty and twenty-one of this act, the commissioner of health is authorized to promulgate, on an emergency basis, any regulations necessary to implement any provision of such sections upon their effective date.

PART B

Section 1. (a) Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments for professional services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice at the State University of New York, in accordance with title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, in amounts that will increase fees for such professional services to an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule or made as aggregate lump sum payments to eligible clinical practice plans authorized to receive professional fees.

(b) The affiliated State University of New York health science centers shall be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments for all services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice, in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

S 2. Subdivision 21 of section 2807-c of the public health law is amended by adding a new paragraph (e-1) to read as follows:

(E-1) FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, FOR PURPOSES OF CALCULATIONS PURSUANT TO PARAGRAPHS (B) AND (C) OF THIS SUBDIVISION OF MAXIMUM DISPROPORTIONATE SHARE PAYMENT DISTRIBUTIONS FOR A RATE YEAR OR PART THEREOF, COSTS INCURRED OF FURNISHING HOSPITAL SERVICES NET OF MEDICAL ASSISTANCE PAYMENTS, OTHER THAN DISPROPORTIONATE SHARE PAYMENTS, AND PAYMENTS BY UNINSURED PATIENTS SHALL FOR THE TWO THOUSAND ELEVEN CALENDAR YEAR, SHALL BE DETERMINED INITIALLY BASED ON EACH HOSPITAL'S SUBMISSION OF A FULLY COMPLETED TWO THOUSAND EIGHT DISPROPORTIONATE SHARE HOSPITAL DATA COLLECTION TOOL, WHICH IS REQUIRED TO BE SUBMITTED TO THE DEPARTMENT BY MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, AND SHALL BE SUBSEQUENTLY REVISED TO REFLECT EACH HOSPITAL'S SUBMISSION OF A FULLY COMPLETED TWO THOUSAND NINE DISPROPORTIONATE SHARE

HOSPITAL DATA COLLECTION TOOL, WHICH IS REQUIRED TO BE SUBMITTED TO THE DEPARTMENT BY OCTOBER FIRST, TWO THOUSAND ELEVEN.

FOR CALENDAR YEARS ON AND AFTER TWO THOUSAND TWELVE, SUCH INITIAL DETERMINATIONS SHALL REFLECT SUBMISSION OF DATA AS REQUIRED BY THE COMMISSIONER ON A SPECIFIED DATE. ALL SUCH INITIAL DETERMINATIONS SHALL SUBSEQUENTLY BE REVISED TO REFLECT ACTUAL RATE PERIOD DATA AND STATISTICS. INDIGENT CARE PAYMENTS WILL BE WITHHELD IN INSTANCES WHEN A HOSPITAL HAS NOT SUBMITTED REQUIRED INFORMATION BY THE DUE DATES PRESCRIBED IN THIS PARAGRAPH, PROVIDED, HOWEVER, THAT SUCH PAYMENTS SHALL BE MADE UPON SUBMISSION OF SUCH REQUIRED DATA. FOR PURPOSES OF CALCULATIONS PURSUANT TO PARAGRAPH (D) OF THIS SUBDIVISION OF ELIGIBILITY TO RECEIVE DISPROPORTIONATE SHARE PAYMENTS FOR A RATE YEAR OR PART THEREOF, THE HOSPITAL INPATIENT UTILIZATION RATE SHALL BE DETERMINED BASED ON THE BASE YEAR STATISTICS IN ACCORDANCE WITH THE METHODOLOGY ESTABLISHED BY THE COMMISSIONER, AND COSTS INCURRED OF FURNISHING HOSPITAL SERVICES SHALL BE DETERMINED IN ACCORDANCE WITH A METHODOLOGY ESTABLISHED BY THE COMMISSIONER CONSISTENT WITH REQUIREMENTS OF THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR PURPOSES OF FEDERAL FINANCIAL PARTICIPATION PURSUANT TO THE TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT IN DISPROPORTIONATE SHARE PAYMENTS.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S4-a. Intentionally omitted.

S 5. Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for periods on and after July 1, 2011, Medicaid rates of payments for inpatient services provided by residential health care facilities which, as of the effective date of this section, operate discrete units for treatment of residents with huntington's disease, shall be increased by a rate add-on amount. The aggregate amount of such rate add-ons for the period July 1, 2011 through December 31, 2011 shall be eight hundred fifty thousand dollars ($850,000), and shall be one million seven hundred thousand dollars ($1,700,000) for the 2012 calendar year and each year thereafter and such amounts shall be allocated to each eligible residential health care facility proportionally, based on the number of beds in each facility's discrete unit for treatment of huntington's disease relative to the total number of such beds in all such units. Such rate add-ons shall be computed utilizing reported Medicaid days from certified cost reports as submitted to the department of health for the calendar year period two years prior to the applicable rate year and, further, such rate add-ons shall not be subject to subsequent adjustment or reconciliation.

S 6. Notwithstanding section 448 of chapter 170 of the laws of 1994 and section 4 of chapter 81 of the laws of 1995, as amended, and any other inconsistent provision of law or regulation and subject to the availability of federal financial participation, for the period April 1, 2011 through June 30, 2011, medical assistance rates of payment to residential health care facilities and diagnostic treatment centers licensed under article 28 of the public health law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall be increased by an aggregate amount of one million eight hundred sixty-seven thousand dollars ($1,867,000). Such amount shall be allocated proportionally among such providers based on the medical assistance visits reported by each provider in the most recently available cost report, as submitted to the department of health by January 1, 2011, and shall be included as adjustments to each provider's daily rate

of payment for such services. Such adjustments shall not be subject to subsequent adjustment or reconciliation.

S 7. Notwithstanding any contrary provision of law or regulation and subject to availability of federal financial participation, for the period April 1, 2011 through June 30, 2011, rates of payment by governmental agencies to residential health care facilities and diagnostic and treatment centers licensed under article 28 of the public health law for adult day health care services provided to registrants with acquired immunodeficiency syndrome (AIDS) or other human immunodeficiency virus (HIV) related illnesses, shall reflect an adjustment to such rates of payments in an aggregate amount of two hundred thirty-six thousand dollars ($236,000) and distributed proportionally as rate add-ons, based on each eligible providers' Medicaid visits as reported in such provider's most recently available cost report as submitted to the department of health prior to January 1, 2011, and provided further, however, that such adjustments shall not be subject to subsequent adjustment or reconciliation.

S 8. Intentionally omitted.

S 9. Intentionally omitted.

S 10. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 11. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 12. 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.

S 13. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011; provided, however, that:

(a) any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

(b) this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act;

(c) the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

(d) notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any

appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date; and

(e) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act.

PART C

Section 1. Subdivision 5 of section 168 of chapter 639 of the laws of 1996, constituting the New York Health Care Reform Act of 1996, as amended by section 1 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

5. sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, as amended or as added by this act, shall expire on December 31, [2011] 2014, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31, [2011] 2014, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 2. Subdivision 1 of section 138 of chapter 1 of the laws of 1999, constituting the New York Health Care Reform Act of 2000, as amended by section 1-a of part B of chapter 58 of the laws of 2008, is amended to read as follows:

1. sections 2807-c, 2807-j, 2807-s, and 2807-t of the public health law, as amended by this act, shall expire on December 31, [2011] 2014, and shall be thereafter effective only in respect to any act done before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as amended or added by this act, related to patient services provided before December 31, [2011] 2014, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 3. Paragraph (a) of subdivision 9 of section 2807-j of the public health law, as amended by section 2 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) funds shall be deposited and credited to a special revenue-other fund to be established by the comptroller or to the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable. To the extent of funds appropriated therefore, the commissioner shall make payments to general hospitals related to bad debt and charity care pursuant to section twenty-eight hundred seven-k of this article. Funds shall be deposited in the following amounts:

(i) fifty-seven and thirty-three-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) fifty-seven and one-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) fifty-five and thirty-two-hundredths percent of the funds accumulated for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand [ten] THIRTEEN, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN.

S 4. Section 34 of part A3 of chapter 62 of the laws of 2003, amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, as amended by section 3 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

S 34. (1) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated pursuant to section 2807-v of the public health law, including income from invested funds, for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by section 2807-v of the public health law.

(2) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated and interest earned through surcharges on payments for health care services pursuant to section 2807-s of the public health law and from assessments pursuant to section 2807-t of the public health law for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by sections 2807-s, 2807-t, and 2807-m of the public health law.

(3) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (a) of subdivision 1 of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the child health insurance plan program authorized pursuant to title 1-A of article 25 of the public health law

into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, child health insurance account, established within the department of health.

(4) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (e) of subdivision 1 of section 2807-l of the public health law for the purpose of payment for administrative costs of the department of health related to the health occupation development and workplace demonstration program established pursuant to section 2807-h and the health workforce retraining program established pursuant to section 2807-g of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health occupation development and workplace demonstration program account, established within the department of health.

(5) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds allocated pursuant to paragraph (j) of subdivision 1 of section 2807-v of the public health law for the purpose of payment for administrative costs of the department of health related to administration of the state's tobacco control programs and cancer services provided pursuant to sections 2807-r and 1399-ii of the public health law into such accounts established within the department of health for such purposes.

(6) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, the funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the programs funded pursuant to section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, pilot health insurance account, established within the department of health.

(7) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of subparagraph (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law from monies accumulated and interest earned in the bad debt and charity care and capital statewide pools through an assessment charged to general hospitals pursuant to the provisions of subdivision 18 of section 2807-c of the public health law and those funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, primary care initiatives account, established within the department of health.

(8) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health care delivery administration account, established within the department of health.

(9) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2011] 2014, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized pursuant to sections 2807-d, 3614-a and 3614-b of the public health law and section 367-i of the social services law and for distribution in accordance with the provisions of subdivision 9 of section 2807-j of the public health law for the purpose of payment for administration of statutory duties for the collections and distributions authorized by sections 2807-c, 2807-d, 2807-j, 2807-k, 2807-l, 3614-a and 3614-b of the public health law and section 367-i of the social services law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, established within the department of health.

S 5. Subparagraphs (xiv) and (xv) of paragraph (a) of subdivision 6 of section 2807-s of the public health law, as amended by section 4 of part I of chapter 2 of the laws of 2009, are amended to read as follows:

(xiv) A gross annual statewide amount for the period January first, two thousand nine through December thirty-first, two thousand [ten] THIRTEEN, shall be nine hundred [thirty-nine] FORTY-FOUR million dollars.

(xv) A gross statewide amount for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN, shall be two hundred [thirty-four] THIRTY-SIX million [seven hundred fifty thousand] dollars.

S 5-a. Subparagraphs (iv) and (v) of paragraph (c) of subdivision 6 of section 2807-s of the public health law, as amended by section 12 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

(iv) A further gross annual statewide amount for two thousand, two thousand one, two thousand two, two thousand three, two thousand four, two thousand five, two thousand six, two thousand seven, two thousand eight, two thousand nine [and], two thousand ten, TWO THOUSAND ELEVEN, TWO THOUSAND TWELVE AND TWO THOUSAND THIRTEEN shall be eighty-nine million dollars.

(v) A further gross statewide amount for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN, shall be twenty-two million two hundred fifty thousand dollars.

S 5-b. Subparagraphs (i) and (ii) of paragraph (e) of subdivision 6 of section 2807-s of the public health law, as amended by section 13 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

(i) A further gross annual statewide amount shall be twelve million dollars for each period prior to January first, two thousand [eleven] FOURTEEN.

(ii) A further gross statewide amount for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN shall be three million dollars.

S 6. Intentionally omitted.

S 7. Section 2807-l of the public health law, as amended by section 4 of part B of chapter 58 of the laws of 2008, clause (A) of subparagraph (i) of paragraph (b) of subdivision 1 as amended by section 51 of part B and paragraph (n) of subdivision 1 as amended by section 9 of part C of chapter 58 of the laws of 2009, subparagraph (iv) of paragraph (c) of subdivision 1 as amended by section 13 of part B of chapter 109 of the laws of 2010, is amended to read as follows:

S 2807-l. Health care initiatives pool distributions. 1. Funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, or the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following.

(a) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to programs to provide health care coverage for uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter from the respective health care initiatives pools established for the following periods in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to one hundred twenty million six hundred thousand dollars;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, up to one hundred sixty-four million five hundred thousand dollars;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to one hundred eighty-one million dollars;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand, two hundred seven million dollars;

(v) from the pool for the period January first, two thousand one through December thirty-first, two thousand one, two hundred thirty-five million dollars;

(vi) from the pool for the period January first, two thousand two through December thirty-first, two thousand two, three hundred twenty-four million dollars;

(vii) from the pool for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred fifty million three hundred thousand dollars;

(viii) from the pool for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred sixty million nine hundred thousand dollars;

(ix) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thou-

sand five through December thirty-first, two thousand five, up to one hundred fifty-three million eight hundred thousand dollars;

(x) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to three hundred twenty-five million four hundred thousand dollars;

(xi) from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred twenty-eight million fifty-nine thousand dollars;

(xii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to four hundred fifty-three million six hundred seventy-four thousand dollars annually; [and]

(xiii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, up to one hundred thirteen million four hundred eighteen thousand dollars[.];

(XIV) FROM THE HEALTH CARE REFORM ACT (HCRA) RESOURCES FUND FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO THREE HUNDRED TWENTY-FOUR MILLION SEVEN HUNDRED FORTY-FOUR THOUSAND DOLLARS;

(XV) FROM THE HEALTH CARE REFORM ACT (HCRA) RESOURCES FUND FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, UP TO THREE HUNDRED FORTY-SIX MILLION FOUR HUNDRED FORTY-FOUR THOUSAND DOLLARS; AND

(XVI) FROM THE HEALTH CARE REFORM ACT (HCRA) RESOURCES FUND FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, UP TO THREE HUNDRED SEVENTY MILLION SIX HUNDRED NINETY-FIVE THOUSAND DOLLARS.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions for health insurance programs under the individual subsidy programs established pursuant to the expanded health care coverage act of nineteen hundred eighty-eight as amended, and for evaluation of such programs from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following amounts:

(i) (A) an amount not to exceed six million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine; up to six million dollars for the period January first, two thousand through December thirty-first, two thousand; up to five million dollars for the period January first, two thousand one through December thirty-first, two thousand one; up to four million dollars for the period January first, two thousand two through December thirty-first, two thousand two; up to two million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three; up to one million three hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four; up to six hundred seventy thousand dollars for the period January first, two thousand five through June thirtieth, two thousand five; up to one million three hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven; and up to one million three hundred thousand dollars annually for the period April first, two thousand seven through March thirty-first,

two thousand nine, shall be allocated to individual subsidy programs; and

(B) an amount not to exceed seven million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and four million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, and three million dollars for the period January first, two thousand three through December thirty-first, two thousand three, and two million dollars for the period January first, two thousand four through December thirty-first, two thousand four, and two million dollars for the period January first, two thousand five through June thirtieth, two thousand five shall be allocated to the catastrophic health care expense program.

(ii) Notwithstanding any law to the contrary, the characterizations of the New York state small business health insurance partnership program as in effect prior to June thirtieth, two thousand three, voucher program as in effect prior to December thirty-first, two thousand one, individual subsidy program as in effect prior to June thirtieth, two thousand five, and catastrophic health care expense program, as in effect prior to June thirtieth, two thousand five, may, for the purposes of identifying matching funds for the community health care conversion demonstration project described in a waiver of the provisions of title XIX of the federal social security act granted to the state of New York and dated July fifteenth, nineteen hundred ninety-seven, may continue to be used to characterize the insurance programs in sections four thousand three hundred twenty-one-a, four thousand three hundred twenty-two-a, four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law, which are successor programs to these programs.

(c) Up to seventy-eight million dollars shall be reserved and accumulated from year to year from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, for purposes of public health programs, up to seventy-six million dollars shall be reserved and accumulated from year to year from the pools for the periods January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to eighty-four million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand through December thirty-first, two thousand, up to eighty-five million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand one through December thirty-first, two thousand one, up to eighty-six million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand two through December thirty-first, two thousand two, up to eighty-six million one hundred fifty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand three through December thirty-first, two thousand three, up to fifty-eight million seven hundred eighty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand four through December thirty-first, two thousand four, up to sixty-eight million seven hundred thirty thousand dollars shall be reserved and accumulated from year to year from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five

through December thirty-first, two thousand five, up to ninety-four million three hundred fifty thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to seventy million nine hundred thirty-nine thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to fifty-five million six hundred eighty-nine thousand dollars annually shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, [and] up to thirteen million nine hundred twenty-two thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, UP TO FUNDING AMOUNTS SPECIFIED BELOW and shall be available, including income from invested funds, for:

(i) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, hospital based grants program account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of services and expenses related to general hospital based grant programs, up to twenty-two million dollars annually from the nineteen hundred ninety-seven pool, nineteen hundred ninety-eight pool, nineteen hundred ninety-nine pool, two thousand pool, two thousand one pool and two thousand two pool, respectively, up to twenty-two million dollars from the two thousand three pool, up to ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to eleven million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty-two million ninety-seven thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, [and] up to five million five hundred twenty-four thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, UP TO THIRTEEN MILLION FOUR HUNDRED FORTY-FIVE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, AND UP TO THIRTEEN MILLION THREE HUNDRED SEVENTY-FIVE THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN;

(ii) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the emergency medical services training account established in section ninety-seven-q of the state finance law or the health care reform act (HCRA) resources fund, whichever is applicable, up to sixteen million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to twenty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to twenty-one million dollars for the period

January first, two thousand one through December thirty-first, two thousand one, up to twenty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to twenty-two million five hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million six hundred eighty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million one hundred thirty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-four million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty million four hundred ninety-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, [and] up to five million one hundred twenty-three thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, UP TO EIGHTEEN MILLION THREE HUNDRED FIFTY THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO EIGHTEEN MILLION NINE HUNDRED FIFTY THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND UP TO NINETEEN MILLION FOUR HUNDRED NINETEEN THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN;

(iii) priority distributions by the commissioner up to thirty-two million dollars on an annualized basis for the period January first, two thousand through December thirty-first, two thousand four, up to thirty-eight million dollars on an annualized basis for the period January first, two thousand five through December thirty-first, two thousand six, up to eighteen million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to three million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, [and] up to seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO TWO MILLION NINE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN to be allocated (A) for the purposes established pursuant to subparagraph (ii) of paragraph (f) of subdivision nineteen of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six and as may thereafter be amended, up to fifteen million dollars annually for the periods January first, two thousand through December thirty-first, two thousand four, up to twenty-one million dollars annually for the period January first, two thousand five through December thirty-first, two thousand six, and up to seven million five hundred thousand dollars for the period January first, two thousand seven through March thirty-first, two thousand seven;

(B) pursuant to a memorandum of understanding entered into by the commissioner, the majority leader of the senate and the speaker of the assembly, for the purposes outlined in such memorandum upon the recommendation of the majority leader of the senate, up to eight million five hundred thousand dollars annually for the period January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and for

the purposes outlined in such memorandum upon the recommendation of the speaker of the assembly, up to eight million five hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven; and

(C) for services and expenses, including grants, related to emergency assistance distributions as designated by the commissioner. Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other contrary provision of law, such distributions shall be limited to providers or programs where, as determined by the commissioner, emergency assistance is vital to protect the life or safety of patients, to ensure the retention of facility caregivers or other staff, or in instances where health facility operations are jeopardized, or where the public health is jeopardized or other emergency situations exist, up to three million dollars annually for the period April first, two thousand seven through March thirty-first, two thousand eleven, AND UP TO TWO MILLION NINE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN. Upon any distribution of such funds, the commissioner shall immediately notify the chair and ranking minority member of the senate finance committee, the assembly ways and means committee, the senate committee on health, and the assembly committee on health;

(iv) distributions by the commissioner related to poison control centers pursuant to subdivision seven of section twenty-five hundred-d of this chapter, up to five million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to three million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-nine, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four million six hundred thousand dollars annually for the periods January first, two thousand three through December thirty-first, two thousand four, up to five million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to five million one hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand nine, up to three million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, [and] up to seven hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO TWO MILLION FIVE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN; and

(v) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, miscellaneous special revenue fund - 339 maternal and child HIV services account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of a special program for HIV services for [infants and pregnant] women AND CHILDREN, INCLUDING ADOLESCENTS pursuant to section [seventy-one of chapter seven hundred thirty-one of the laws of nineteen hundred ninety-three, amend-

ing] TWENTY-FIVE HUNDRED-F-ONE OF the public health law [and other laws relating to reimbursement, delivery and capital costs of ambulatory health care services and inpatient hospital services], up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to two million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to two million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to five million dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, [and] up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO FIVE MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN;

(d) (i) An amount of up to twenty million dollars annually for the period January first, two thousand through December thirty-first, two thousand six, up to ten million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, up to twenty million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, [and] up to five million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO NINETEEN MILLION SIX HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, shall be transferred to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article;

(ii) provided, however, amounts transferred pursuant to subparagraph (i) of this paragraph may be reduced in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the health facility restructuring program.

(e) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to organizations to support the health workforce retraining program established pursuant to section twenty-eight hundred seven-g of this article from the respective health care initiatives pools established for the following periods in the following amounts from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to fifty million dollars on an annualized basis, up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to fifty million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand four through

December thirty-first, two thousand four, up to fifty-eight million three hundred sixty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to fifty-two million three hundred sixty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to thirty-five million four hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten [and], up to eight million eight hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO TWENTY-EIGHT MILLION FOUR HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, less the amount of funds available for allocations for rate adjustments for workforce training programs for payments by state governmental agencies for inpatient hospital services.

(f) Funds shall be accumulated and transferred from as follows:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, (A) thirty-four million six hundred thousand dollars shall be transferred to funds reserved and accumulated pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article, and (B) eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iv) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand through December thirty-first, two thousand four, eighty-two million dollars annually, and for the period January first, two thousand five through December thirty-first, two thousand five, eighty-two million dollars, and for the period January first, two thousand six through December thirty-first, two thousand six, eighty-two million dollars, and for the period January first, two thousand seven through December thirty-first, two thousand seven, eighty-two million dollars, and for the period January first, two thousand eight through December thirty-first, two thousand eight, ninety million seven hundred thousand dollars shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account;

(v) from the health care reform act (HCRA) resources fund for the period January first, two thousand nine through December thirty-first, two thousand nine, one hundred eight million nine hundred seventy-five thousand dollars, and for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-six million one hundred thousand dollars, [and] for the period January first, two thousand eleven through March thirty-first, two thousand

eleven, twenty million five hundred thousand dollars, AND FOR EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, ONE HUNDRED FORTY-SIX MILLION FOUR HUNDRED THOUSAND DOLLARS, shall be deposited by the commissioner, and the state comptroller is hereby authorized and directed to receive for deposit, to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account.

(g) Funds shall be transferred to primary health care services pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with former section twenty-eight hundred seven-bb of this article from the respective health care initiatives pools for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, fifteen and eighty-seven-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, fifteen and eighty-seven-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, sixteen and thirteen-hundredths percent.

(h) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for purposes of primary care education and training pursuant to article nine of this chapter from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision and shall be available for distributions as follows:

(i) funds shall be reserved and accumulated:

(A) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(B) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(C) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(ii) funds shall be available for distributions including income from invested funds as follows:

(A) for purposes of the primary care physician loan repayment program in accordance with section nine hundred three of this chapter, up to five million dollars on an annualized basis;

(B) for purposes of the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter, up to two million dollars on an annualized basis;

(C) for purposes of minority participation in medical education grants in accordance with section nine hundred six of this chapter, up to one million dollars on an annualized basis; and

(D) provided, however, that the commissioner may reallocate any funds remaining or unallocated for distributions for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for distributions in accordance with section twenty-nine hundred fifty-two and section twenty-nine hundred fifty-eight of this chapter for rural health care delivery development and rural health care access development, respectively, from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirteen and forty-nine-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirteen and forty-nine-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirteen and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, seventeen million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to fifteen million eight hundred fifty thousand dollars;

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million eight hundred fifty thousand dollars, and for the period January first, two thousand five through December thirty-first, two thousand five, up to nineteen million two hundred thousand dollars, and for the period January first, two thousand six through December thirty-first, two thousand six, up to nineteen million two hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eighteen million one hundred fifty thousand dollars annually, [and] for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million five hundred thirty-eight thousand dollars, AND FOR EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, UP TO SIXTEEN MILLION TWO HUNDRED THOUSAND DOLLARS.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions related to health information and health care quality improvement pursuant to former section twenty-eight hundred seven-n of this article from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent.

(k) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for allocations and distributions in accordance with section twenty-eight hundred seven-p of this article for diagnostic and treatment center uncompensated care from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirty-eight and one-tenth percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirty-eight and one-tenth percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirty-eight and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, forty-eight million dollars annually, and for the period January first, two thousand three through June thirtieth, two thousand three, twenty-four million dollars;

(v) (A) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars, for the period January first, two thousand four through December thirty-first, two thousand six, up to twelve million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand [ten] THIRTEEN, up to forty-eight million dollars annually, and for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN, up to twelve million dollars;

(B) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, an additional seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand [ten] THIRTEEN, an additional seven million five hundred thousand dollars annually, and for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN, an additional one million eight hundred seventy-five thousand dollars, for voluntary non-profit diagnostic and treatment center uncompensated care in accordance with subdivision four-c of section twenty-eight hundred seven-p of this article; and

(vi) funds reserved and accumulated pursuant to this paragraph for periods on and after July first, two thousand three, shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of funding the state share of rate adjustments made pursuant to section twenty-eight hundred seven-p of this article, provided, however, that in the event federal financial participation is not available for rate adjustments made pursuant to

paragraph (b) of subdivision one of section twenty-eight hundred seven-p of this article, funds shall be distributed pursuant to paragraph (a) of subdivision one of section twenty-eight hundred seven-p of this article from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable.

(l) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for transfer to and allocation for services and expenses for the payment of benefits to recipients of drugs under the AIDS drug assistance program (ADAP) - HIV uninsured care program as administered by Health Research Incorporated from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, nine and fifty-two-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, nine and fifty-two-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, nine and sixty-eight-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, up to twelve million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to forty million dollars; and

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the periods January first, two thousand four through December thirty-first, two thousand four, up to fifty-six million dollars, for the period January first, two thousand five through December thirty-first, two thousand six, up to sixty million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to sixty million dollars annually, [and] for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fifteen million dollars, AND EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, UP TO FORTY-TWO MILLION THREE HUNDRED THOUSAND DOLLARS.

(m) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions pursuant to section twenty-eight hundred seven-r of this article for cancer related services from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, seven and ninety-four-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, seven and ninety-four-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand two, up to ten million dollars on an annual basis;

(v) from the pool for the period January first, two thousand three through December thirty-first, two thousand four, up to eight million nine hundred fifty thousand dollars on an annual basis;

(vi) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand six, up to ten million fifty thousand dollars on an annual basis, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to nineteen million dollars annually, and for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million seven hundred fifty thousand dollars.

(n) Funds shall be accumulated and transferred from the health care reform act (HCRA) resources fund as follows: for the period April first, two thousand seven through March thirty-first, two thousand eight, and on an annual basis for the periods April first, two thousand eight through November thirtieth, two thousand nine, funds within amounts appropriated shall be transferred and deposited and credited to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of funding the state share of rate adjustments made to public and voluntary hospitals in accordance with paragraphs (i) and (j) of subdivision one of section twenty-eight hundred seven-c of this article.

2. Notwithstanding any inconsistent provision of law, rule or regulation, any funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, as a result of surcharges, assessments or other obligations during the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, which are unused or uncommitted for distributions pursuant to this section shall be reserved and accumulated from year to year by the commissioner and, within amounts appropriated, transferred and deposited into the special revenue funds - other, miscellaneous special revenue fund - 339, child health insurance account or any successor fund or account, for purposes of distributions to implement the child health insurance program established pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for periods on and after January first, two thousand one; provided, however, funds reserved and accumulated for priority distributions pursuant to subparagraph (iii) of paragraph (c) of subdivision one of this section shall not be transferred and deposited into such account pursuant to this subdivision; and provided further, however, that any unused or uncommitted pool funds accumulated and allocated pursuant to paragraph (j) of subdivision one of this section shall be distributed for purposes of the health information and quality improvement act of 2000.

3. Revenue from distributions pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c

of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 8. Subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, paragraphs (g), (h), (i) and (i-1) as amended by section 5 of part I of chapter 2 of the laws of 2009, subparagraphs (xi) and (xii) of paragraph (j) as amended by section 12, paragraph (jj) as amended by section 10, subparagraph (vii) of paragraph (qq) as amended by section 11 and subparagraph (vii) of paragraph (uu) as amended by section 9 of part B of chapter 109 of the laws of 2010, paragraph (s) as amended by section 8, paragraphs (x) and (y) as amended by section 6, paragraph (kk) as amended by section 124, subparagraph (vi) of paragraph (uu) as amended by section 120, paragraph (xx) as amended by section 10 and paragraphs (ggg) and (hhh) as amended by section 7 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

1. Funds accumulated in the tobacco control and insurance initiatives pool or in the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following:

(a) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of services and expenses related to the toll-free medicaid fraud hotline established pursuant to section one hundred eight of chapter one of the laws of nineteen hundred ninety-nine from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: four hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to four hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to four hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to four hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, [and] up to one hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven AND WITHIN AMOUNTS APPROPRIATED ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of payment of audits or audit contracts necessary to determine payor and provider compliance with requirements set forth in sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article [and hospital compliance with paragraph six of subdivision (a) of section 405.4 of title 10 of the official compilation of codes, rules and regulations of the state of New York in accordance with subdivision nine of section twenty-eight hundred three of this article] from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five million six hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to five million dollars for the period January first, two thousand five through December thirty first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to seven million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and up to eight million three hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, [and] up to two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND UP TO FOURTEEN MILLION SEVEN HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(c) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, enhanced community services account, or any successor fund or account, for mental health services programs for case management services for adults and children; supported housing; home and community based waiver services; family based treatment; family support services; mobile mental health teams; transitional housing; and community oversight, established pursuant to articles seven and forty-one of the mental hygiene law and subdivision nine of section three hundred sixty-six of the social services law; and for comprehensive care centers for eating disorders pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the enhanced community services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law; from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) forty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand, for the

period January first, two thousand through December thirty-first, two thousand;

(ii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand one, for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand two, for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand three, for the period January first, two thousand three through December thirty-first, two thousand three;

(v) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand four, and pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand five, and pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand six, and pursuant to section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) eighty-six million four hundred thousand dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand seven and pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) twenty-two million nine hundred thirteen thousand dollars, plus one hundred twenty-five thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand eight and pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand eight through March thirty-first, two thousand eight.

(d) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two, for administration and marketing costs associated with such program established pursuant to clause (A) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-seven million dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) fifty-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(e) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two for administration and marketing costs associated with such program established pursuant to clause (B) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) thirty million five hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) sixty-six million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(f) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of payment of administrative expenses of the department related to the family health plus program established pursuant to section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five hundred thousand dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand six, five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, [and] one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven AND WITHIN AMOUNTS APPROPRIATED ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN.

(g) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the health maintenance organization direct pay market program established pursuant to sections forty-three hundred twenty-one-a and forty-three hundred twenty-two-a of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-five million dollars for the period January first, two thousand through December thirty-first, two thousand of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(ii) up to thirty-six million dollars for the period January first, two thousand one through December thirty-first, two thousand one of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iii) up to thirty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iv) up to forty million dollars for the period January first, two thousand three through December thirty-first, two thousand three of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(v) up to forty million dollars for the period January first, two thousand four through December thirty-first, two thousand four of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vi) up to forty million dollars for the period January first, two thousand five through December thirty-first, two thousand five of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vii) up to forty million dollars for the period January first, two thousand six through December thirty-first, two thousand six of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(viii) up to forty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law; and

(ix) up to forty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight of which fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law.

(h) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York individual program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to six million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to twenty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iii) up to five million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York group program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(ii) up to seventy-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iii) up to ten million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million six hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to thirty-four million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to fifty-four million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i-1) Notwithstanding the provisions of paragraphs (h) and (i) of this subdivision, the commissioner shall reserve and accumulate up to two million five hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, one million four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, from funds otherwise available for distribution under such paragraphs for the services and expenses related to the pilot program for entertainment industry employees included in subsection (b) of section one thousand one hundred twenty-two of the insurance law, and an additional seven hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, an additional three hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven for services and expenses related to the pilot program for displaced workers included in subsection (c) of section one thousand one hundred twenty-two of the insurance law.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the tobacco use prevention and control program established pursuant to sections thirteen hundred ninety-nine-ii and thirteen hundred ninety-nine-jj of this chapter, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to forty million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to forty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to eighty-one million nine hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(viii) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(ix) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) up to eighty-seven million seven hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(xii) up to twenty-one million four hundred twelve thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XIII) UP TO FIFTY-TWO MILLION ONE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(k) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes of services and expenses related to public health programs, including comprehensive care centers for eating disorders pursuant to THE FORMER section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the health care services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law FOR PERIODS PRIOR TO MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-one million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to forty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to eighty-one million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) one hundred twenty-two million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) one hundred eight million five hundred seventy-five thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) ninety-one million eight hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) one hundred fifty-six million six hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) one hundred fifty-one million four hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the peri-

od January first, two thousand eight through December thirty-first, two thousand eight;

(x) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(xii) twenty-nine million two hundred thirty-seven thousand two hundred fifty dollars, plus an additional one hundred twenty-five thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.];

(XIII) ONE HUNDRED TWENTY MILLION THIRTY-EIGHT THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE; AND

(XIV) ONE HUNDRED NINETEEN MILLION FOUR HUNDRED SEVEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(l) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the personal care and certified home health agency rate or fee increases established pursuant to subdivision three of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-three million two hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-three million two hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) twenty-three million two hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to sixty-five million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to sixty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to sixty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to sixteen million three hundred thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(m) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of services and expenses related to home care workers insurance pilot demonstration programs established pursuant to subdivision two of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million eight hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) three million eight hundred thousand dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) up to three million eight hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) up to three million eight hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) up to three million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) up to three million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to three million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to nine hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(n) Funds shall be transferred by the commissioner and shall be deposited to the credit of the special revenue funds - other, miscellaneous special revenue fund - 339, elderly pharmaceutical insurance coverage program premium account authorized pursuant to the provisions of title three of article two of the elder law, or any successor fund or account, for funding state expenses relating to the program from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one hundred seven million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) one hundred sixty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) three hundred twenty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) four hundred thirty-three million three hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) five hundred four million one hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) five hundred sixty-six million eight hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) six hundred three million one hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) six hundred sixty million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) three hundred sixty-seven million four hundred sixty-three thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) three hundred thirty-four million eight hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) three hundred forty-four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(xii) eighty-seven million seven hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.];

(XIII) ONE HUNDRED FORTY-THREE MILLION ONE HUNDRED FIFTY THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE;

(XIV) ONE HUNDRED TWENTY MILLION NINE HUNDRED FIFTY THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN; AND

(XV) ONE HUNDRED TWENTY-EIGHT MILLION EIGHT HUNDRED FIFTY THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(o) Funds shall be reserved and accumulated and shall be transferred to the Roswell Park Cancer Institute Corporation, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to ninety million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) up to sixty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) up to eighty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-five million two hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(v) seventy-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) seventy-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) ninety-one million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) seventy-eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) seventy-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) seventy-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) seventy-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(xii) nineteen million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XIII) SIXTY-NINE MILLION EIGHT HUNDRED FORTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(p) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, indigent care fund - 068, indigent care account, or any successor fund or account, for purposes of providing a medicaid disproportionate share payment from the high need indigent care adjustment pool established pursuant to section twenty-eight hundred seven-w of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two;

(ii) up to eighty-two million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to eighty-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eighty-two million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eighty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to eighty-two million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to eighty-two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to eighty-two million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to eighty-two million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) up to twenty million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; AND

(XI) UP TO EIGHTY-TWO MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(q) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing distributions to eligible school based health centers established pursuant to section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million dollars annually for the period January first, two thousand through December thirty-first, two thousand two;

(ii) up to seven million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to seven million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to seven million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
(v) up to seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six;
(vi) up to seven million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(vii) up to seven million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
(viii) up to seven million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
(ix) up to seven million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]
(x) up to one million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; AND
(XI) UP TO FIVE MILLION SIX HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.
(r) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions for supplementary medical insurance for Medicare part B premiums, physicians services, outpatient services, medical equipment, supplies and other health services, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:
(i) forty-three million dollars for the period January first, two thousand through December thirty-first, two thousand;
(ii) sixty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;
(iii) sixty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;
(iv) sixty-seven million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;
(v) sixty-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;
(vi) sixty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
(vii) sixty-eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six;
(viii) seventeen million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(ix) sixty-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
(x) sixty-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
(xi) sixty-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]
(xii) seventeen million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND
(XIII) SIXTY-EIGHT MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(s) Funds shall be deposited by the commissioner within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of providing distributions pursuant to paragraphs (s-5), (s-6), (s-7) and (s-8) of subdivision eleven of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) twenty-four million dollars annually for the periods January first, two thousand one through December thirty-first, two thousand two;

(iii) up to twenty-four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iv) up to twenty-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(v) up to twenty-four million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(vi) up to twenty-four million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vii) up to twenty-four million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(viii) up to twenty-four million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(ix) up to twenty-two million dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(t) Funds shall be reserved and accumulated from year to year by the commissioner and shall be made available, including income from invested funds:

(i) For the purpose of making grants to a state owned and operated medical school which does not have a state owned and operated hospital on site and available for teaching purposes. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, such grants shall be made in the amount of up to five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) For the purpose of making grants to medical schools pursuant to section eighty-six-a of chapter one of the laws of nineteen hundred ninety-nine in the sum of up to four million dollars for the period January first, two thousand through December thirty-first, two thousand; and

(iii) The funds disbursed pursuant to subparagraphs (i) and (ii) of this paragraph from the tobacco control and insurance initiatives pool are contingent upon meeting all funding amounts established pursuant to paragraphs (a), (b), (c), (d), (e), (f), (l), (m), (n), (p), (q), (r) and (s) of this subdivision, paragraph (a) of subdivision nine of section twenty-eight hundred seven-j of this article, and paragraphs (a), (i) and (k) of subdivision one of section twenty-eight hundred seven-l of this article.

(u) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state

share of services and expenses related to the nursing home quality improvement demonstration program established pursuant to section twenty-eight hundred eight-d of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to twenty-five million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two, and on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand four;

(ii) up to eighteen million seven hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(iii) up to fifty-six million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(v) Funds shall be transferred by the commissioner and shall be deposited to the credit of the hospital excess liability pool created pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, or any successor fund or account, for purposes of expenses related to the purchase of excess medical malpractice insurance and the cost of administrating the pool, including costs associated with the risk management program established pursuant to section forty-two of part A of chapter one of the laws of two thousand two required by paragraph (a) of subdivision one of section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as may be amended from time to time, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty million dollars or so much as is needed for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to seventy-six million seven hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to sixty-five million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to sixty-five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to one hundred thirteen million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to one hundred thirty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to one hundred thirty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to one hundred thirty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to one hundred thirty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) up to thirty-two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) UP TO ONE HUNDRED TWENTY-SEVEN MILLION FOUR HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(w) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the treatment of breast and cervical cancer pursuant to paragraph (v) of subdivision four of section three hundred sixty-six of the social services law, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four hundred fifty thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two million one hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to two million one hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to two million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to two million one hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million one hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million one hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million one hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million one hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) up to five hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) UP TO TWO MILLION ONE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(x) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public general hospital rates increases for recruitment and retention of health care workers from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-seven million one hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) fifty million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixty-nine million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixty-nine million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) sixty-nine million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) sixty-five million three hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) sixty-one million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) forty-eight million seven hundred twenty-one thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(y) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public general hospitals for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighteen million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) fifty-two million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) fifty-two million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) forty-nine million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) forty-nine million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) twelve million two hundred fifty thousand dollars for the period January first, two thousand nine through March thirty-first, two thousand nine.

Provided, however, amounts pursuant to this paragraph may be reduced in an amount to be approved by the director of the budget to reflect amounts received from the federal government under the state's 1115

waiver which are directed under its terms and conditions to the health workforce recruitment and retention program.

(z) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public residential health care facility rate increases for recruitment and retention of health care workers pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-one million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) thirty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) forty-six million three hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) forty-six million three hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) forty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million nine hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) twelve million three hundred seventy-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) nine million three hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) two million three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(aa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to public residential health care facilities for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven million five hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) sixteen million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) sixteen million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) ten million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) six million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) one million three hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine.

(bb)(i) Funds shall be deposited by the commissioner, within amounts appropriated, and subject to the availability of federal financial participation, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which include a city with a population of over one million persons and computed and distributed in accordance with memorandums of understanding to be entered into between the state of New York and such local social service districts for the purpose of supporting the recruitment and retention of personal care service workers or any worker with direct patient care responsibility, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(A) forty-four million dollars, on an annualized basis, for the period April first, two thousand two through December thirty-first, two thousand two;

(B) seventy-four million dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(C) one hundred four million dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(D) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(E) one hundred thirty-six million dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(F) one hundred thirty-six million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(G) one hundred thirty-six million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(H) one hundred thirty-six million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(I) one hundred thirty-six million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(J) thirty-four million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(K) ONE HUNDRED THIRTY-SIX MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(ii) Adjustments to Medicaid rates made pursuant to this paragraph shall not, in aggregate, exceed the following amounts for the following periods:

(A) for the period April first, two thousand two through December thirty-first, two thousand two, one hundred ten million dollars;

(B) for the period January first, two thousand three through December thirty-first, two thousand three, one hundred eighty-five million dollars;

(C) for the period January first, two thousand four through December thirty-first, two thousand four, two hundred sixty million dollars;

(D) for the period January first, two thousand five through December thirty-first, two thousand five, three hundred forty million dollars;

(E) for the period January first, two thousand six through December thirty-first, two thousand six, three hundred forty million dollars;

(F) for the period January first, two thousand seven through December thirty-first, two thousand seven, three hundred forty million dollars;

(G) for the period January first, two thousand eight through December thirty-first, two thousand eight, three hundred forty million dollars;

(H) for the period January first, two thousand nine through December thirty-first, two thousand nine, three hundred forty million dollars;

(I) for the period January first, two thousand ten through December thirty-first, two thousand ten, three hundred forty million dollars; [and]

(J) for the period January first, two thousand eleven through March thirty-first, two thousand eleven, eighty-five million dollars[.]; AND

(K) FOR EACH STATE FISCAL YEAR WITHIN THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, THREE HUNDRED FORTY MILLION DOLLARS.

(iii) Personal care service providers which have their rates adjusted pursuant to this paragraph shall use such funds for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility only and are prohibited from using such funds for any other purpose. Each such personal care services provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(cc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which shall not include a city with a population of over one million persons for the purpose of supporting the personal care services worker recruitment and retention program as established pursuant to section three hundred sixty-seven-q of the social services law, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(i) two million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) five million six hundred thousand dollars, on an annualized basis, for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eight million four hundred thousand dollars, on an annualized basis, for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand five through December thirty-first, two thousand five;

(v) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eleven million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eleven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eleven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eleven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) two million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) ELEVEN MILLION TWO HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(dd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for physician services from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) eighty-one million two hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighty-five million two hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eighty-five million two hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eighty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) [eight-five] EIGHTY-FIVE million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eighty-five million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eighty-five million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eighty-five million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) twenty-one million three hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) EIGHTY-FIVE MILLION TWO HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(ee) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the free-standing diagnostic and treatment center rate increases for recruitment and retention of health care workers pursuant to subdivision seventeen of section twenty-eight hundred seven of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million two hundred fifty thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) three million two hundred fifty thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) three million two hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) three million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) three million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) three million four hundred thirty-eight thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) two million four hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) three hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ff) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures for disabled persons as authorized pursuant to subparagraphs twelve and thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) one million eight hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) sixteen million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eighteen million seven hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) thirty million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) thirty million six hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) thirty million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) FIFTEEN MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(gg) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (c) of

subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to one million three hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to three million two hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to five million six hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to eight million six hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight million six hundred thousand dollars on an annualized basis for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to two million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to two million six hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million six hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) up to six hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(hh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue fund - other, HCRA transfer fund, medical assistance account for purposes of providing financial assistance to residential health care facilities pursuant to subdivisions nineteen and twenty-one of section twenty-eight hundred eight of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) for the period April first, two thousand two through December thirty-first, two thousand two, ten million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, nine million four hundred fifty thousand dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, nine million three hundred fifty thousand dollars;

(iv) up to fifteen million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to fifteen million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to fifteen million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to fifteen million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) up to three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) FIFTEEN MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(ii) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for disabled persons as authorized by sections 1619 (a) and (b) of the federal social security act pursuant to the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million four hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

(ii) eight million five hundred thousand dollars, for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) eight million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) eight million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) eight million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) eight million six hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) eight million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; AND

(XI) EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(jj) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purposes of a grant program to improve access to infertility services, treatments and procedures, from the tobacco control and insurance initi-

atives pool established for the period January first, two thousand two through December thirty-first, two thousand two in the amount of nine million one hundred seventy-five thousand dollars, for the period April first, two thousand six through March thirty-first, two thousand seven in the amount of five million dollars, for the period April first, two thousand seven through March thirty-first, two thousand eight in the amount of five million dollars, for the period April first, two thousand eight through March thirty-first, two thousand nine in the amount of five million dollars, and for the period April first, two thousand nine through March thirty-first, two thousand ten in the amount of five million dollars, [and] for the period April first, two thousand ten through March thirty-first, two thousand eleven in the amount of two million two hundred thousand dollars, AND FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE UP TO ONE MILLION ONE HUNDRED THOUSAND DOLLARS.

(kk) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medical Assistance Program expenditures from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) thirty-eight million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) up to two hundred ninety-five million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) up to four hundred seventy-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) up to nine hundred million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) up to eight hundred sixty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to six hundred sixteen million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) up to five hundred seventy-eight million nine hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(viii) within amounts appropriated on and after January first, two thousand nine.

(ll) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of Medicaid expenditures related to the city of New York from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million seven hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

(ii) one hundred twenty-four million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(iii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iv) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(v) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(vii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(x) thirty-one million one hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(XI) ONE HUNDRED TWENTY-FOUR MILLION SEVEN HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(mm) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding specified percentages of the state share of services and expenses related to the family health plus program in accordance with the following schedule:

(i) (A) for the period January first, two thousand three through December thirty-first, two thousand four, one hundred percent of the state share;

(B) for the period January first, two thousand five through December thirty-first, two thousand five, seventy-five percent of the state share; and,

(C) for periods beginning on and after January first, two thousand six, fifty percent of the state share.

(ii) Funding for the family health plus program will include up to five million dollars annually for the period January first, two thousand three through December thirty-first, two thousand six, up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to seven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to seven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to seven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, [and]

up to one million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, UP TO SIX MILLION FORTY-NINE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO SIX MILLION TWO HUNDRED EIGHTY-NINE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND UP TO SIX MILLION FOUR HUNDRED SIXTY-ONE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, for administration and marketing costs associated with such program established pursuant to clauses (A) and (B) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(A) one hundred ninety million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(B) three hundred seventy-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(C) five hundred thirty-eight million four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(D) three hundred eighteen million seven hundred seventy-five thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(E) four hundred eighty-two million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(F) five hundred seventy million twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(G) six hundred ten million seven hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(H) six hundred twenty-seven million two hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(I) one hundred fifty-seven million eight hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.];

(J) SIX HUNDRED TWENTY-EIGHT MILLION FOUR HUNDRED THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE;

(K) SIX HUNDRED FIFTY MILLION FOUR HUNDRED THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN; AND

(L) SIX HUNDRED FIFTY MILLION FOUR HUNDRED THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(nn) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, health care services account, or any successor fund or account, for purposes related to adult home initiatives for medicaid eligible residents of residential facilities

licensed pursuant to section four hundred sixty-b of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four million dollars for the period January first, two thousand three through December thirty-first, two thousand three;

(ii) up to six million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(iii) up to eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(iv) up to eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(v) up to eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(vi) up to two million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(viii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(ix) up to six hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(oo) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (e) of subdivision twenty-five of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to five million dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vii) up to five million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(viii) up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(pp) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the provision of tax credits for long term care insurance pursuant to subdivision one of section one hundred ninety of the tax law, paragraph (a) of subdivision twenty-five-a of section two hundred ten of such law, subsection (aa) of section six hundred six of such law, paragraph one of subsection (k) of section fourteen hundred fifty-six of such law and paragraph one of subdivision (m) of section fifteen hundred eleven of such law, in the following amounts:

(i) ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) ten million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) ten million dollars for the period January first, two thousand six through December thirty-first, two thousand six; and

(iv) five million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

(qq) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the long-term care insurance education and outreach program established pursuant to section two hundred seventeen-a of the elder law for the following periods in the following amounts:

(i) up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care

insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(vi) up to five million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long-term care insurance resource centers with the necessary resources to carry out their operations;

(vii) up to four hundred eighty-eight thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten; of such funds four hundred eighty-eight thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program.

(rr) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and shall be available, including income from invested funds, for the purpose of supporting expenses related to implementation of the provisions of title III of article twenty-nine-D of this chapter, for the following periods and in the following amounts:

(i) up to ten million dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(ii) up to ten million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) up to ten million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) up to ten million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) up to ten million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(vi) up to two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ss) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and used for a health care stabilization program established by the commissioner for the purposes of stabilizing critical health care providers and health care programs whose ability to continue to provide appropriate services are threatened by financial or other challenges, in the amount of up to twenty-eight million dollars for the period July first, two thousand four through June thirtieth, two thousand five. Notwithstanding the provisions of section one hundred twelve of the state finance law or any other inconsistent provision of the state finance law or any other law, funds available for distribution pursuant to this paragraph may be allocated and distributed by the commissioner, or the state comptroller as applicable without a competitive bid or request for proposal process. Considerations relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (i) the importance of the provider or program in meeting critical health care needs in the community in which it operates; (ii) the provider or program provision of care to under-served populations; (iii) the quality of the care or services the provider or program delivers; (iv) the ability of the provider or program to continue to deliver an appropriate level of care or services if additional funding is made available; (v) the ability of the provider or program to access, in a timely manner, alternative sources of funding, including other sources of government funding; (vi) the ability of other providers or programs in the community to meet the community health care needs; (vii) whether the provider or program has an appropriate plan to improve its financial condition; and (viii) whether additional funding would permit the provider or program to consolidate, relocate, or close programs or services where such actions would result in greater stability and efficiency in the delivery of needed health care services or programs.

(tt) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing grants for two long term care demonstration projects designed to test new models for the delivery of long term care services established pursuant to section twenty-eight hundred seven-x of this chapter, for the following periods and in the following amounts:

(i) up to five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(ii) up to five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iv) up to one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(v) up to two hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(uu) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting disease management and telemedicine demonstration programs authorized pursuant to [sections] SECTION twenty-one hundred eleven [and thirty-six hundred twenty-one] of this chapter[, respectively,] for the following periods in the following amounts:

(i) five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(ii) five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iii) nine million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(iv) nine million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and one million dollars shall be available for telemedicine demonstration programs;

(v) nine million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(vi) seven million eight hundred thirty-three thousand three hundred thirty-three dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and three hundred thirty-three thousand three hundred thirty-three dollars shall be available for telemedicine demonstration programs for the period January first, two thousand nine through March first, two thousand nine;

(vii) one million eight hundred seventy-five thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten shall be available for disease management demonstration programs.

(ww) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for recruitment and retention of health care workers pursuant to paragraph (e) of subdivision thirty of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) sixty million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(ii) sixty million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(xx) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the general hospital rates increases for rural hospitals pursuant to subdivision thirty-two of section twenty-eight hundred seven-c of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) three million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) three million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(iii) three million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iv) three million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; and

(v) three million two hundred eight thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(yy) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated and notwithstanding section one hundred twelve of the state finance law and any other contrary provision of law, for the purpose of supporting grants not to exceed five million dollars to be made by the commissioner without a competitive bid or request for proposal process, in support of the delivery of critically needed health care services, to health care providers located in the counties of Erie and Niagara which executed a memorandum of closing and conducted a merger closing in escrow on November twenty-fourth, nineteen hundred ninety-seven and which entered into a settlement dated December thirtieth, two thousand four for a loss on disposal of assets under the provisions of title XVIII of the federal social security act applicable to mergers occurring prior to December first, nineteen hundred ninety-seven.

(zz) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated, for the purpose of supporting expenditures authorized pursuant to section twenty-eight hundred eighteen of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(ii) one hundred eight million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iii) one hundred seventy-one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iv) one hundred seventy-one million five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(v) one hundred twenty-eight million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(vi) one hundred thirty-one million three hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(vii) thirty-four million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.];

(VIII) FOUR HUNDRED THIRTY-THREE MILLION THREE HUNDRED SIXTY-SIX THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE;

(IX) ONE HUNDRED FIFTY MILLION EIGHT HUNDRED SIX THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN; AND

(X) SEVENTY-EIGHT MILLION SEVENTY-ONE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(aaa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for services and expenses related to school based health centers, in an amount up to three million five hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million five hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million five hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, [and] up to three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven, AND UP TO TWO MILLION EIGHT HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN. The total amount of funds provided herein shall be distributed as grants based on the ratio of each provider's total enrollment for all sites to the total enrollment of all providers. This formula shall be applied to the total amount provided herein.

(bbb) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of awarding grants to operators of adult homes, enriched housing programs and residences through the enhancing abilities and life experience (EnAbLe) program to provide for the installation, operation and maintenance of air conditioning in resident rooms, consistent with this paragraph, in an amount up to two million dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million eight hundred thousand dollars for the period April

first, two thousand seven through March thirty-first, two thousand eight, up to three million eight hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million eight hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, and up to three million eight hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven. Residents shall not be charged utility cost for the use of air conditioners supplied under the EnAbLe program. All such air conditioners must be operated in occupied resident rooms consistent with requirements applicable to common areas.

(ccc) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the rates for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs and managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter for recruitment and retention of health care workers pursuant to subdivisions nine and ten of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-five million dollars for the period June first, two thousand six through December thirty-first, two thousand six;

(ii) fifty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) fifty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(iv) fifty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(v) fifty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; [and]

(vi) twelve million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[.]; AND

(VII) FIFTY MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN.

(ddd) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for the deposit to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of increases in the medical assistance rates for providers for purposes of enhancing the provision, quality and/or efficiency of home care services pursuant to subdivision eleven of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following period in the amount of eight million dollars for the period April first, two thousand six through December thirty-first, two thousand six.

(eee) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, to the Center for Functional Genomics at the State University of New York at Albany,

for the purposes of the Adirondack network for cancer education and research in rural communities grant program to improve access to health care and shall be made available from the tobacco control and insurance initiatives pool established for the following period in the amount of up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(fff) Funds shall be made available to the empire state stem cell fund established by section ninety-nine-p of the state finance law from the public asset as defined in section four thousand three hundred one of the insurance law and accumulated from the conversion of one or more article forty-three corporations and its or their not-for-profit subsidiaries occurring on or after January first, two thousand seven. Such funds shall be made available within amounts appropriated up to fifty million dollars annually and shall not exceed five hundred million dollars in total.

(ggg) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for hospital translation services as authorized pursuant to paragraph (k) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) sixteen million dollars for the period July first, two thousand eight through December thirty-first, two thousand eight; and

(ii) fourteen million seven hundred thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(hhh) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue fund - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for the purpose of supporting the state share of Medicaid expenditures for adjustments to inpatient rates of payment for general hospitals located in the counties of Nassau and Suffolk as authorized pursuant to paragraph (l) of subdivision one of section twenty-eight hundred seven-c of this article from the tobacco control and initiatives pool established for the following periods in the following amounts:

(i) two million five hundred thousand dollars for the period April first, two thousand eight through December thirty-first, two thousand eight; and

(ii) two million two hundred ninety-two thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

S 9. Subdivision 3 of section 1680-j of the public authorities law, as amended by section 34 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA) resources fund (061) to the general fund, upon the request of the director of the budget, up to $6,500,000 on or before March 31, 2006, and the comptroller is further hereby authorized and directed to transfer from

the healthcare reform act (HCRA); Resources fund (061) to the Capital Projects Fund, upon the request of the director of budget, up to $139,000,000 for the period April 1, 2006 through March 31, 2007, up to $171,100,000 for the period April 1, 2007 through March 31, 2008, up to $208,100,000 for the period April 1, 2008 through March 31, 2009, up to $151,600,000 for the period April 1, 2009 through March 31, 2010, [and] up to [$238,000,000] $215,743,000 for the period April 1, 2010 through March 31, 2011, UP TO $433,366,000 FOR THE PERIOD APRIL 1, 2011 THROUGH MARCH 31, 2012, UP TO $150,806,000 FOR THE PERIOD APRIL 1, 2012 THROUGH MARCH 31, 2013, UP TO $78,071,000 FOR THE PERIOD APRIL 1, 2013 THROUGH MARCH 31, 2014, AND UP TO $86,005,000 FOR THE PERIOD APRIL 1, 2014 THROUGH MARCH 31, 2015.

S 10. Paragraph (a) of subdivision 12 of section 367-b of the social services law, as amended by section 8 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through March thirty-first two thousand [eleven] FOURTEEN, by such hospitals which elect to participate in the system.

S 11. Section 2 of chapter 600 of the laws of 1986, amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, as amended by section 9 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

S 2. This act shall take effect immediately, except that this act shall expire and be of no further force and effect on and after April 1, [2011] 2014; provided, however, that the commissioner of health shall submit a report to the governor and the legislature detailing the objective, impact, design and computation of any pilot reimbursement program established pursuant to this act, on or before March 31, 1994 and annually thereafter. Such report shall include an assessment of the financial impact of such payment system on providers, as well as the impact of such system on access to care.

S 12. Paragraph (i) of subdivision (b) of section 1 of chapter 520 of the laws of 1978, relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, as amended by section 11 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(i) oversight and evaluation of the inpatient financing system in place for 1988 through March 31, [2011] 2014, and the appropriateness and effectiveness of the bad debt and charity care financing provisions;

S 13. The opening paragraph of section 2952 of the public health law, as amended by section 21 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

To the extent of funds available therefor, the sum of seven million dollars shall annually be available for periods prior to January first, two thousand three, and up to six million five hundred thirty thousand dollars annually for the period January first, two thousand three through December thirty-first, two thousand four, up to seven million sixty-two thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to seven million sixty-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, [and] up to one million seven hundred sixty-six thousand dollars

for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND WITHIN AMOUNTS APPROPRIATED FOR EACH STATE FISCAL YEAR ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, shall be available to the commissioner from funds made available pursuant to section twenty-eight hundred seven-l of this chapter for grants pursuant to this section.

S 14. Subdivision 1 of section 2958 of the public health law, as amended by section 22 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

1. To the extent of funds available therefor, the sum of ten million dollars shall annually be made available for periods prior to January first, two thousand three, and up to nine million three hundred twenty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million three hundred twenty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million eighty-eight thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twelve million eighty-eight thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to eleven million eighty-eight thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, [and] up to two million seven hundred seventy-two thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND WITHIN AMOUNTS APPROPRIATED FOR EACH STATE FISCAL YEAR ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, shall be available to the commissioner from funds pursuant to section twenty-eight hundred seven-l of this chapter to provide assistance to general hospitals classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of title XVIII of the federal social security act (Medicare) or under state regulations, in recognition of the unique costs incurred by these facilities to provide hospital services in remote or sparsely populated areas pursuant to subdivision two of this section.

S 15. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 23 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) The superintendent of insurance and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision [(5)] 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph [(1)] 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of insurance for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July

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

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

S 16. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 24 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

(b) The superintendent of insurance shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July

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

S 17. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 25 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision [(5)] 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002

to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010 [and], during the period July 1, 2010 to June 30, 2011, DURING THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, DURING THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, AND DURING THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 allocated or reallocated in accordance with paragraph (a) of subdivision [(4-a)] 4-A of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, OR COVERING THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, OR COVERING THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, OR COVERING THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of insurance.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering

the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, OR COVERING THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, OR COVERING THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, OR COVERING THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of insurance pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of insurance and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, OR COVERING THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, OR COVERING THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, OR COVERING THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the

period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, AND TO THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, AND TO THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, AND TO THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, AND COVERING THE PERIOD JULY 1, 2011 TO JUNE 30, 2012, AND COVERING THE PERIOD JULY 1, 2012 TO JUNE 30, 2013, AND COVERING THE PERIOD JULY 1, 2013 TO JUNE 30, 2014 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

S 18. 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 chapter 216 of the laws of 2009, is amended to read as follows:

S 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2011] 2014; 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, [2011] 2014, 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, [2011] 2014 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.

S 19. Subsection (c) of section 2343 of the insurance law, as amended by section 27 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(c) Notwithstanding any other provision of this chapter, no application for an order of rehabilitation or liquidation of a domestic insurer whose primary liability arises from the business of medical malpractice insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter, shall be made on the grounds specified in subsection (a) or (c) of section seven thousand four hundred two of this chapter at any time prior to June thirtieth, two thousand [eleven] FOURTEEN.

S 20. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 20 of the laws of 2001 amending the military law and other laws relating to making appropriations for the support of government, as amended by section 28 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

S 5. The superintendent of insurance and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, [and] June 15, 2011, JUNE 15, 2012, JUNE 15, 2013, AND JUNE 15, 2014, the amount of funds available in the hospital

excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, OR JULY 1, 2011 TO JUNE 30, 2012, OR JULY 1, 2012 TO JUNE 30, 2013, OR JULY 1, 2013 TO JUNE 30, 2014, as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of insurance and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, OR JULY 1, 2011 TO JUNE 30, 2012, OR JULY 1, 2012 TO JUNE 30, 2013, OR JULY 1, 2013 TO JUNE 30, 2014, as applicable.

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

S 21. Section 18 of chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, as amended by section 64 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 18. This act shall take effect immediately, except that sections six, nine, ten and eleven of this act shall take effect on the sixtieth day after it shall have become a law, sections two, three, four and nine of this act shall expire and be of no further force or effect on or after March 31, [2012] 2014, section two of this act shall take effect on April 1, 1985 or seventy-five days following the submission of the report required by section one of this act, whichever is later, and sections eleven and thirteen of this act shall expire and be of no further force or effect on or after March 31, 1988.

S 22. Paragraphs (i) and (j) of subdivision 1 of section 367-q of the social services law, as added by section 22-d of part B of chapter 58 of

the laws of 2008, are amended and three new paragraphs (k), (l) and (m) are added to read as follows:

(i) for the period April first, two thousand nine through March thirty-first, two thousand ten, twenty-eight million five hundred thousand dollars; [and]

(j) for the period April first, two thousand ten through March thirty-first, two thousand eleven, twenty-eight million five hundred thousand dollars[.];

(K) FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS;

(L) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS; AND

(M) FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS.

S 23. Paragraph (f) of subdivision 9 of section 3614 of the public health law, as added by section 22-e of part B of chapter 58 of the laws of 2008, is amended and three new paragraphs (g), (h) and (i) are added to read as follows:

(f) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to one hundred million dollars[.];

(G) FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO ONE HUNDRED MILLION DOLLARS;

(H) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, UP TO ONE HUNDRED MILLION DOLLARS;

(I) FOR THE PERIOD APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, UP TO ONE HUNDRED MILLION DOLLARS.

S 24. Paragraph (a) of subdivision 10 of section 3614 of the public health law, as amended by section 5 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health agency's, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most [recent] RECENTLY AVAILABLE cost report as submitted to the department [prior to November first, two thousand five] or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation.

S 25. Section 4 of chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, as amended by section 29 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

S 4. This act shall take effect on the sixtieth day after it shall have become a law; provided, however, that this act shall remain in effect until July 1, [2011] 2014 when upon such date the provisions of this act shall expire and be deemed repealed; provided, further, that a displaced worker shall be eligible for continuation assistance retroactive to July 1, 2004.

S 26. The opening paragraph and clauses (C), (D) and (G) of subparagraph (i) of paragraph (b) and paragraphs (c), (d), (e), (f) and (g) of

subdivision 5-a of section 2807-m of the public health law, the opening paragraph and clauses (C), (D) and (G) of subparagraph (i) of paragraph (b) as amended by section 4 of part B of chapter 109 of the laws of 2010, paragraphs (c), (f) and (g) and the opening paragraphs of paragraphs (d) and (e) as amended by section 98 of part C of chapter 58 of the laws of 2009 and paragraphs (d) and (e) as added by section 75-c of part C of chapter 58 of the laws of 2008, are amended to read as follows:

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, AND 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, through March thirty-first, two thousand eleven, 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:

(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 [thirty percent of the funding available pursuant to] THE TOTAL AMOUNT APPROPRIATED FOR PURPOSES OF this paragraph, [or an amount equal to the sum of one clinical research position per teaching general hospital in the region, whichever is greater,] 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 [thirty percent of the regional pool, or an amount equal to the sum of one clinical research position per teaching general hospital in the region, whichever is greater] 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 [reduction] METHODOLOGY.

(D) Each consortium or teaching general hospital shall receive [fifty percent of its annual distribution amount calculated pursuant to this subparagraph once the requirements set forth in clause (G) of this subparagraph have been met. The remaining distribution amount shall be disbursed subsequent to the submission of information required pursuant to clause (G) of this subparagraph] ITS ANNUAL DISTRIBUTION AMOUNT IN ACCORDANCE WITH THE FOLLOWING:

(I) EACH CONSORTIUM OR TEACHING GENERAL HOSPITAL WITH A ONE-YEAR ECRIP AWARD SHALL RECEIVE ITS ANNUAL DISTRIBUTION AMOUNT IN FULL UPON

COMPLETION OF THE REQUIREMENTS SET FORTH IN ITEMS (I) AND (II) OF CLAUSE (G) OF THIS SUBPARAGRAPH. THE REQUIREMENTS SET FORTH IN ITEMS (IV) AND (V) OF CLAUSE (G) OF THIS SUBPARAGRAPH MUST BE COMPLETED BY THE CONSORTIUM OR TEACHING GENERAL HOSPITAL IN ORDER FOR THE CONSORTIUM OR TEACHING GENERAL HOSPITAL TO BE ELIGIBLE TO APPLY FOR ECRIP FUNDING IN ANY SUBSEQUENT FUNDING CYCLE.

(II) EACH CONSORTIUM OR TEACHING GENERAL HOSPITAL WITH A TWO-YEAR ECRIP AWARD SHALL RECEIVE ITS FIRST ANNUAL DISTRIBUTION AMOUNT IN FULL UPON COMPLETION OF THE REQUIREMENTS SET FORTH IN ITEMS (I) AND (II) OF CLAUSE (G) OF THIS SUBPARAGRAPH. EACH CONSORTIUM OR TEACHING GENERAL HOSPITAL WILL RECEIVE ITS SECOND ANNUAL DISTRIBUTION AMOUNT IN FULL UPON COMPLETION OF THE REQUIREMENTS SET FORTH IN ITEM (III) OF CLAUSE (G) OF THIS SUBPARAGRAPH. THE REQUIREMENTS SET FORTH IN ITEMS (IV) AND (V) OF CLAUSE (G) OF THIS SUBPARAGRAPH MUST BE COMPLETED BY THE CONSORTIUM OR TEACHING GENERAL HOSPITAL IN ORDER FOR THE CONSORTIUM OR TEACHING GENERAL HOSPITAL TO BE ELIGIBLE TO APPLY FOR ECRIP FUNDING IN ANY SUBSEQUENT FUNDING CYCLE.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided [six months after the clinical research position has commenced and every six months thereafter for a full-time position and for a half-time position, one year after the clinical research position has commenced and every year thereafter] 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.

(c) 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, [and] one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND 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, 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.

(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, [and] four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND 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, 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. 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 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.

(e) 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, [and] one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND 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, 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. 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 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.

(f) 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, [and] one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND FIVE HUNDRED SIXTEEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, 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, [and] four hundred ninety thousand dollars for the period January first,

two thousand eleven through March thirty-first, two thousand eleven, AND 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, 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.

S 26-a. Subdivision 7 of section 2807-m of the public health law, as amended by section 99 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

7. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, up to one million dollars for the period January first, two thousand through December thirty-first, two thousand, one million six hundred thousand dollars annually for the periods January first, two thousand one through December thirty-first, two thousand eight, one million five hundred thousand dollars annually for the periods January first, two thousand nine through December thirty-first, two thousand ten, [and] three hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND ONE MILLION THREE HUNDRED TWENTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, 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 New York state area health education center program for the purpose of expanding community-based training of medical students. In addition, one million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, [and] two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, AND EIGHT HUNDRED EIGHTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, 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 New York state area health education center program for the purpose of post-secondary training of health care professionals who will achieve specific program outcomes within the New York state area health education center program. The New York state area health education center program shall report to the commissioner on an annual basis regarding the use of funds for each purpose in such form and manner as specified by the commissioner.

S 27. Subdivision 4-c of section 2807-p of the public health law, as amended by section 13-c of Part C of chapter 58 of the laws of 2009, 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 thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven, seven million five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight, seven million five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine, fifteen million five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten, seven million five hundred thousand dollars, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND ELEVEN THOUGH DECEMBER THIRTY-FIRST, TWO THOUSAND ELEVEN, SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND TWELVE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TWELVE, SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND THIRTEEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS, and for the period January first, two thousand [eleven] FOURTEEN through March thirty-first, two thousand [eleven] FOURTEEN, in the amount of one million eight hundred seventy-five thousand dollars, provided, however, that for periods on and after January first, two thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

S 28. Subdivision 3 and paragraph (a) of subdivision 4 of section 2807-k of the public health law, as amended by section 15 of part C of chapter 58 of the laws of 2010, are amended to read as follows:

3. Each major public general hospital shall be allocated for distribution from the pools established pursuant to this section for each year through December thirty-first, two thousand [eleven] FOURTEEN, an amount equal to the amount allocated to such major public general hospital from the regional pool established pursuant to subdivision seventeen of section twenty-eight hundred seven-c of this article for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

(a) From funds in the pool for each year, thirty-six million dollars shall be reserved on an annual basis through December thirty-first, two thousand [eleven] FOURTEEN, for distribution as high need adjustments in accordance with subdivision six of this section, provided, however, that payments on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of this section.

S 29. The opening paragraph, paragraph (a) of subdivision 1 and subdivision 2 of section 2807-w of the public health law, as amended by section 14 of part C of chapter 58 of the laws of 2010, are amended to read as follows:

Funds allocated pursuant to paragraph (p) of subdivision one of section twenty-eight hundred seven-v of this article, shall be deposited as authorized and used for the purpose of making medicaid disproportionate share payments of up to eighty-two million dollars on an annualized basis pursuant to subdivision twenty-one of section twenty-eight hundred seven-c of this article, for the period January first, two thousand through March thirty-first, two thousand [eleven] FOURTEEN, in accordance with the following:

(a) Each eligible rural hospital shall receive one hundred forty thousand dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand [eleven] FOURTEEN, provided as a disproportionate share payment; provided, however, that if such payment pursuant to this paragraph exceeds a hospital's applicable disproportionate share limit, then the total amount in excess of such limit shall be provided as a nondisproportionate share payment in the form of a grant directly from this pool without allocation to the special revenue funds - other, indigent care fund - 068, or any successor fund or account, and provided further that payments for periods on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of section twenty-eight hundred seven-k of this article;

2. From the funds in the pool each year, thirty-six million dollars on an annualized basis for the periods January first, two thousand through December thirty-first, two thousand [eleven] FOURTEEN, of the funds not distributed in accordance with subdivision one of this section, shall be distributed in accordance with the formula set forth in subdivision six of section twenty-eight hundred seven-k of this article, provided, however, that payments for periods on and after January first, two thousand nine shall be subject to the provisions of subdivision five-a of section twenty-eight hundred seven-k of this article.

S 30. Subparagraph (v) of paragraph (a) of subdivision 3 of section 2807-j of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

(v) revenue received from physician practice or faculty practice plan discrete billings for [private practicing] physician services;

S 31. Clause (D) of subparagraph (ii) of paragraph (b) of subdivision 3 of section 2807-j of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

(D) revenue received from physician practice or faculty practice plan discrete billings for [private practicing] physician services;

S 32. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 33. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 34. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgement shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgement shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 35. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011, provided that:

(a) any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law;

(b) this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act;

(c) the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

(d) notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

(e) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act;

(f) the amendments to sections 2807-j and 2807-s of the public health law made by sections three, five, five-a, five-b, six, thirty and thirty-one, respectively, of this act shall not affect the expiration of such sections and shall expire therewith; and

(g) the amendments to paragraph (i-l) of subdivision 1 of section 2807-v of the public health law made by section eight of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith.

PART D

Section 1. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as separately amended by section 11 of part B and section 21 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, addi-

tional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and of up to three hundred million dollars in such aggregate annual additional payments for the state fiscal year beginning April first, two thousand nine, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, AND FOR THE STATE FISCAL YEARS BEGINNING APRIL FIRST, TWO THOUSAND TWELVE AND APRIL FIRST, TWO THOUSAND THIRTEEN. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable.

S 2. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 2 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, [2011] 2013, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled

data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 3. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 14 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

S 11. This act shall take effect immediately and:

(a) sections one and three shall expire on December 31, 1996,

(b) sections four through ten shall expire on June 30, [2011] 2013, and

(c) provided that the amendment to section 2807-b of the public health law by section two of this act shall not affect the expiration of such section 2807-b as otherwise provided by law and shall be deemed to expire therewith.

S 4. Subdivision 2 of section 246 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 section 15 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 AND SECTIONS TWELVE, THIRTEEN AND FOURTEEN

OF THIS ACT SHALL BE DEEMED TO BE IN FULL FORCE AND EFFECT ON AND AFTER APRIL 1, 2011 THROUGH MARCH 31, 2013;

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Paragraphs (a) and (e) of subdivision 8 of section 2807-c of the public health law, paragraph (a) as amended by chapter 731 of the laws of 1993 and paragraph (e) as added by chapter 81 of the laws of 1995, are amended to read as follows:

(a) Capital related inpatient expenses including but not limited to straight line depreciation on buildings and non-movable equipment, accelerated depreciation on major movable equipment if requested by the hospital, rentals and interest on capital debt (or for hospitals financed pursuant to article twenty-eight-B of this chapter, such expenses, including amortization in lieu of depreciation, as determined pursuant to the reimbursement regulations promulgated pursuant to such article and article twenty-eight of this chapter), [and excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare),] shall be included in rates of payment determined pursuant to this section based on a budget for capital related inpatient expenses and subsequently reconciled to actual expenses and statistics through appropriate audit procedures. General hospitals shall submit to the commissioner, at least one hundred twenty days prior to the commencement of each year, a schedule of capital related inpatient expenses for the forthcoming year. Any capital expenditure which requires or required approval pursuant to this article must have received such approval for any capital related expense generated by such capital expenditure to be included in rates of payment. The basis for determining capital related inpatient expenses shall be the lesser of actual cost or the final amount specifically approved for the construction of the capital asset. The submitted budget may include the capital related inpatient expenses for all existing capital assets as well as estimates of capital related inpatient expenses for capital assets to be acquired or placed in use prior to the commencement of the rate year or during the rate year provided all required approvals have been obtained.

The council shall adopt, with the approval of the commissioner, regulations to:

(i) identify by type the eligible capital related inpatient expenses;

(ii) safeguard the future financial viability of voluntary, non-profit general hospitals by requiring funding of inpatient depreciation on building and fixed and movable equipment;

(iii) provide authorization to adjust inpatient rates by advancing payment of depreciation as needed, in instances of capital debt related financial distress of voluntary, non-profit general hospitals; and

(iv) provide a methodology for the reimbursement treatment of sales.

(e) Notwithstanding any inconsistent provision of this subdivision, commencing April first, nineteen hundred ninety-five, when a factor for reconciliation of budgeted capital related inpatient expenses to actual capital related inpatient expenses [excluding costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare)] for a prior year is included in the capital related inpatient expenses component of rates of payment, such capital related inpatient expenses component of rates of payment shall be reduced by the commissioner by the difference between the reconciled capital related inpatient expenses included in rates of payment determined in accordance with paragraphs (a), (b) and (c) of this subdivision for such prior year

and capital related inpatient expenses for such prior year calculated [based on a determination of costs related to services provided to beneficiaries of title XVIII of the federal social security act (medicare)] based on the hospital's average capital related inpatient expenses computed on a per diem basis.

S 8. Paragraph (d) of subdivision 8 of section 2807-c of the public health law is REPEALED.

S 9. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 24 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

S 194. 1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 AND ON AND AFTER APRIL 1, 2011 THROUGH MARCH 31, 2013 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

2. The commissioner of health shall adjust such rates of payment to reflect the exclusion pursuant to this section of such specified trend factor projections or adjustments.

S 10. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 25 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, AND ON AND AFTER APRIL 1, 2011 THROUGH MARCH 31, 2013 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

S 11. Paragraph (f) of subdivision 1 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 section 26 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, [and] February 1, 2011, FEBRUARY 1, 2012, AND FEBRUARY 1, 2013 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 statewide target percentage respectively.

S 12. Subparagraph (ii) of paragraph (b) of subdivision 3 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 section 27 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is 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 [and], 2011, 2012, AND 2013 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 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.

S 13. 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 section 28 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 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 [and], 2011, 2012, AND 2013 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 reduction amount.

S 14. Paragraph (b) of subdivision 5 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 section 29 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 facility specific reduction amounts respectively.

S 14-a. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 30 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

S 228. 1. Definitions. (a) Regions, for purposes of this section, shall mean a downstate region to consist of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region to consist of all other New York state counties. A certified home health agency or long term home health care program shall be located in the same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law.

(b) Certified home health agency (CHHA) shall mean such term as defined in section 3602 of the public health law.

(c) Long term home health care program (LTHHCP) shall mean such term as defined in subdivision 8 of section 3602 of the public health law.

(d) Regional group shall mean all those CHHAs and LTHHCPs, respectively, located within a region.

(e) Medicaid revenue percentage, for purposes of this section, shall mean CHHA and LTHHCP revenues attributable to services provided to persons eligible for payments pursuant to title 11 of article 5 of the social services law divided by such revenues plus CHHA and LTHHCP revenues attributable to services provided to beneficiaries of Title XVIII of the federal social security act (medicare).

(f) Base period, for purposes of this section, shall mean calendar year 1995.

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November

30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 AND THE 2012 TARGET PERIOD SHALL MEAN JANUARY 1, 2012 THROUGH NOVEMBER 30, 2012 AND THE 2013 TARGET PERIOD SHALL MEAN JANUARY 1, 2013 THROUGH NOVEMBER 30, 2013.

2. (a) Prior to February 1, 1997, for each regional group the commissioner of health shall calculate the 1996 medicaid revenue percentages for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate.

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010 [and], prior to February 1, 2011, PRIOR TO FEBRUARY 1, 2012 AND PRIOR TO FEBRUARY 1, 2013 for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

3. By September 15, 1996, for each regional group the commissioner of health shall calculate the base period medicaid revenue percentage.

4. (a) For each regional group, the 1996 target medicaid revenue percentage shall be calculated by subtracting the 1996 medicaid revenue reduction percentages from the base period medicaid revenue percentages. The 1996 medicaid revenue reduction percentage, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPs located within the downstate region; and

(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPs located within the upstate region.

5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

6. (a) For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the reduction factor for a particular year shall be zero, there shall be no state share reduction amount for such year.

(c) For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

(i) one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region;

(ii) five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

(iii) nine hundred fifty-two thousand five hundred dollars ($952,500) for LTHHCPs located within the downstate region; and

(iv) four hundred forty-two thousand five hundred dollars ($442,500) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1999 reduction factor shall be zero, there shall be no 1999 state share reduction amount.

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph (a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

8. (a) The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and LTHHCP and may be recouped by the

state by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

(b) The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010 [and], 2011, 2012, AND 2013 respectively, shall be due to the state from each CHHA and LTHHCP and each year the amount due for such year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

9. CHHAs and LTHHCPs shall submit such data and information at such times as the commissioner of health may require for purposes of this section. The commissioner of health may use data available from third-party payors.

10. On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided in paragraph (a) of subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 of this section. The provider specific state share reduction amount calculated in accordance with this subdivision shall be compared to the 1996 provider specific state share reduction amount calculated in accordance with paragraph (a) of subdivision 7 of this section. Any amount in excess of the amount determined in accordance with paragraph (a) of subdivision 7 of this section shall be due to the state from each CHHA and LTHHCP and may be recouped in accordance with paragraph (a) of subdivision 8 of this section. If the amount is less than the amount determined in accordance with paragraph (a) of subdivision 7 of this section, the difference shall be refunded to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

11. If a CHHA or LTHHCP fails to submit data and information as required for purposes of this section:

(a) such CHHA or LTHHCP shall be presumed to have no decrease in medicaid revenue percentage between the applicable base period and the applicable target period for purposes of the calculations pursuant to this section; and

(b) the commissioner of health shall reduce the current rate paid to such CHHA and such LTHHCP by state governmental agencies pursuant to article 36 of the public health law by one percent for a period beginning on the first day of the calendar month following the applicable due date as established by the commissioner of health and continuing until the last day of the calendar month in which the required data and information are submitted.

12. The commissioner of health shall inform in writing the director of the budget and the chair of the senate finance committee and the chair of the assembly ways and means committee of the results of the calculations pursuant to this section.

S 15. Subdivision 5-a of section 246 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 section 32 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999

and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, AND ON AND AFTER APRIL 1, 2011 THROUGH MARCH 31, 2013;

S 16. Section 64-b 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 section 33 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

S 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, AND ON AND AFTER APRIL 1, 2011 THROUGH MARCH 31, 2013.

S 17. Subdivision 1 of section 20 of chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, as amended by section 38 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [2011] 2013;

S 18. The opening paragraph of subdivision 7-a of section 3614 of the public health law, as amended by section 46 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, AND ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

S 19. Subdivisions 3, 4 and 5 of section 47 of chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, as amended by section 24 of part A of chapter 58 of the laws of 2007, are amended to read as follows:

3. section six of this act shall take effect January 1, 1999; provided, however, that subparagraph (iii) of paragraph (c) of subdivision 9 of section 2510 of the public health law, as added by this act, shall expire on July 1, [2011] 2014;

4. sections two, three, four, seven, eight, nine, fourteen, fifteen, sixteen, eighteen, eighteen-a, twenty-three, twenty-four, and twenty-nine of this act shall take effect January 1, 1999 and shall expire on July 1, [2011] 2014; section twenty-five of this act shall take effect on January 1, 1999 and shall expire on April 1, 2005;

5. section twelve of this act shall take effect January 1, 1999; provided, however, paragraphs (g) and (h) of subdivision 2 of section 2511 of the public health law, as added by such section, shall expire on July 1, [2011] 2014;

S 20. Section 10 of chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, as amended by section 63 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed on March 31, [2012] 2016 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

S 21. 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, is amended to read as follows:

(i-1) section thirty-one-a of this act shall be deemed repealed July 1, [2011] 2014;

S 22. Section 2 of chapter 535 of the laws of 1983, amending the social services law relating to eligibility of certain enrollees for medical assistance, as amended by section 69 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 2. This act shall take effect immediately and shall remain in full force and effect through March 31, [2012] 2016.

S 23. Subdivision 12 of section 246 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 section 56 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

12. Sections one hundred five-b through one hundred five-f of this act shall expire March 31, [2011] 2013.

S 24. Intentionally omitted.

S 25. 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 66 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 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, [2012] 2016, 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.

S 26. 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 67 of part C of chapter 58 of the laws of 2008, 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, [2012] 2015 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;

S 26-a. Subdivision (x) of section 165 of chapter 41 of the laws of 1992, amending the public health law and other laws relating to health care providers, is REPEALED.

S 27. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 28. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 29. 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 judgement shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 30. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011; provided, however, that the amendments to paragraph (e) of subdivision 8 of section 2807-c of the public health law made by section seven of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith.

PART E

Section 1. Section 366 of the social services law is amended by adding a new subdivision 1-b to read as follows:

1-B. NOTWITHSTANDING ANY OTHER PROVISION OF LAW, IN THE EVENT THAT A PERSON WHO IS AN INPATIENT IN AN INSTITUTION FOR MENTAL DISEASES, AS DEFINED BY FEDERAL LAW AND REGULATIONS, AND WHO WAS IN RECEIPT OF MEDICAL ASSISTANCE PURSUANT TO THIS TITLE IMMEDIATELY PRIOR TO BEING

ADMITTED TO SUCH FACILITY, OR WHO WAS DIRECTLY ADMITTED TO SUCH FACILITY AFTER BEING AN INPATIENT IN ANOTHER INSTITUTION FOR MENTAL DISEASES AND WHO WAS IN RECEIPT OF MEDICAL ASSISTANCE PRIOR TO ADMISSION TO SUCH TRANSFERRING INSTITUTION, SUCH PERSON SHALL REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE WHILE AN INPATIENT IN SUCH FACILITY; PROVIDED, HOWEVER, THAT NO MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS TITLE FOR ANY CARE, SERVICES, OR SUPPLIES PROVIDED DURING THE TIME THAT SUCH PERSON IS AN INPATIENT, EXCEPT TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SUCH CARE, SERVICES, OR SUPPLIES. UPON RELEASE FROM SUCH FACILITY, SUCH PERSON SHALL CONTINUE TO BE ELIGIBLE FOR RECEIPT OF MEDICAL ASSISTANCE FURNISHED PURSUANT TO THIS TITLE UNTIL SUCH TIME AS THE PERSON IS DETERMINED TO NO LONGER BE ELIGIBLE FOR RECEIPT OF SUCH ASSISTANCE. TO THE EXTENT PERMITTED BY FEDERAL LAW, THE TIME DURING WHICH SUCH PERSON IS AN INPATIENT IN AN INSTITUTION FOR MENTAL DISEASES SHALL NOT BE INCLUDED IN ANY CALCULATION OF WHEN THE PERSON MUST RECERTIFY HIS OR HER ELIGIBILITY FOR MEDICAL ASSISTANCE IN ACCORDANCE WITH THIS ARTICLE.

S 2. Paragraph (c) of subdivision 1 of section 366 of the social services law, as amended by chapter 355 of the laws of 2007, is amended to read as follows:

(c) except as provided in subparagraph six of paragraph (a) of this subdivision or subdivision one-a OR SUBDIVISION ONE-B of this section, is not an inmate or patient in an institution or facility wherein medical assistance for needy persons may not be provided in accordance with applicable federal or state requirements; and

S 3. This act shall take effect April 1, 2011; provided that all actions necessary for the timely implementation of this act, including revisions to information, eligibility and benefit computer systems utilized by social services districts and administered by the department of health of the state of New York, shall be taken prior to such effective date so that the provisions of this act may be implemented on such date.

PART F

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part F of chapter 111 of the laws of 2010, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [2011] 2012, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [2011] 2012 and ending March 31, [2014] 2015, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

S 2. Section 4 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 2 of part F of chapter 111 of the laws of 2010, is amended to read as follows:

S 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided section one of this act shall expire and be deemed repealed April 1, [2014] 2015; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART G

Section 1. Subdivision (b) of section 7.17 of the mental hygiene law, as amended by section 1 of part J of chapter 58 of the laws of 2005, is amended to read as follows:

(b) There shall be in the office the hospitals named below for the care, treatment and rehabilitation of [the mentally disabled] PERSONS WITH MENTAL ILLNESS and for research and teaching in the science and skills required for the care, treatment and rehabilitation of such [mentally disabled] PERSONS WITH MENTAL ILLNESS.

Greater Binghamton Health Center
Bronx Psychiatric Center
Buffalo Psychiatric Center
Capital District Psychiatric Center
Central New York Psychiatric Center
Creedmoor Psychiatric Center
Elmira Psychiatric Center
Hudson River Psychiatric Center
Kingsboro Psychiatric Center
Kirby Forensic Psychiatric Center
Manhattan Psychiatric Center
Mid-Hudson Forensic Psychiatric Center
Mohawk Valley Psychiatric Center
Nathan S. Kline Institute for Psychiatric Research
New York State Psychiatric Institute
Pilgrim Psychiatric Center
Richard H. Hutchings Psychiatric Center
Rochester Psychiatric Center
Rockland Psychiatric Center
St. Lawrence Psychiatric Center
South Beach Psychiatric Center
Bronx Children's Psychiatric Center
Brooklyn Children's [Psychiatric] Center
Queens Children's Psychiatric Center
Rockland Children's Psychiatric Center
Sagamore Children's Psychiatric Center
Western New York Children's Psychiatric Center

The New York State Psychiatric Institute and The Nathan S. Kline Institute for Psychiatric Research are designated as institutes for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of mental illness. THE BROOKLYN CHILDREN'S CENTER IS A FACILITY OPERATED BY THE OFFICE TO PROVIDE COMMUNITY-BASED MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

S 2. Notwithstanding the provisions of subdivisions (b) and (e) of section 7.17 of the mental hygiene law, section 41.55 of the mental hygiene law, or any other law to the contrary, the office of mental health is authorized in state fiscal year 2011-12 to close, consolidate, reduce, transfer or otherwise redesign services of hospitals, other facilities and programs operated by the office of mental health, and to implement significant service reductions and reconfigurations according to this section as shall be determined by the commissioner of mental health to be necessary for the cost-effective and efficient operation of such hospitals, other facilities and programs.

(a) In addition to the closure, consolidation or merger of one or more facilities, the commissioner of mental health is authorized to perform any significant service reductions that would reduce inpatient bed capacity by up to 600 beds, which shall include but not be limited to closures of wards at a state-operated psychiatric center or the conversion of beds to transitional placement programs, provided that the commissioner provide at least 30 days notice of such reductions to the temporary president of the senate and the speaker of the assembly and simultaneously post such notice upon its public website. In assessing which significant service reductions to undertake, the commissioner shall consider data related to inpatient census, indicating nonutilization or under utilization of beds, and the efficient operation of facilities.

(b) At least sixty days prior to the anticipated closure, consolidation or merger of any hospitals named in subdivision (b) of section 7.17 of the mental hygiene law, the commissioner of mental health shall provide notice of such closure, consolidation or merger to the temporary president of the senate and speaker of the assembly, the chief executive officer of the county in which the facility is located, and shall post such notice upon its public website. The commissioner shall be authorized to conduct any and all preparatory actions which may be required to effectuate such closures during such sixty day period. In assessing which of such hospitals to close, the commissioner shall consider the following factors: (1) the size, scope and type of services provided by the hospital; (2) the current and anticipated long-term need for the types of services provided by the facility within its catchment area, which may include, but not be limited to, services for adults or children, or other specialized services, such as forensic services; (3) the availability of staff sufficient to address the current and anticipated long term service needs; (4) the long term capital investment required to ensure that the facility meets relevant state and federal regulatory and capital construction requirements, and national accreditation standards; (5) the proximity of the facility to other facilities with space that could accommodate anticipated need, the relative cost of any necessary renovations of such space, the relative potential operating efficiency of such facilities, and the size, scope and types of services provided by the other facilities; (6) anticipated savings based upon economies of scale or other factors; (7) community mental health services available in the facility catchment area and the ability of such community mental health services to meet the behavioral health needs of the impacted consumers; and (8) the anticipated impact of the closure on access to mental health services.

(c) Any transfers of inpatient capacity or any resulting transfer of functions shall be authorized to be made by the commissioner of mental health and any transfer of personnel upon such transfer of capacity or

transfer of functions shall be accomplished in accordance with the provisions of section 70 of the civil service law.

S 3. 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.

S 4. This act shall take effect April 1, 2011; provided that section two of this act shall expire and be deemed repealed March 31, 2012.

PART H

Section 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after April 1, 2011, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities that provide services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2011 and 2012 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors for such 2011 and 2012 calendar years shall also be applied to rates of payment for personal care services provided in those local social service districts, including New York City, whose rates of payment for such services are established by such local social service districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after April 1, 2011, trend factors attributable to the 2011 and 2012 calendar years shall be established at no greater than zero percent.

S 2. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2013 through March 31, 2013, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities that provide services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law, by certified home health agencies, long term home

health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2013 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors for such 2013 calendar year shall also be applied to rates of payment for personal care services provided in those local social service districts, including New York city, whose rates of payment for such services are established by such local social service districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social service districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2013 through March 31, 2013, trend factors attributable to the 2013 calendar year shall be established at no greater than zero percent.

S 2-a. Intentionally omitted.

S 3. Section 3614 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, EFFECTIVE ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, RATES OF PAYMENT BY GOVERNMENT AGENCIES FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES, EXCEPT FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND OTHER DISCRETE GROUPS AS MAY BE DETERMINED BY THE COMMISSIONER PURSUANT TO REGULATIONS, SHALL REFLECT CEILING LIMITATIONS DETERMINED IN ACCORDANCE WITH THIS SUBDIVISION, PROVIDED, HOWEVER, THAT AT THE DISCRETION OF THE COMMISSIONER SUCH CEILINGS MAY, AS AN ALTERNATIVE, BE APPLIED TO PAYMENTS FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, EXCEPT FOR SUCH SERVICES PROVIDED TO CHILDREN AND OTHER DISCRETE GROUPS AS MAY BE DETERMINED BY THE COMMISSIONER PURSUANT TO REGULATIONS. IN DETERMINING SUCH PAYMENTS OR RATES OF PAYMENT, AGENCY CEILINGS SHALL BE ESTABLISHED. SUCH CEILINGS SHALL BE APPLIED TO PAYMENTS OR RATES OF PAYMENT FOR CERTIFIED HOME HEALTH AGENCY SERVICES AS ESTABLISHED PURSUANT TO THIS SECTION AND APPLICABLE REGULATIONS. CEILINGS SHALL BE BASED ON A BLEND OF: (I) AN AGENCY'S TWO THOUSAND NINE AVERAGE PER PATIENT MEDICAID CLAIMS, WEIGHTED AT A PERCENTAGE AS DETERMINED BY THE COMMISSIONER; AND (II) THE TWO THOUSAND NINE STATEWIDE AVERAGE PER PATIENT MEDICAID CLAIMS ADJUSTED BY A REGIONAL WAGE INDEX FACTOR AND AN AGENCY PATIENT CASE MIX INDEX, WEIGHTED AT A PERCENTAGE AS DETERMINED BY THE COMMISSIONER. SUCH CEILINGS WILL BE EFFECTIVE APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE. AN INTERIM PAYMENT OR RATE OF PAYMENT ADJUSTMENT EFFECTIVE APRIL FIRST, TWO THOUSAND ELEVEN, SHALL BE APPLIED TO AGENCIES WITH PROJECTED AVERAGE PER PATIENT MEDICAID CLAIMS, AS DETERMINED BY THE COMMISSIONER, TO BE OVER THEIR CEILINGS. SUCH AGENCIES SHALL HAVE THEIR PAYMENTS OR RATES OF PAYMENT REDUCED TO REFLECT THE AMOUNT BY WHICH SUCH CLAIMS EXCEED THEIR CEILINGS.

(B) CEILING LIMITATIONS DETERMINED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE SUBJECT TO RECONCILIATION. IN DETERMINING PAYMENT OR RATE OF PAYMENT ADJUSTMENTS BASED ON SUCH RECONCILIATION, ADJUSTED AGENCY CEILINGS SHALL BE ESTABLISHED. SUCH ADJUSTED CEILINGS SHALL BE BASED ON A BLEND OF: (I) AN AGENCY'S TWO THOUSAND NINE AVERAGE PER PATIENT MEDICAID CLAIMS ADJUSTED BY THE PERCENTAGE OF INCREASE OR DECREASE IN SUCH AGENCY'S PATIENT CASE MIX FROM THE TWO THOUSAND NINE

CALENDAR YEAR TO THE ANNUAL PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, WEIGHTED AT A PERCENTAGE AS DETERMINED BY THE COMMISSIONER; AND (II) THE TWO THOUSAND NINE STATEWIDE AVERAGE PER PATIENT MEDICAID CLAIMS ADJUSTED BY A REGIONAL WAGE INDEX FACTOR AND THE AGENCY'S PATIENT CASE MIX INDEX FOR THE ANNUAL PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, WEIGHTED AT A PERCENTAGE AS DETERMINED BY THE COMMISSIONER. SUCH ADJUSTED AGENCY CEILING SHALL BE COMPARED TO ACTUAL MEDICAID PAID CLAIMS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE. IN THOSE INSTANCES WHEN AN AGENCY'S ACTUAL PER PATIENT MEDICAID CLAIMS ARE DETERMINED TO EXCEED THE AGENCY'S ADJUSTED CEILING, THE AMOUNT OF SUCH EXCESS SHALL BE DUE FROM EACH SUCH AGENCY TO THE STATE AND MAY BE RECOUPED BY THE DEPARTMENT IN A LUMP SUM AMOUNT OR THROUGH REDUCTIONS IN THE MEDICAID PAYMENTS DUE TO THE AGENCY. IN THOSE INSTANCES WHERE AN INTERIM PAYMENT OR RATE OF PAYMENT ADJUSTMENT WAS APPLIED TO AN AGENCY IN ACCORDANCE WITH PARAGRAPH (A) OF THIS SUBDIVISION, AND SUCH AGENCY'S ACTUAL PER PATIENT MEDICAID CLAIMS ARE DETERMINED TO BE LESS THAN THE AGENCY'S ADJUSTED CEILING, THE AMOUNT BY WHICH SUCH MEDICAID CLAIMS ARE LESS THAN THE AGENCY'S ADJUSTED CEILING SHALL BE REMITTED TO EACH SUCH AGENCY BY THE DEPARTMENT IN A LUMP SUM AMOUNT OR THROUGH AN INCREASE IN THE MEDICAID PAYMENTS DUE TO THE AGENCY.

(C) INTERIM PAYMENT OR RATE OF PAYMENT ADJUSTMENTS PURSUANT TO THIS SUBDIVISION SHALL BE BASED ON MEDICAID PAID CLAIMS, AS DETERMINED BY THE COMMISSIONER, FOR SERVICES PROVIDED BY AGENCIES IN THE BASE YEAR TWO THOUSAND NINE. AMOUNTS DUE FROM RECONCILING RATE ADJUSTMENTS SHALL BE BASED ON MEDICAID PAID CLAIMS, AS DETERMINED BY THE COMMISSIONER, FOR SERVICES PROVIDED BY AGENCIES IN THE BASE YEAR TWO THOUSAND NINE AND MEDICAID PAID CLAIMS, AS DETERMINED BY THE COMMISSIONER, FOR SERVICES PROVIDED BY AGENCIES IN THE RECONCILIATION PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE. IN DETERMINING CASE MIX, EACH PATIENT SHALL BE CLASSIFIED USING A SYSTEM BASED ON MEASURES WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, CLINICAL AND FUNCTIONAL MEASURES, AS REPORTED ON THE FEDERAL OUTCOME AND ASSESSMENT INFORMATION SET (OASIS), AS MAY BE AMENDED.

(D) THE COMMISSIONER MAY REQUIRE AGENCIES TO COLLECT AND SUBMIT ANY DATA REQUIRED TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION. THE COMMISSIONER MAY PROMULGATE REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

(E) PAYMENTS OR RATE OF PAYMENT ADJUSTMENTS DETERMINED PURSUANT TO THIS SUBDIVISION SHALL, FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, BE RETROACTIVELY RECONCILED UTILIZING THE METHODOLOGY IN PARAGRAPH (B) OF THIS SUBDIVISION AND UTILIZING ACTUAL PAID CLAIMS FROM SUCH PERIOD.

(F) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION, PAYMENTS OR RATE OF PAYMENT ADJUSTMENTS MADE PURSUANT TO THIS SUBDIVISION SHALL NOT RESULT IN AN AGGREGATE ANNUAL DECREASE IN MEDICAID PAYMENTS TO PROVIDERS SUBJECT TO THIS SUBDIVISION THAT IS IN EXCESS OF TWO HUNDRED MILLION DOLLARS, AS DETERMINED BY THE COMMISSIONER AND NOT SUBJECT TO SUBSEQUENT ADJUSTMENT, AND THE COMMISSIONER SHALL MAKE SUCH ADJUSTMENTS TO SUCH PAYMENTS OR RATES OF PAYMENT AS ARE NECESSARY TO ENSURE THAT SUCH AGGREGATE LIMITS ON PAYMENT DECREASES ARE NOT EXCEEDED.

S 4. Section 3614 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTIC-

IPATION, EFFECTIVE APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, PAYMENTS BY GOVERNMENT AGENCIES FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES, EXCEPT FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND OTHER DISCREET GROUPS AS MAY BE DETERMINED BY THE COMMISSIONER PURSUANT TO REGULATIONS, SHALL BE BASED ON EPISODIC PAYMENTS. IN ESTABLISHING SUCH PAYMENTS, A STATEWIDE BASE PRICE SHALL BE ESTABLISHED FOR EACH SIXTY DAY EPISODE OF CARE AND ADJUSTED BY A REGIONAL WAGE INDEX FACTOR AND AN INDIVIDUAL PATIENT CASE MIX INDEX. SUCH EPISODIC PAYMENTS MAY BE FURTHER ADJUSTED FOR LOW UTILIZATION CASES AND TO REFLECT A PERCENTAGE LIMITATION OF THE COST FOR HIGH-UTILIZATION CASES THAT EXCEED OUTLIER THRESHOLDS OF SUCH PAYMENTS.

(B) INITIAL BASE YEAR EPISODIC PAYMENTS SHALL BE BASED ON MEDICAID PAID CLAIMS, AS DETERMINED AND ADJUSTED BY THE COMMISSIONER TO ACHIEVE SAVINGS COMPARABLE TO THE PRIOR STATE FISCAL YEAR, FOR SERVICES PROVIDED BY ALL CERTIFIED HOME HEALTH AGENCIES IN THE BASE YEAR TWO THOUSAND NINE. SUBSEQUENT BASE YEAR EPISODIC PAYMENTS MAY BE BASED ON MEDICAID PAID CLAIMS FOR SERVICES PROVIDED BY ALL CERTIFIED HOME HEALTH AGENCIES IN A BASE YEAR SUBSEQUENT TO TWO THOUSAND NINE, AS DETERMINED BY THE COMMISSIONER, PROVIDED, HOWEVER, THAT SUCH BASE YEAR ADJUSTMENT SHALL BE MADE NOT LESS FREQUENTLY THAN EVERY THREE YEARS. IN DETERMINING CASE MIX, EACH PATIENT SHALL BE CLASSIFIED USING A SYSTEM BASED ON MEASURES WHICH MAY INCLUDE, BUT NOT LIMITED TO, CLINICAL AND FUNCTIONAL MEASURES, AS REPORTED ON THE FEDERAL OUTCOME AND ASSESSMENT INFORMATION SET (OASIS), AS MAY BE AMENDED.

(C) THE COMMISSIONER MAY REQUIRE AGENCIES TO COLLECT AND SUBMIT ANY DATA REQUIRED TO IMPLEMENT THIS SUBDIVISION. THE COMMISSIONER MAY PROMULGATE REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

S 5. Sections 365-i and 369-dd of the social services law are REPEALED.

S 5-a. Subparagraph (v) of paragraph (e) of subdivision 1 and subdivision 2-b of section 369-ee of the social services law, subparagraph (v) of paragraph (e) of subdivision 1 as amended by section 1 of part C and subdivision 2-b as added by section 2 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(v) prescription drugs [as defined in section two hundred seventy of the public health law, which shall be provided pursuant to subdivision two-b of this section,] and non-prescription smoking cessation products or devices;

2-b. Prescription drug payments. [(a) Subject to paragraph (b) of this subdivision, payment for drugs, except for such drugs provided by medical practitioners, and for which payment is authorized pursuant to paragraph (e) of subdivision one of this section, shall be made pursuant to subdivision nine of section three hundred sixty-seven-a of this article and article two-A of the public health law and subdivision four of section three hundred sixty-five-a of this article. Payment for such drugs provided by medical practitioners shall be included in the capitation payment for services or supplies provided to persons eligible for health care services under this title.

(b)] Payment for drugs for which payment is authorized pursuant to paragraph (e) of subdivision one of this section[, and that are provided by an employer partnership for family health plus plan authorized by section three hundred sixty-nine-ff of this title,] shall be included in the capitation payment for services or supplies provided to persons eligible for health care services under [such] A FAMILY HEALTH INSURANCE plan.

S 6. Section 368-d of the social services law is amended by adding three new subdivisions 4, 5 and 6 to read as follows:

4. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO CONDUCT A STUDY TO DETERMINE ACTUAL DIRECT AND INDIRECT COSTS INCURRED BY PUBLIC SCHOOL DISTRICTS AND STATE OPERATED/STATE SUPPORTED SCHOOLS WHICH OPERATE PURSUANT TO ARTICLE EIGHTY-FIVE, EIGHTY-SEVEN OR EIGHTY-EIGHT OF THE EDUCATION LAW FOR MEDICAL CARE, SERVICES AND SUPPLIES, INCLUDING RELATED SPECIAL EDUCATION SERVICES AND SPECIAL TRANSPORTATION, FURNISHED TO CHILDREN WITH HANDICAPPING CONDITIONS.

5. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER SUBDIVISION FOUR OF THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(A) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(II) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH; AND

(C) THE COMMISSIONER OF HEALTH SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

(D) UPON SELECTION OF A CONTRACTOR OR CONTRACTORS, THE DEPARTMENT OF HEALTH SHALL PROVIDE WRITTEN NOTIFICATION OF SUCH SELECTION AND A SUMMARY OF THE CRITERIA EMPLOYED IN SUCH SELECTION TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE.

6. THE COMMISSIONER SHALL EVALUATE THE RESULTS OF THE STUDY CONDUCTED PURSUANT TO SUBDIVISION FOUR OF THIS SECTION TO DETERMINE, AFTER IDENTIFICATION OF ACTUAL DIRECT AND INDIRECT COSTS INCURRED BY PUBLIC SCHOOL DISTRICTS AND STATE OPERATED/STATE SUPPORTED SCHOOLS, WHETHER IT IS ADVISABLE TO CLAIM FEDERAL REIMBURSEMENT FOR EXPENDITURES UNDER THIS SECTION AS CERTIFIED PUBLIC EXPENDITURES. IN THE EVENT SUCH CLAIMS ARE SUBMITTED, IF FEDERAL REIMBURSEMENT RECEIVED FOR CERTIFIED PUBLIC EXPENDITURES ON BEHALF OF MEDICAL ASSISTANCE RECIPIENTS WHOSE ASSISTANCE AND CARE ARE THE RESPONSIBILITY OF A SOCIAL SERVICES DISTRICT IN A CITY WITH A POPULATION OF OVER TWO MILLION, RESULTS IN A DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES PURSUANT TO THIS SECTION FOR SUCH RECIPIENTS, THEN TO THE EXTENT THAT THE AMOUNT OF ANY SUCH DECREASE WHEN COMBINED WITH ANY DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES DESCRIBED IN SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-EIGHT-E OF THIS TITLE EXCEEDS FIFTY MILLION DOLLARS, THE EXCESS AMOUNT SHALL BE TRANSFERRED TO SUCH CITY. ANY SUCH EXCESS AMOUNT TRANSFERRED SHALL NOT BE CONSIDERED A REVENUE RECEIVED BY SUCH SOCIAL SERVICES DISTRICT IN DETERMINING THE DISTRICT'S ACTUAL MEDICAL ASSISTANCE EXPENDITURES FOR PURPOSES OF PARAGRAPH (B) OF SECTION ONE OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE.

S 7. Section 368-e of the social services law is amended by adding three new subdivisions 3, 4 and 5 to read as follows:

3. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO CONDUCT A STUDY TO DETERMINE ACTUAL DIRECT AND INDIRECT COSTS INCURRED BY COUNTIES FOR MEDICAL CARE, SERVICES AND SUPPLIES, INCLUDING RELATED SPECIAL EDUCATION SERVICES AND SPECIAL TRANSPORTATION, FURNISHED TO PRE-SCHOOL CHILDREN WITH HANDICAPPING CONDITIONS.

4. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER SUBDIVISION THREE OF THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(A) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(II) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH; AND

(C) THE COMMISSIONER OF HEALTH SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

(D) UPON SELECTION OF A CONTRACTOR OR CONTRACTORS, THE DEPARTMENT OF HEALTH SHALL PROVIDE WRITTEN NOTIFICATION OF SUCH SELECTION AND A SUMMARY OF THE CRITERIA EMPLOYED IN SUCH SELECTION TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE.

5. THE COMMISSIONER SHALL EVALUATE THE RESULTS OF THE STUDY CONDUCTED PURSUANT TO SUBDIVISION THREE OF THIS SECTION TO DETERMINE, AFTER IDENTIFICATION OF ACTUAL DIRECT AND INDIRECT COSTS INCURRED BY COUNTIES FOR MEDICAL CARE, SERVICES, AND SUPPLIES FURNISHED TO PRE-SCHOOL CHILDREN WITH HANDICAPPING CONDITIONS, WHETHER IT IS ADVISABLE TO CLAIM FEDERAL REIMBURSEMENT FOR EXPENDITURES UNDER THIS SECTION AS CERTIFIED PUBLIC EXPENDITURES. IN THE EVENT SUCH CLAIMS ARE SUBMITTED, IF FEDERAL REIMBURSEMENT RECEIVED FOR CERTIFIED PUBLIC EXPENDITURES ON BEHALF OF MEDICAL ASSISTANCE RECIPIENTS WHOSE ASSISTANCE AND CARE ARE THE RESPONSIBILITY OF A SOCIAL SERVICES DISTRICT IN A CITY WITH A POPULATION OF OVER TWO MILLION, RESULTS IN A DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES PURSUANT TO THIS SECTION FOR SUCH RECIPIENTS, THEN TO THE EXTENT THAT THE AMOUNT OF ANY SUCH DECREASE WHEN COMBINED WITH ANY DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES DESCRIBED IN SUBDIVISION SIX OF SECTION THREE HUNDRED SIXTY-EIGHT-D OF THIS TITLE EXCEEDS FIFTY MILLION DOLLARS, THE EXCESS AMOUNT SHALL BE TRANSFERRED TO SUCH CITY. ANY SUCH EXCESS AMOUNT TRANSFERRED SHALL NOT BE CONSIDERED A REVENUE RECEIVED BY SUCH SOCIAL SERVICES DISTRICT IN DETERMINING THE DISTRICT'S ACTUAL MEDICAL ASSISTANCE EXPENDITURES FOR PURPOSES OF PARAGRAPH (B) OF SECTION ONE OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE.

S 8. Paragraph d of subdivision 20 of section 2808 of the public health law is REPEALED and a new paragraph d is added to read as follows:

D. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, RULE OR REGULATION, FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, THE COMMISSIONER MAY REDUCE OR ELIMINATE THE PAYMENT FACTOR FOR RETURN ON OR RETURN OF EQUITY IN THE CAPITAL COST COMPONENT OF MEDICAID RATES OF PAYMENT FOR SERVICES PROVIDED BY RESIDENTIAL HEALTH CARE FACILITIES.

S 9. Paragraph (b) of subdivision 11 of section 272 of the public health law, as added by section 36 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(b) The commissioner may designate a pharmaceutical manufacturer as one with whom the commissioner is negotiating or has negotiated a manufacturer agreement, and all of the drugs it manufactures or markets shall be included in the preferred drug program. The commissioner may negotiate directly with a pharmaceutical manufacturer for rebates relating to any or all of the drugs it manufactures or markets. A manufacturer agreement shall designate any or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as being preferred or non preferred drugs. When a pharmaceutical manufacturer has been designated by the commissioner under this paragraph but THE COMMISSIONER has not reached a manufacturer agreement with the pharmaceutical manufacturer, then THE COMMISSIONER MAY DESIGNATE SOME OR all of the drugs manufactured or marketed by the pharmaceutical manufacturer [shall be] AS non preferred drugs. However, notwithstanding this paragraph, any drug that is selected to be on the preferred drug list under paragraph (b) of subdivision ten of this section on grounds that it is significantly more clinically effective and safer than other drugs in its therapeutic class shall be a preferred drug.

S 10. Subparagraphs (i) and (ii) of paragraph (b) of subdivision 9 of section 367-a of the social services law, subparagraph (i) as amended by section 10 and subparagraph (ii) as amended by section 4 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(i) if the drug dispensed is a multiple source prescription drug for which an upper limit has been set by the federal centers for medicare and medicaid services, the lower of: (A) an amount equal to the specific upper limit set by such federal agency for the multiple source prescription drug; (B) the estimated acquisition cost of such drug to pharmacies which, for purposes of this subparagraph, shall mean the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof; (C) the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision; [or] (D) the dispensing pharmacy's usual and customary price charged to the general public[,]; OR (E) THE AVERAGE ACQUISITION COST IF AVAILABLE; and

(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies, THE AVERAGE ACQUISITION COST IF AVAILABLE or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less [sixteen and twenty-five one hundredths] SEVENTEEN percent thereof OR THE WHOLE-

SALE ACQUISITION COST OF A PRESCRIPTION DRUG BASED UPON PACKAGE SIZE DISPENSED FROM, AS REPORTED BY THE PRESCRIPTION DRUG PRICING SERVICE USED BY THE DEPARTMENT, MINUS ZERO AND FORTY-ONE HUNDREDTHS PERCENT THEREOF, and updated monthly by the department[; or, for a specialized HIV pharmacy, as defined in paragraph (f) of this subdivision, acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twelve percent thereof, and updated monthly by the department]. For multiple source generic drugs, estimated acquisition cost means the lower of THE AVERAGE ACQUISITION COST, the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision[; or, for a specialized HIV pharmacy, as defined in paragraph (f) of this subdivision, acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twelve percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision].

S 10-a. Subparagraph (i) of paragraph (d) of subdivision 9 of section 367-a of the social services law, as amended by chapter 19 of the laws of 1998, is amended to read as follows:

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

S 10-b. Paragraph (f) of subdivision 9 of section 367-a of the social services law is REPEALED and a new paragraph (f) is added to read as follows:

(F) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION TO THE CONTRARY, THE COMMISSIONER SHALL HAVE THE AUTHORITY TO ESTABLISH THE AMOUNT OF PAYMENTS AND DISPENSING FEES UNDER THIS TITLE FOR THOSE DRUGS WHICH MAY NOT BE DISPENSED WITHOUT A PRESCRIPTION AS REQUIRED BY SECTION SIXTY-EIGHT HUNDRED TEN OF THE EDUCATION LAW AND FOR WHICH PAYMENT IS AUTHORIZED PURSUANT TO PARAGRAPH (G) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE. THE COMMISSIONER SHALL NOT CHANGE THE AMOUNTS OF OR METHOD FOR SUCH PAYMENTS OR DISPENSING FEES ON OR AFTER APRIL FIRST, TWO THOUSAND ELEVEN UNLESS NOTICE IS GIVEN SIXTY DAYS IN ADVANCE OF SUCH CHANGE TO THE CHAIRS OF THE COMMITTEES ON SENATE FINANCE, ASSEMBLY WAYS AND MEANS, SENATE HEALTH, AND ASSEMBLY HEALTH.

S 11. Subdivision 1 of section 3-d of part B of chapter 58 of the laws of 2010 amending the public health law and other laws relating to Medicaid payments, is amended to read as follows;

1. Notwithstanding any provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, for periods on and after April 1, 2010, payments made to managed care providers sponsored by a public benefit corporation located in a city of more than one million persons which provide coverage primarily to Medicaid patients in accordance with sections 364-j and 369-ee of the social services law may, at the election of the social services district, be increased up to an annual aggregate amount of two hundred million dollars; provided, however that, notwithstanding the social services district Medicaid cap provisions of part C of chapter 58 of the laws of 2005, such social services district shall be responsible for payment of one hundred percent of the non-federal share of such

increase, and provided further, however, that such payment increases shall not be applied to payments related to the Medicaid advantage program [or the HIV special needs plan]. Social services district funding of the non-federal share of any such payments shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009; provided however that, in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such Act, the provisions of this section shall be null and void.

S 12. Intentionally omitted.

S 13. Subdivision 1 of section 271 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

1. There is hereby established in the department a pharmacy and therapeutics committee. The committee shall consist of [seventeen] EIGHTEEN members, who shall be appointed by the commissioner and who shall serve three year terms; except that for the initial appointments to the committee, five members shall serve one year terms, seven shall serve two year terms, and five shall serve three year terms. Committee members may be reappointed upon the completion of their terms. [No] WITH THE EXCEPTION OF THE CHAIRPERSON, NO member of the committee shall be an employee of the state or any subdivision of the state, other than for his or her membership on the committee, except for employees of health care facilities or universities operated by the state, a public benefit corporation, the State University of New York or municipalities.

S 14. Paragraphs (d) and (e) of subdivision 2 of section 271 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended, and a new paragraph (f) is added to read as follows:

(d) one person with expertise in drug utilization review who is either a health care professional licensed under title eight of the education law, is a pharmacologist or has a doctorate in pharmacology; [and]

(e) three persons who shall be consumers or representatives of organizations with a regional or statewide constituency and who have been involved in activities related to health care consumer advocacy, including issues affecting Medicaid or EPIC recipients[.]; AND

(F) A CHAIRPERSON DESIGNATED PURSUANT TO SUBDIVISION FOUR OF THIS SECTION.

S 15. Subdivision 4 of section 271 of the public health law is REPEALED and a new subdivision 4 is added to read as follows:

4. THE COMMISSIONER SHALL DESIGNATE A MEMBER OF THE DEPARTMENT TO SERVE AS CHAIRPERSON OF THE COMMITTEE.

S 16. Intentionally omitted.

S 17. Subdivision 10 of section 272 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D) NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, THE COMMISSIONER MAY DESIGNATE THERAPEUTIC CLASSES OF DRUGS, INCLUDING CLASSES WITH ONLY ONE DRUG, AS ALL PREFERRED PRIOR TO ANY REVIEW THAT MAY BE CONDUCTED BY THE COMMITTEE PURSUANT TO THIS SECTION.

S 18. Intentionally omitted.

S 19. Subdivision 4 of section 364-j of the social services law is amended by adding a new paragraph (u) to read as follows:

(U) A MANAGED CARE PROVIDER THAT PROVIDES COVERAGE FOR PRESCRIPTION DRUGS SHALL PERMIT EACH PARTICIPANT TO FILL ANY MAIL ORDER COVERED PRESCRIPTION, AT HIS OR HER OPTION, AT ANY MAIL ORDER PHARMACY OR

NON-MAIL-ORDER RETAIL PHARMACY IN THE MANAGED CARE PROVIDER NETWORK, IF THE NON-MAIL-ORDER RETAIL PHARMACY OFFERS TO ACCEPT A PRICE THAT IS COMPARABLE TO THAT OF THE MAIL ORDER PHARMACY.

S 20. Paragraph (g) of subdivision 4 of section 365-a of the social services law, as amended by section 61 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act[; provided however that, for purposes of this paragraph, "covered part D drugs" shall not mean atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants].

S 21. Subdivision 12 of section 272 of the public health law is REPEALED.

S 22. Paragraph (c) of subdivision 8 of section 2807 of the public health law, as added by section 28 of part B of chapter 1 of the laws of 2002, is amended to read as follows:

(c) Rates of payments to facilities which first qualify as federally qualified health centers or rural health centers on or after October first, two thousand shall be computed in accordance with the provisions of paragraph (b) of subdivision two of this section, provided, however, that the operating cost component of such rates shall reflect an average of the operating cost component of rates of payments issued to other facilities subject to this subdivision during the same rate period, located in the same geographic region and with a similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data as reported to the department. For each twelve month period following the rate period in which such facilities commence operation, the operating cost component of rates of payment for such facilities shall be computed in accordance with paragraph (b) of this subdivision. IN CALCULATING THE OPERATING COST COMPONENT OF SUCH RATES FOR FACILITIES WHICH FIRST QUALIFY AS FEDERALLY QUALIFIED HEALTH CARE CENTERS ON OR AFTER OCTOBER FIRST, TWO THOUSAND, THE COUNTIES COMPRISING THE GEOGRAPHIC REGION KNOWN AS DOWNSTATE SHALL BE THE SAME AS THE COUNTIES COMPRISING THE DOWNSTATE REGION FOR PURPOSES OF REIMBURSING DIAGNOSTIC AND TREATMENT CENTERS UNDER AMBULATORY PATIENT GROUPS, WHICH COUNTIES ARE SPECIFIED IN THE REGULATIONS ADOPTED BY THE COMMISSIONER IMPLEMENTING SECTION 18 OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND EIGHT.

S 23. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 1 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department[,]; provided FURTHER that: (I) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (II) ENTERAL FORMULA THERAPY AND NUTRITIONAL SUPPLEMENTS ARE LIMITED TO COVERAGE ONLY FOR NASOGASTRIC, JEJUNOSTOMY, OR GASTROSTOMY TUBE FEEDING OR FOR TREATMENT OF AN INBORN METABOLIC DISORDER, OR TO ADDRESS GROWTH AND DEVELOPMENT PROBLEMS IN CHILDREN; (III) PRESCRIPTION FOOTWEAR AND INSERTS ARE LIMITED TO COVERAGE ONLY WHEN USED AS AN INTEGRAL PART OF A

LOWER LIMB ORTHOTIC APPLIANCE, AS PART OF A DIABETIC TREATMENT PLAN, OR TO ADDRESS GROWTH AND DEVELOPMENT PROBLEMS IN CHILDREN; AND (IV) COMPRESSION AND SUPPORT STOCKINGS ARE LIMITED TO COVERAGE ONLY FOR PREGNANCY OR TREATMENT OF VENOUS STASIS ULCERS;

(G-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when less than seventy-five percent of the previously dispensed amount per fill should have been used were the product used as normally indicated; PROVIDED FURTHER THAT THE COMMISSIONER OF HEALTH IS AUTHORIZED TO REQUIRE PRIOR AUTHORIZATION OF PRESCRIPTIONS OF OPIOID ANALGESICS IN EXCESS OF FOUR PRESCRIPTIONS IN A THIRTY-DAY PERIOD IN ACCORDANCE WITH SECTION TWO HUNDRED SEVENTY-THREE OF THE PUBLIC HEALTH LAW; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

S 24. Intentionally omitted.

S 25. Section 367-w of the social services law is REPEALED.

S 26. Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for periods on and after April 1, 2011, clinics certified pursuant to articles 16, 31 or 32 of the mental hygiene law shall be subject to targeted Medicaid reimbursement rate reductions in accordance with the provisions of this section. Such reductions shall be based on utilization thresholds which may be established either as provider-specific or patient-specific thresholds. Provider-specific thresholds shall be based on average patient utilization for a given provider in comparison to a peer based standard to be determined for each service. The commissioners of the office of mental health, the office for persons with developmental disabilities, and the office of alcoholism and substance abuse services, in consultation with the commissioner of health, are authorized to waive utilization thresholds for patients of clinics certified pursuant to article 16, 31, or 32 of the mental hygiene law who are enrolled in specific treatment programs or otherwise meet criteria as may be specified by such commissioners. When applying a provider-specific threshold, rates will be reduced on a prospective basis based on the amount any provider is over the determined threshold level. Patient-specific thresholds will be based on annual thresholds determined for each service over which the per visit payment for each visit in excess of the standard during a twelve month period shall be reduced by a pre-deter-

mined amount. The thresholds, peer based standards and the payment reductions shall be determined by the department of health, with the approval of the division of the budget, and in consultation with the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services, and any such resulting rates shall be subject to certification by the appropriate commissioners pursuant to subdivision (a) of section 43.02 of the mental hygiene law. The base period used to establish the thresholds shall be the 2009 calendar year. The total annualized reduction in payments shall be not more than $10,900,000 for Article 31 clinics, not more than $2,400,000 for Article 16 clinics, and not more than $13,250,000 for Article 32 clinics. The commissioner of health may promulgate regulations to implement the provisions of this section.

S 27. Paragraph (h) of subdivision 2 of section 365-a of the social services law, as amended by chapter 444 of the laws of 1979 and as relettered by chapter 478 of the laws of 1980, is amended to read as follows:

(h) SPEECH THERAPY, AND WHEN PROVIDED AT THE DIRECTION OF A PHYSICIAN OR NURSE PRACTITIONER, physical therapy [and relative] INCLUDING RELATED rehabilitative services [when provided at the direction of a physician] AND OCCUPATIONAL THERAPY; PROVIDED, HOWEVER, THAT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY EACH SHALL BE LIMITED TO COVERAGE OF TWENTY VISITS PER YEAR; SUCH LIMITATION SHALL NOT APPLY TO PERSONS WITH DEVELOPMENTAL DISABILITIES;

S 28. Section 3614 of the public health law is amended by adding a new subdivision 2-a to read as follows:

2-A. NOTWITHSTANDING ANY CONTRARY LAW, RULE OR REGULATION, FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, MEDICAID RATES OF PAYMENTS FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES, BY LONG TERM HOME HEALTH CARE PROGRAMS OR BY AN AIDS HOME CARE PROGRAM SHALL NOT REFLECT A SEPARATE PAYMENT FOR HOME CARE NURSING SERVICES PROVIDED TO PATIENTS DIAGNOSED WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

S 29. Intentionally omitted.

S 30. Subparagraphs (x), (xi), (xii), (xiii) and (xiv) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 100 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(x) forty-seven million two hundred ten thousand dollars on an annual basis for the periods January first, two thousand nine through December thirty-first, two thousand ten; [and]

(xi) eleven million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xii) TWENTY-THREE MILLION EIGHT HUNDRED THIRTY-SIX THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE;

(XIII) TWENTY-THREE MILLION EIGHT HUNDRED THIRTY-SIX THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN;

(XIV) provided, however, for periods prior to January first, two thousand nine, amounts set forth in this paragraph may be reduced by the commissioner in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to

the graduate medical education program established pursuant to section twenty-eight hundred seven-m of this article;

[(xiii)] (XV) 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 total actual distribution reductions for all facilities pursuant to paragraph (e) of subdivision three of section twenty-eight hundred seven-m of this article; and

[(xiv)] (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) of subdivision one of section twenty-eight hundred seven-m of this article.

S 31. Paragraph (s) of subdivision 2 of section 365-a of the social services law, as amended by section 46 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(s) smoking cessation counseling services [for pregnant women on any day of pregnancy through the end of the month in which the one hundred eightieth day following the end of the pregnancy occurs, and children and adolescents ten to twenty years of age, during a medical visit when provided by a general hospital outpatient department or a free-standing clinic, or by a physician, registered physician's assistant, registered nurse practitioner or licensed midwife in office-based settings]; provided, however, that the provisions of this paragraph [relating to smoking cessation counseling services] shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

S 32. Subparagraph (i) of paragraph (b-1) of subdivision 1 of section 2807-c of the public health law, as amended by section 10 of part C of chapter 58 of the laws of 2010, is amended to read as follows:

(i) For patients discharged on and after January first, nineteen hundred ninety-seven and prior to January first, two thousand and on and after January first, two thousand, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law, and the comprehensive motor vehicle insurance reparations act shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision fourteen-f of this section and subdivision thirty-three of this section [and], excluding such further reductions to such payments as are enacted as part of the state budget for the state fiscal year commencing April first, two thousand ten AND EXCLUDING SUCH FURTHER REDUCTIONS TO SUCH PAYMENTS AS ARE ENACTED AS PART OF THE STATE BUDGET FOR STATE FISCAL YEARS COMMENCING ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN.

S 33. The public health law is amended by adding a new section 3614-c to read as follows:

S 3614-C. HOME CARE WORKER WAGE PARITY. 1. AS USED IN THIS SECTION, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANING:

(A) "LIVING WAGE LAW" MEANS ANY LAW ENACTED BY NASSAU, SUFFOLK OR WESTCHESTER COUNTY OR A CITY WITH A POPULATION OF ONE MILLION OR MORE WHICH ESTABLISHES A MINIMUM WAGE FOR SOME OR ALL EMPLOYEES WHO PERFORM WORK ON CONTRACTS WITH SUCH COUNTY OR CITY.

(B) "TOTAL COMPENSATION" MEANS ALL WAGES AND OTHER DIRECT COMPENSATION PAID TO OR PROVIDED ON BEHALF OF THE EMPLOYEE INCLUDING, BUT NOT LIMITED TO, WAGES, HEALTH, EDUCATION OR PENSION BENEFITS, SUPPLEMENTS IN LIEU OF

BENEFITS AND COMPENSATED TIME OFF, EXCEPT THAT IT DOES NOT INCLUDE EMPLOYER TAXES OR EMPLOYER PORTION OF PAYMENTS FOR STATUTORY BENEFITS, INCLUDING BUT NOT LIMITED TO FICA, DISABILITY INSURANCE, UNEMPLOYMENT INSURANCE AND WORKERS' COMPENSATION.

(C) "PREVAILING RATE OF TOTAL COMPENSATION" MEANS THE AVERAGE HOURLY AMOUNT OF TOTAL COMPENSATION PAID TO ALL HOME CARE AIDES COVERED BY WHATEVER COLLECTIVELY BARGAINED AGREEMENT COVERS THE GREATEST NUMBER OF HOME CARE AIDES IN A CITY WITH A POPULATION OF ONE MILLION OR MORE. FOR PURPOSES OF THIS DEFINITION, ANY SET OF COLLECTIVELY BARGAINED AGREEMENTS IN SUCH CITY WITH SUBSTANTIALLY THE SAME TERMS AND CONDITIONS RELATING TO TOTAL COMPENSATION SHALL BE CONSIDERED AS A SINGLE COLLECTIVELY BARGAINED AGREEMENT.

(D) "HOME CARE AIDE" MEANS A HOME HEALTH AIDE, PERSONAL CARE AIDE, HOME ATTENDANT OR OTHER LICENSED OR UNLICENSED PERSON WHOSE PRIMARY RESPONSIBILITY INCLUDES THE PROVISION OF IN-HOME ASSISTANCE WITH ACTIVITIES OF DAILY LIVING, INSTRUMENTAL ACTIVITIES OF DAILY LIVING OR HEALTH-RELATED TASKS; PROVIDED, HOWEVER, THAT HOME CARE AIDE DOES NOT INCLUDE ANY INDIVIDUAL (I) WORKING ON A CASUAL BASIS, OR (II) WHO IS A RELATIVE THROUGH BLOOD, MARRIAGE OR ADOPTION OF: (1) THE EMPLOYER; OR (2) THE PERSON FOR WHOM THE WORKER IS DELIVERING SERVICES, UNDER A PROGRAM FUNDED OR ADMINISTERED BY FEDERAL, STATE OR LOCAL GOVERNMENT.

(E) "MANAGED CARE PLAN" MEANS ANY MANAGED CARE PROGRAM, ORGANIZATION OR DEMONSTRATION COVERING PERSONAL CARE OR HOME HEALTH AIDE SERVICES, AND WHICH RECEIVES PREMIUMS FUNDED, IN WHOLE OR IN PART, BY THE NEW YORK STATE MEDICAL ASSISTANCE PROGRAM, INCLUDING BUT NOT LIMITED TO ALL MEDICAID MANAGED CARE, MEDICAID MANAGED LONG TERM CARE, MEDICAID ADVANTAGE, AND MEDICAID ADVANTAGE PLUS PLANS AND ALL PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY.

(F) "EPISODE OF CARE" MEANS ANY SERVICE UNIT REIMBURSED, IN WHOLE OR IN PART, BY THE NEW YORK STATE MEDICAL ASSISTANCE PROGRAM, WHETHER THROUGH DIRECT REIMBURSEMENT OR COVERED BY A PREMIUM PAYMENT, AND WHICH COVERS, IN WHOLE OR IN PART, ANY SERVICE PROVIDED BY A HOME CARE AIDE, INCLUDING BUT NOT LIMITED TO ALL SERVICE UNITS DEFINED AS VISITS, HOURS, DAYS, MONTHS OR EPISODES.

2. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, RULE OR REGULATION, NO PAYMENTS BY GOVERNMENT AGENCIES SHALL BE MADE TO CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS OR MANAGED CARE PLANS FOR ANY EPISODE OF CARE FURNISHED, IN WHOLE OR IN PART, BY ANY HOME CARE AIDE WHO IS COMPENSATED AT AMOUNTS LESS THAN THE APPLICABLE MINIMUM RATE OF HOME CARE AIDE TOTAL COMPENSATION ESTABLISHED PURSUANT TO THIS SECTION.

3. (A) THE MINIMUM RATE OF HOME CARE AIDE TOTAL COMPENSATION IN A CITY WITH A POPULATION OF ONE MILLION OR MORE SHALL BE:

(I) FOR THE PERIOD MARCH FIRST, TWO THOUSAND TWELVE THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND THIRTEEN, NINETY PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW OF SUCH CITY;

(II) FOR THE PERIOD MARCH FIRST, TWO THOUSAND THIRTEEN THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND FOURTEEN, NINETY-FIVE PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW OF SUCH CITY;

(III) FOR ALL PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND FOURTEEN, NO LESS THAN THE PREVAILING RATE OF TOTAL COMPENSATION AS OF JANUARY FIRST, TWO THOUSAND ELEVEN, OR THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW OF SUCH CITY, WHICHEVER IS GREATER.

(B) THE MINIMUM RATE OF HOME CARE AIDE TOTAL COMPENSATION IN THE COUNTIES OF NASSAU, SUFFOLK AND WESTCHESTER SHALL BE:

(I) FOR THE PERIOD MARCH FIRST, TWO THOUSAND THIRTEEN THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND FOURTEEN, NINETY PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW AS SET ON MARCH FIRST, TWO THOUSAND THIRTEEN OF A CITY WITH A POPULATION OF A MILLION OR MORE;

(II) FOR THE PERIOD MARCH FIRST, TWO THOUSAND FOURTEEN THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND FIFTEEN, NINETY-FIVE PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW AS SET ON MARCH FIRST, TWO THOUSAND FOURTEEN OF A CITY WITH A POPULATION OF A MILLION OR MORE;

(III) FOR THE PERIOD MARCH FIRST, TWO THOUSAND FIFTEEN, THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND SIXTEEN, ONE HUNDRED PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW AS SET ON MARCH FIRST, TWO THOUSAND FIFTEEN OF A CITY WITH A POPULATION OF A MILLION OR MORE;

(IV) FOR ALL PERIODS ON OR AFTER MARCH FIRST, TWO THOUSAND SIXTEEN, THE LESSER OF (I) ONE HUNDRED AND FIFTEEN PERCENT OF THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW AS SET ON MARCH FIRST OF EACH SUCCEEDING YEAR OF A CITY WITH A POPULATION OF ONE MILLION OR MORE OR; (II) THE TOTAL COMPENSATION MANDATED BY THE LIVING WAGE LAW OF NASSAU, SUFFOLK OR WESTCHESTER COUNTY, BASED ON THE LOCATION OF THE EPISODE OF CARE

4. ANY PORTION OF THE MINIMUM RATE OF HOME CARE AIDE TOTAL COMPENSATION ATTRIBUTABLE TO HEALTH BENEFIT COSTS OR PAYMENTS IN LIEU OF HEALTH BENEFITS, AND PAID TIME OFF, AS ESTABLISHED PURSUANT TO SUBDIVISION THREE OF THIS SECTION SHALL BE SUPERSEDED BY THE TERMS OF ANY EMPLOYER BONA FIDE COLLECTIVE BARGAINING AGREEMENT IN EFFECT AS OF JANUARY FIRST, TWO THOUSAND ELEVEN, OR A SUCCESSOR TO SUCH AGREEMENT, WHICH PROVIDES FOR HOME CARE AIDES' HEALTH BENEFITS THROUGH PAYMENTS TO JOINTLY ADMINISTERED LABOR-MANAGEMENT FUNDS.

5. THE TERMS OF THIS SECTION SHALL APPLY EQUALLY TO SERVICES PROVIDED BY HOME CARE AIDES WHO WORK ON EPISODES OF CARE AS DIRECT EMPLOYEES OF CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, OR MANAGED CARE PLANS, OR AS EMPLOYEES OF LICENSED HOME CARE SERVICES AGENCIES, LIMITED LICENSED HOME CARE SERVICES AGENCIES, OR UNDER ANY OTHER ARRANGEMENT.

6. NO PAYMENTS BY GOVERNMENT AGENCIES SHALL BE MADE TO CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, OR MANAGED CARE PLANS FOR ANY EPISODE OF CARE WITHOUT THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR MANAGED CARE PLAN HAVING DELIVERED PRIOR WRITTEN CERTIFICATION TO THE COMMISSIONER, ON FORMS PREPARED BY THE DEPARTMENT IN CONSULTATION WITH THE DEPARTMENT OF LABOR, THAT ALL SERVICES PROVIDED UNDER EACH EPISODE OF CARE ARE IN FULL COMPLIANCE WITH THE TERMS OF THIS SECTION AND ANY REGULATIONS PROMULGATED PURSUANT TO THIS SECTION.

7. IF A CERTIFIED HOME HEALTH AGENCY OR LONG TERM HOME HEALTH CARE PROGRAM ELECTS TO PROVIDE HOME CARE AIDE SERVICES THROUGH CONTRACTS WITH LICENSED HOME CARE SERVICES AGENCIES OR THROUGH OTHER THIRD PARTIES, PROVIDED THAT THE EPISODE OF CARE ON WHICH THE HOME CARE AIDE WORKS IS COVERED UNDER THE TERMS OF THIS SECTION, THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR MANAGED CARE PLAN MUST OBTAIN A WRITTEN CERTIFICATION FROM THE LICENSED HOME CARE SERVICES AGENCY OR OTHER THIRD PARTY, ON FORMS PREPARED BY THE DEPARTMENT IN CONSULTATION WITH THE DEPARTMENT OF LABOR, WHICH ATTESTS TO THE LICENSED HOME CARE SERVICES AGENCY'S OR OTHER THIRD PARTY'S COMPLIANCE WITH THE TERMS OF THIS SECTION. SUCH CERTIFICATIONS SHALL ALSO OBLIGATE THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR MANAGED CARE PLAN

TO OBTAIN, ON NO LESS THAN A QUARTERLY BASIS, ALL INFORMATION FROM THE LICENSED HOME CARE SERVICES AGENCY OR OTHER THIRD PARTIES NECESSARY TO VERIFY COMPLIANCE WITH THE TERMS OF THIS SECTION. SUCH CERTIFICATIONS AND THE INFORMATION EXCHANGED PURSUANT TO THEM SHALL BE RETAINED BY ALL CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, OR MANAGED CARE PLANS, AND ALL LICENSED HOME CARE SERVICES AGENCIES, OR OTHER THIRD PARTIES FOR A PERIOD OF NO LESS THAN TEN YEARS, AND MADE AVAILABLE TO THE DEPARTMENT UPON REQUEST.

8. THE COMMISSIONER SHALL DISTRIBUTE TO ALL CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, AND MANAGED CARE PLANS OFFICIAL NOTICE OF THE MINIMUM RATES OF HOME CARE AIDE COMPENSATION AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE EFFECTIVE DATE OF EACH MINIMUM RATE FOR EACH SOCIAL SERVICES DISTRICT COVERED BY THE TERMS OF THIS SECTION.

9. THE COMMISSIONER IS AUTHORIZED TO PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

10. NOTHING IN THIS SECTION SHOULD BE CONSTRUED AS APPLICABLE TO ANY SERVICE PROVIDED BY CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, OR MANAGED CARE PLANS EXCEPT FOR ALL EPISODES OF CARE REIMBURSED IN WHOLE OR IN PART BY THE NEW YORK MEDICAID PROGRAM.

11. NO CERTIFIED HOME HEALTH AGENCY, MANAGED CARE PLAN OR LONG TERM HOME HEALTH CARE PROGRAM SHALL BE LIABLE FOR RECOUPMENT OF PAYMENTS FOR SERVICES PROVIDED THROUGH A LICENSED HOME CARE SERVICES AGENCY OR OTHER THIRD PARTY WITH WHICH THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR MANAGED CARE PLAN HAS A CONTRACT BECAUSE THE LICENSED AGENCY OR OTHER THIRD PARTY FAILED TO COMPLY WITH THE PROVISIONS OF THIS SECTION IF THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR MANAGED CARE PLAN HAS REASONABLY AND IN GOOD FAITH COLLECTED CERTIFICATIONS AND ALL INFORMATION REQUIRED PURSUANT TO SUBDIVISIONS SIX AND SEVEN OF THIS SECTION.

S 33-a. Intentionally omitted.

S 34. Subdivision 22-a of section 2808 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D) (I) NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF SUBDIVISIONS TWO-B OR TWO-C OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR INPATIENT SERVICES PROVIDED BY RESIDENTIAL HEALTH CARE FACILITIES ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, THE COMMISSIONER MAY, SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET, GRANT APPROVAL OF A TEMPORARY ADJUSTMENT TO MEDICAID RATES FOR ELIGIBLE FACILITIES, AS DETERMINED IN ACCORDANCE WITH THIS PARAGRAPH.

(II) ELIGIBLE FACILITIES SHALL BE THOSE RESIDENTIAL HEALTH CARE FACILITIES WHICH, AS DETERMINED BY THE COMMISSIONER, REQUIRE SHORT-TERM ASSISTANCE TO ACCOMMODATE ADDITIONAL PATIENT SERVICES REQUIREMENTS STEMMING FROM THE CLOSURE OF OTHER FACILITIES IN THE AREA, INCLUDING, BUT NOT LIMITED TO, ADDITIONAL STAFF, SERVICE RECONFIGURATION AND ENHANCED INFORMATION TECHNOLOGY CAPABILITY.

(III) ELIGIBLE FACILITIES SHALL SUBMIT WRITTEN PROPOSALS DEMONSTRATING THE NEED FOR ADDITIONAL SHORT-TERM RESOURCES AND HOW SUCH ADDITIONAL RESOURCES WILL RESULT IN IMPROVEMENTS TO:

(A) THE COST EFFECTIVENESS OF SERVICE DELIVERY;

(B) QUALITY OF CARE; AND

(C) OTHER FACTORS DEEMED APPROPRIATE BY THE COMMISSIONER.

(IV) SUCH WRITTEN PROPOSALS SHALL BE SUBMITTED TO THE DEPARTMENT AT LEAST SIXTY DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE OF THE TEMPORARY

RATE ADJUSTMENT. THE TEMPORARY RATE ADJUSTMENT SHALL BE IN EFFECT FOR A SPECIFIED PERIOD OF TIME AS DETERMINED BY THE COMMISSIONER. AT THE END OF THE SPECIFIED TIMEFRAME, THE FACILITY WILL BE REIMBURSED IN ACCORDANCE WITH OTHERWISE APPLICABLE RATE-SETTING METHODOLOGIES. THE COMMISSIONER MAY ESTABLISH, AS A CONDITION OF RECEIVING SUCH A TEMPORARY RATE ADJUSTMENT, BENCHMARKS AND GOALS TO BE ACHIEVED IN ACCORDANCE WITH THE FACILITY'S APPROVED PROPOSALS AND MAY ALSO REQUIRE THAT THE FACILITY SUBMIT SUCH PERIODIC REPORTS CONCERNING THE ACHIEVEMENT OF SUCH BENCHMARKS AND GOALS AS THE COMMISSIONER DEEMS NECESSARY. FAILURE TO ACHIEVE SATISFACTORY PROGRESS, AS DETERMINED BY THE COMMISSIONER, IN ACCOMPLISHING SUCH BENCHMARKS AND GOALS SHALL BE A BASIS FOR ENDING THE FACILITY'S TEMPORARY RATE ADJUSTMENT PRIOR TO THE END OF THE SPECIFIED TIMEFRAME.

S 35. The public health law is amended by adding a new article 29-AA to read as follows:

ARTICLE 29-AA

PATIENT CENTERED MEDICAL HOMES

SECTION 2959-A. MULTIPAYOR PATIENT CENTERED MEDICAL HOME PROGRAM.

S 2959-A. MULTIPAYOR PATIENT CENTERED MEDICAL HOME PROGRAM. 1. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH MEDICAL HOME MULTIPAYOR PROGRAMS (REFERRED TO IN THIS SECTION AS A "PROGRAM") WHEREBY ENHANCED PAYMENTS ARE MADE TO PRIMARY CARE CLINICIANS AND CLINICS STATEWIDE THAT ARE CERTIFIED AS MEDICAL HOMES FOR THE PURPOSE OF IMPROVING HEALTH CARE OUTCOMES AND EFFICIENCY THROUGH IMPROVED ACCESS, PATIENT CARE CONTINUITY AND COORDINATION OF HEALTH SERVICES.

(B) AS USED IN THIS SECTION:

(I) "CLINIC" MEANS A GENERAL HOSPITAL PROVIDING OUTPATIENT CARE OR DIAGNOSTIC AND TREATMENT CENTER, LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER; AND

(II) "PRIMARY CARE CLINICIAN" MEANS A PHYSICIAN, NURSE PRACTITIONER, OR MIDWIFE ACTING WITHIN HIS OR HER LAWFUL SCOPE OF PRACTICE UNDER TITLE EIGHT OF THE EDUCATION LAW AND WHO IS PRACTICING IN A PRIMARY CARE SPECIALTY.

(III) "PRIMARY CARE MEDICAL HOME COLLABORATIVE" MEANS AN ENTITY APPROVED BY THE COMMISSIONER WHICH SHALL INCLUDE BUT NOT BE LIMITED TO HEALTH CARE PROVIDERS, WHICH MAY INCLUDE BUT NOT BE LIMITED TO HOSPITALS, DIAGNOSTIC AND TREATMENT CENTERS, PRIVATE PRACTICES AND INDEPENDENT PRACTICE ASSOCIATIONS, AND PAYORS OF HEALTH CARE SERVICES, WHICH MAY INCLUDE BUT NOT BE LIMITED TO EMPLOYERS, HEALTH PLANS AND INSURERS.

2. (A) IN ORDER TO PROMOTE IMPROVED QUALITY OF, AND ACCESS TO, HEALTH CARE SERVICES AND PROMOTE IMPROVED CLINICAL OUTCOMES, IT IS THE POLICY OF THE STATE TO ENCOURAGE COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS AMONG PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE SERVICES PROVIDERS WHO MIGHT OTHERWISE BE COMPETITORS, UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. IT IS THE INTENT OF THE STATE TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENTS AND REGULATION ONLY TO THE EXTENT NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS ARTICLE, AND TO PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS TO PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE SERVICES PROVIDERS WITH RESPECT TO THE PLANNING, IMPLEMENTATION AND OPERATION OF THE MULTIPAYOR PATIENT CENTERED MEDICAL HOME PROGRAM.

(B) THE COMMISSIONER OR HIS OR HER DULY AUTHORIZED REPRESENTATIVE MAY ENGAGE IN APPROPRIATE STATE SUPERVISION NECESSARY TO PROMOTE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS, AND MAY INSPECT OR REQUEST ADDITIONAL DOCUMENTATION FROM PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE SERVICES PROVIDERS TO VERIFY THAT MEDICAL HOMES

CERTIFIED PURSUANT TO THIS SECTION OPERATE IN ACCORDANCE WITH ITS INTENT AND PURPOSE.

3. THE COMMISSIONER IS AUTHORIZED TO PARTICIPATE IN, ACTIVELY SUPERVISE, FACILITATE AND APPROVE A PRIMARY CARE MEDICAL HOME COLLABORATIVE FOR EACH PROGRAM AROUND THE STATE TO ESTABLISH: (A) THE BOUNDARIES OF EACH PROGRAM AND THE PROVIDERS ELIGIBLE TO PARTICIPATE, PROVIDED THAT THE BOUNDARIES OF PROGRAMS MAY OVERLAP; (B) PRACTICE STANDARDS FOR EACH MEDICAL HOME PROGRAM ADOPTED WITH CONSIDERATION OF EXISTING STANDARDS DEVELOPED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE ("NCQA"), THE JOINT COMMISSION OF ACCREDITATION OF HEALTHCARE ORGANIZATIONS ("JCAHCO" OR THE "JOINT COMMISSION"), AMERICAN ACCREDITATION HEALTHCARE COMMISSION ("URAC"), AMERICAN COLLEGE OF PHYSICIANS, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, THE AMERICAN ACADEMY OF PEDIATRICS, AND THE AMERICAN OSTEOPATHIC ASSOCIATION; THE AMERICAN ACADEMY OF NURSE PRACTITIONERS, AND THE AMERICAN COLLEGE OF NURSE PRACTITIONERS; (C) STANDARDS FOR IMPLEMENTATION AND USE OF HEALTH INFORMATION TECHNOLOGY, INCLUDING PARTICIPATION IN HEALTH INFORMATION EXCHANGES THROUGH THE STATEWIDE HEALTH INFORMATION NETWORK; (D) METHODOLOGIES BY WHICH PAYORS WILL PROVIDE ENHANCED RATES OF PAYMENT TO CERTIFIED MEDICAL HOMES; (E) REQUIREMENTS FOR COLLECTING DATA RELATING TO THE PROVIDING AND PAYING FOR HEALTH CARE SERVICES UNDER THE PROGRAM AND PROVIDING OF DATA TO THE COMMISSIONER, PAYORS AND HEALTH CARE PROVIDERS UNDER THE PROGRAM, TO PROMOTE THE EFFECTIVE OPERATION AND EVALUATION OF THE PROGRAM, CONSISTENT WITH PROTECTION OF THE CONFIDENTIALITY OF INDIVIDUAL PATIENT INFORMATION; AND (F) PROVISIONS UNDER WHICH THE COMMISSIONER MAY TERMINATE THE PROGRAM.

3-A. THE COMMISSIONER MAY DEVELOP OR APPROVE (A) METHODOLOGIES TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS ESTABLISHED BY EACH MULTIPAYOR PATIENT CENTERED MEDICAL HOME COLLABORATIVE; (B) ALTERNATIVE METHODOLOGIES FOR PAYORS OF HEALTH CARE SERVICES TO HEALTH CARE PROVIDERS UNDER THE PROGRAM; (C) PROVISIONS FOR PAYMENTS TO PROVIDERS THAT MAY VARY BY SIZE OR FORM OF ORGANIZATION OF THE PROVIDER, OR PATIENT CASE MIX, TO ACCOMMODATE DIFFERENT LEVELS OF RESOURCES AND DIFFICULTY TO MEET THE STANDARDS OF THE PROGRAM; (D) PROVISIONS FOR PAYMENTS TO ENTITIES THAT PROVIDE SERVICES TO HEALTH CARE PROVIDERS TO ASSIST THEM IN MEETING MEDICAL HOME STANDARDS UNDER THE PROGRAM SUCH AS THE SERVICES OF COMMUNITY HEALTH WORKERS.

4. THE COMMISSIONER IS AUTHORIZED TO ESTABLISH AN ADVISORY GROUP OF STATE AGENCIES AND STAKEHOLDERS, SUCH AS PROFESSIONAL ORGANIZATIONS AND ASSOCIATIONS, AND CONSUMERS, TO IDENTIFY LEGAL AND/OR ADMINISTRATIVE BARRIERS TO THE SHARING OF CARE MANAGEMENT AND CARE COORDINATION SERVICES AMONG PARTICIPATING HEALTH CARE SERVICES PROVIDERS AND TO MAKE RECOMMENDATIONS FOR STATUTORY AND/OR REGULATORY CHANGES TO ADDRESS SUCH BARRIERS.

5. PATIENT, PAYOR AND HEALTH CARE SERVICES PROVIDER PARTICIPATION IN THE MULTIPAYOR PATIENT CENTERED MEDICAL HOME PROGRAM SHALL BE ON A VOLUNTARY BASIS.

6. CLINICS AND PRIMARY CARE CLINICIANS PARTICIPATING IN A PROGRAM ARE NOT ELIGIBLE FOR ADDITIONAL ENHANCEMENTS OR BONUSES UNDER THE STATEWIDE PATIENT CENTERED MEDICAL HOME PROGRAM ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-M OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL DEVELOP OR APPROVE A METHOD FOR DETERMINING PAYMENT UNDER A PROGRAM WHERE A PROVIDER PARTICIPATES, OR A PATIENT IS SERVED, IN AN AREA WHERE PROGRAM BOUNDARIES OVERLAP.

7. SUBJECT TO THE AVAILABILITY OF FUNDING AND FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED:

(A) TO PAY ENHANCED RATES OF PAYMENT UNDER MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS TO CLINICS AND CLINICIANS THAT ARE CERTIFIED AS PATIENT CENTERED MEDICAL HOMES UNDER THIS TITLE;

(B) TO PAY ADDITIONAL AMOUNTS FOR MEDICAL HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER IN CONSULTATION WITH EACH MULTIPAYOR PATIENT CENTERED MEDICAL HOME COLLABORATIVE;

(C) TO AUTHORIZE ALTERNATIVE PAYMENT METHODOLOGIES UNDER MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS FOR HEALTH CARE PROVIDERS AND TO SERVE THE PURPOSES OF THE PROGRAM, INCLUDING PAYMENTS TO ENTITIES UNDER PARAGRAPH (G) OF SUBDIVISION THREE OF THIS SECTION; AND

(D) TO TEST NEW MODELS OF PAYMENT TO HIGH VOLUME MEDICAID PRIMARY CARE MEDICAL HOME PRACTICES THAT INCORPORATE RISK ADJUSTED GLOBAL PAYMENTS COMBINED WITH CARE MANAGEMENT AND PAY FOR PERFORMANCE ADJUSTMENTS.

8. (A) THE COMMISSIONER IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO ASSIST THE STATE IN IMPLEMENTING THE PROVISIONS OF THIS SECTION. SUCH ENTITY OR ENTITIES SHALL BE THE SAME ENTITY OR ENTITIES CHOSEN TO ASSIST IN THE IMPLEMENTATION OF THE HEALTH HOME PROVISIONS OF SECTION THREE HUNDRED SIXTY-FIVE-L OF THE SOCIAL SERVICES LAW. RESPONSIBILITIES OF THE CONTRACTOR SHALL INCLUDE BUT NOT BE LIMITED TO: DEVELOPING RECOMMENDATIONS WITH RESPECT TO PROGRAM POLICY, REIMBURSEMENT, SYSTEM REQUIREMENTS, REPORTING REQUIREMENTS, EVALUATION PROTOCOLS, AND PROVIDER AND PATIENT ENROLLMENT; PROVIDING TECHNICAL ASSISTANCE TO POTENTIAL MEDICAL HOME AND HEALTH HOME PROVIDERS; DATA COLLECTION; DATA SHARING; PROGRAM EVALUATION, AND PREPARATION OF REPORTS.

(B) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER PARAGRAPH (A) OF THIS SUBDIVISION WITHOUT A REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(I) THE DEPARTMENT SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(1) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(2) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(3) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(4) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(II) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER; AND

(III) THE COMMISSIONER SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

9. THE COMMISSIONER MAY DIRECTLY, OR BY CONTRACT, PROVIDE:

(A) TECHNICAL ASSISTANCE TO A PRIMARY CARE MEDICAL HOME COLLABORATIVE IN RELATION TO ESTABLISHING AND OPERATING A PROGRAM;

(B) CONSUMER ASSISTANCE TO PATIENTS PARTICIPATING IN A PROGRAM AS TO MATTERS RELATING TO THE PROGRAM;

(C) TECHNICAL AND OTHER ASSISTANCE TO HEALTH CARE PROVIDERS PARTICIPATING IN A PROGRAM AS TO MATTERS RELATING TO THE PROGRAM, INCLUDING ACHIEVING MEDICAL HOME STANDARDS;

(D) CARE COORDINATION PROVIDER TECHNICAL AND OTHER ASSISTANCE TO INDIVIDUALS AND ENTITIES PROVIDING CARE COORDINATION SERVICES TO HEALTH CARE PROVIDERS UNDER A PROGRAM; AND

(E) INFORMATION SHARING AND OTHER ASSISTANCE AMONG PROGRAMS TO IMPROVE THE OPERATION OF PROGRAMS, CONSISTENT WITH APPLICABLE LAWS RELATING TO PATIENT CONFIDENTIALITY.

10. THE COMMISSIONER SHALL, TO THE EXTENT NECESSARY FOR THE PURPOSE OF THIS SECTION, SUBMIT THE APPROPRIATE WAIVERS AND OTHER APPLICATIONS, INCLUDING, BUT NOT LIMITED TO, THOSE AUTHORIZED PURSUANT TO SECTIONS ELEVEN HUNDRED FIFTEEN AND NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, OR SUCCESSOR PROVISIONS, AND ANY OTHER WAIVERS OR APPLICATIONS NECESSARY TO ACHIEVE THE PURPOSES OF HIGH QUALITY, INTEGRATED, AND COST EFFECTIVE CARE AND INTEGRATED FINANCIAL ELIGIBILITY POLICIES UNDER MEDICAID, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS OR MEDICARE. COPIES OF SUCH ORIGINAL WAIVER AND OTHER APPLICATIONS SHALL BE PROVIDED TO THE CHAIRMAN OF THE SENATE FINANCE COMMITTEE AND THE CHAIRMAN OF THE ASSEMBLY WAYS AND MEANS COMMITTEE SIMULTANEOUSLY WITH THEIR SUBMISSION TO THE FEDERAL GOVERNMENT.

11. THE ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM (INCLUDING THE ADIRONDACK MEDICAL HOME COLLABORATIVE) PREVIOUSLY ESTABLISHED UNDER SECTION TWENTY-NINE HUNDRED FIFTY-NINE OF THIS CHAPTER IS CONTINUED AND SHALL BE DEEMED TO BE A PROGRAM UNDER THIS SECTION.

12. THE COMMISSIONER SHALL ANNUALLY REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE OPERATION OF THE PROGRAMS AND THEIR EFFECTIVENESS IN ACHIEVING THE PURPOSES OF THIS SECTION, WITH PARTICULAR REFERENCE TO THE QUALITY, COST, AND OUTCOMES FOR ENROLLEES IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS.

S 35-a. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 2 of part B of chapter 109 of the laws of 2010, is amended to read as follows:

(v) [Such] SUCH regulations shall incorporate quality related measures [pertaining to], INCLUDING, BUT NOT LIMITED TO, potentially preventable [complications and] re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs AND OTHER POTENTIALLY PREVENTABLE NEGATIVE OUTCOMES (PPNOS), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a [risk adjusted] comparison of the actual and [the] RISK ADJUSTED expected number of PPRs AND OTHER PPNOS in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than [forty-seven] FIFTY-ONE million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, PROVIDED FURTHER THAT SUCH AGGREGATE REDUCTIONS SHALL BE OFFSET BY MEDICAID PAYMENT REDUCTIONS OCCURRING AS A RESULT OF DECREASED PPRS DURING THE PERIOD JULY FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN AND THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE AND AS A RESULT OF DECREASED PPNOS DURING THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE; and provided further that [the regulations promulgated pursuant to this subparagraph shall be effective on and after July first, two thousand ten, and provided further, however, that] for the period July first, two thousand ten through March thirty-first, two

thousand twelve, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than [April] JULY first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

S 36. Subparagraph (xi) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, is amended and two new subparagraphs (xii) and (xiii) are added to read as follows:

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations. In addition, such regulations shall specify the reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided[.];

(XII) SUCH REGULATIONS MAY INCORPORATE QUALITY RELATED MEASURES PERTAINING TO THE INAPPROPRIATE USE OF CERTAIN MEDICAL PROCEDURES, INCLUDING, BUT NOT LIMITED TO, CESAREAN DELIVERIES, CORONARY ARTERY BYPASS GRAFTS AND PERCUTANEOUS CORONARY INTERVENTIONS;

(XIII) SUCH REGULATIONS MAY IMPOSE A FEE ON GENERAL HOSPITAL SUFFICIENT TO COVER THE COSTS OF AUDITING THE INSTITUTIONAL COST REPORTS SUBMITTED BY GENERAL HOSPITALS, WHICH SHALL BE DEPOSITED IN THE HEALTH CARE REFORM ACT (HCRA) RESOURCES ACCOUNT.

S 37. The social services law is amended by adding a new section 365-l to read as follows:

S 365-L. HEALTH HOMES. 1. NOTWITHSTANDING ANY LAW, RULE OR REGULATION TO THE CONTRARY, THE COMMISSIONER OF HEALTH IS AUTHORIZED, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AND OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, TO (A) ESTABLISH, IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS, STANDARDS FOR THE PROVISION OF HEALTH HOME SERVICES TO MEDICAID ENROLLEES WITH CHRONIC CONDITIONS, (B) ESTABLISH PAYMENT METHODOLOGIES FOR HEALTH HOME SERVICES BASED ON FACTORS INCLUDING BUT NOT LIMITED TO THE COMPLEXITY OF THE CONDITIONS PROVIDERS WILL BE MANAGING, THE ANTICIPATED AMOUNT OF PATIENT CONTACT NEEDED TO MANAGE SUCH CONDITIONS, AND THE HEALTH CARE COST SAVINGS REALIZED BY PROVISION OF HEALTH HOME SERVICES, (C) ESTABLISH THE CRITERIA UNDER WHICH A MEDICAID ENROLLEE WILL BE DESIGNATED AS BEING AN ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS FOR PURPOSES OF THIS PROGRAM, (D) ASSIGN ANY MEDICAID ENROLLEE DESIGNATED AS AN ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS TO A PROVIDER OF HEALTH HOME SERVICES.

2. IN ADDITION TO PAYMENTS MADE FOR HEALTH HOME SERVICES PURSUANT TO SUBDIVISION ONE OF THIS SECTION, THE COMMISSIONER IS AUTHORIZED TO PAY ADDITIONAL AMOUNTS TO PROVIDERS OF HEALTH HOME SERVICES THAT MEET PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER.

3. UNTIL SUCH TIME AS THE COMMISSIONER OBTAINS NECESSARY WAIVERS AND/OR APPROVALS OF THE FEDERAL SOCIAL SECURITY ACT, MEDICAID ENROLLEES ASSIGNED TO PROVIDERS OF HEALTH HOME SERVICES WILL BE ALLOWED TO OPT OUT OF SUCH SERVICES. IN ADDITION, UPON ENROLLMENT, AN ENROLLEE SHALL BE OFFERED AN OPTION OF AT LEAST TWO PROVIDERS OF HEALTH HOME SERVICES, TO THE EXTENT PRACTICABLE.

4. PAYMENTS AUTHORIZED PURSUANT TO THIS SECTION WILL BE MADE WITH STATE FUNDS ONLY, TO THE EXTENT THAT SUCH FUNDS ARE APPROPRIATED THERE-

FORE, UNTIL SUCH TIME AS FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH SERVICES IS AVAILABLE.

5. THE COMMISSIONER IS AUTHORIZED TO SUBMIT AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, TO OBTAIN FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF HEALTH HOME SERVICES PROVIDED PURSUANT TO THIS SECTION, AND AS PROVIDED IN SUBDIVISION THREE OF THIS SECTION.

6. NOTWITHSTANDING ANY LIMITATIONS IMPOSED BY SECTION THREE HUNDRED SIXTY-FOUR-L OF THIS TITLE ON ENTITIES PARTICIPATING IN DEMONSTRATION PROJECTS ESTABLISHED PURSUANT TO SUCH SECTION, THE COMMISSIONER IS AUTHORIZED TO ALLOW SUCH ENTITIES WHICH MEET THE REQUIREMENTS OF THIS SECTION TO PROVIDE HEALTH HOME SERVICES.

7. NOTWITHSTANDING ANY LAW, RULE, OR REGULATION TO THE CONTRARY, THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH, THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO JOINTLY ESTABLISH A SINGLE SET OF OPERATING AND REPORTING REQUIREMENTS AND A SINGLE SET OF CONSTRUCTION AND SURVEY REQUIREMENTS FOR ENTITIES THAT:

(A) CAN DEMONSTRATE EXPERIENCE IN THE DELIVERY OF HEALTH, AND MENTAL HEALTH AND/OR ALCOHOL AND SUBSTANCE ABUSE SERVICES AND/OR SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THE CAPACITY TO OFFER INTEGRATED DELIVERY OF SUCH SERVICES IN EACH LOCATION APPROVED BY THE COMMISSIONER; AND

(B) MEET THE STANDARDS ESTABLISHED PURSUANT TO SUBDIVISION ONE OF THIS SECTION FOR PROVIDING AND RECEIVING PAYMENT FOR HEALTH HOME SERVICES; PROVIDED, HOWEVER, THAT AN ENTITY MEETING THE STANDARDS ESTABLISHED PURSUANT TO SUBDIVISION ONE OF THIS SECTION SHALL NOT BE REQUIRED TO BE AN INTEGRATED SERVICE PROVIDER PURSUANT TO THIS SUBDIVISION.

IN ESTABLISHING A SINGLE SET OF OPERATING AND REPORTING REQUIREMENTS AND A SINGLE SET OF CONSTRUCTION AND SURVEY REQUIREMENTS FOR ENTITIES DESCRIBED IN THIS SUBDIVISION, THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH, THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO WAIVE ANY REGULATORY REQUIREMENTS AS ARE NECESSARY TO AVOID DUPLICATION OF REQUIREMENTS AND TO ALLOW THE INTEGRATED DELIVERY OF SERVICES IN A RATIONAL AND EFFICIENT MANNER.

8. (A) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO ASSIST THE STATE IN IMPLEMENTING THE PROVISIONS OF THIS SECTION. SUCH ENTITY OR ENTITIES SHALL BE THE SAME ENTITY OR ENTITIES CHOSEN TO ASSIST IN THE IMPLEMENTATION OF THE MULTIPAYOR PATIENT CENTERED MEDICAL HOME PROGRAM PURSUANT TO SECTION TWENTY-NINE HUNDRED FIFTY-NINE-A OF THE PUBLIC HEALTH LAW. RESPONSIBILITIES OF THE CONTRACTOR SHALL INCLUDE BUT NOT BE LIMITED TO: DEVELOPING RECOMMENDATIONS WITH RESPECT TO PROGRAM POLICY, REIMBURSEMENT, SYSTEM REQUIREMENTS, REPORTING REQUIREMENTS, EVALUATION PROTOCOLS, AND PROVIDER AND PATIENT ENROLLMENT; PROVIDING TECHNICAL ASSISTANCE TO POTENTIAL MEDICAL HOME AND HEALTH HOME PROVIDERS; DATA COLLECTION; DATA SHARING; PROGRAM EVALUATION, AND PREPARATION OF REPORTS.

(B) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER PARAGRAPH (A) OF THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(I) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(1) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(2) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(3) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(4) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(II) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH; AND

(III) THE COMMISSIONER OF HEALTH SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

S 38. Section 2816 of the public health law, as added by chapter 225 of the laws of 2001, paragraph (a) of subdivision 2 as amended by section 19 of part D of chapter 57 of the laws of 2006, is amended to read as follows:

S 2816. Statewide planning and research cooperative system. 1. (A) The statewide planning and research cooperative system in the department is continued, as provided in AND SUBJECT TO this section, WITHIN AMOUNTS APPROPRIATED FOR THAT PURPOSE. The [statewide planning and research cooperative] system shall be developed and operated by the commissioner in consultation with the council, [and shall be comprised of such data elements] as may be specified by regulation OF THE COMMISSIONER. ANY COMPONENT OR COMPONENTS OF THE SYSTEM MAY BE OPERATED UNDER A DIFFERENT NAME OR NAMES, AND MAY BE STRUCTURED AS SEPARATE SYSTEMS. IN MAKING REGULATIONS UNDER THIS SECTION, SUBSEQUENT TO APRIL FIRST, TWO THOUSAND ELEVEN, THE COMMISSIONER SHALL CONSULT WITH THE SUPERINTENDENT OF INSURANCE OR THE HEAD OF ANY AGENCY THAT SUCCEEDS THE INSURANCE DEPARTMENT, HEALTH CARE PROVIDERS, THIRD-PARTY HEALTH CARE PAYERS, AND ADVOCATES REPRESENTING PATIENTS; PROTECT THE CONFIDENTIALITY OF PATIENT-IDENTIFIABLE INFORMATION; PROMOTE THE ACCURACY AND COMPLETENESS OF REPORTING; AND MINIMIZE THE BURDEN ON INSTITUTIONAL AND NON-INSTITUTIONAL HEALTH CARE PROVIDERS AND THIRD-PARTY HEALTH CARE PAYERS.

(B) AS USED IN THIS SECTION, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

(I) "HEALTH CARE" MEANS ANY SERVICES, SUPPLIES, EQUIPMENT, OR PRESCRIPTION DRUGS REFERRED TO IN SUBDIVISION TWO OF THIS SECTION.

(II) "HEALTH CARE PROVIDER" INCLUDES, IN ADDITION TO ITS COMMON MEANINGS, A CLINICAL LABORATORY, A PHARMACY, AN ENTITY THAT IS AN INTEGRATED ORGANIZATION OF HEALTH CARE PROVIDERS, AND AN ACCOUNTABLE CARE ORGANIZATION OF HEALTH CARE PROVIDERS.

(III) "SYSTEM" MEANS THE STATEWIDE PLANNING AND RESEARCH COOPERATIVE SYSTEM UNDER THIS SECTION, AND ANY SEPARATE SYSTEM UNDER THIS SUBDIVISION.

(IV) "THIRD-PARTY HEALTH CARE PAYER" INCLUDES, BUT IS NOT LIMITED TO, AN INSURER, ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE THIRTY-TWO, FORTY-THREE OR FORTY-SEVEN OF THE INSURANCE LAW, OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR AN ENTITY SUCH AS A PHARMACY BENEFITS MANAGER, FISCAL ADMINISTRATOR, OR ADMINISTRATIVE SERVICES PROVIDER THAT PARTICIPATES IN THE ADMINISTRATION OF A THIRD-PARTY HEALTH CARE PAYER SYSTEM.

(V) "COVERED PERSON" IS A PERSON COVERED UNDER A THIRD-PARTY HEALTH CARE PAYER CONTRACT, AGREEMENT, OR ARRANGEMENT.

2. [Regulations] NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, REGULATIONS governing the [statewide planning and research cooperative] system shall include, but not be limited to, the following:

(a) Specification of patient, COVERED PERSON, CLAIMS, and other data elements and format [to] WHICH SHALL be reported including data related to:

(i) inpatient hospitalization data from general hospitals;

(ii) ambulatory surgery data from hospital-based ambulatory surgery services and all other ambulatory surgery facilities licensed under this article;

(iii) emergency department data from general hospitals;

(iv) outpatient [clinic], CLINICAL LABORATORY, AND PRESCRIPTION DATA, INCLUDING BUT NOT LIMITED TO data from OR RELATING TO SERVICES, SUPPLIES, EQUIPMENT, AND PRESCRIPTION DRUGS PROVIDED OR ORDERED BY general hospitals and diagnostic and treatment centers licensed under this article, [provided, however, that notwithstanding subdivision one of this section the commissioner, in consultation with the health care industry, is authorized to promulgate or adopt any rules or regulations necessary to implement the collection of data pursuant to this subparagraph] PHARMACIES, CLINICAL LABORATORIES, AND OTHER HEALTH CARE PROVIDERS;

(v) COVERED PERSON AND CLAIMS DATA; and

(VI) the data specified in this paragraph shall include the identification of patients transferred, admitted or treated subsequent to a medical, surgical or diagnostic procedure by a licensed health care professional OR at a HEALTH CARE site or facility [other than those specified in subparagraph (i), (ii), (iii) or (iv) of this paragraph].

(b) Standards to assure the protection of patient privacy in data collected [and], PUBLISHED, released [under this section], USED AND ACCESSED UNDER THIS SECTION, INCLUDING COMPLIANCE WITH APPLICABLE FEDERAL LAW.

(c) Standards for the publication [and], release, AND USE of AND ACCESS TO data reported in accordance with this section, INCLUDING FEES TO BE CHARGED.

(D) PROVISIONS REQUIRING SPECIFIED HEALTH CARE PROVIDERS AND THIRD-PARTY HEALTH CARE PAYERS TO REPORT DATA TO THE SYSTEM, WITH SPECIFICATIONS OF THE DATA, CIRCUMSTANCES, FORMAT, TIME AND METHOD OF REPORTING.

(E) PROVISIONS TO ACQUIRE DATA RELATING TO HEALTH CARE PROVIDED (I) TO PATIENTS FOR WHOM THERE IS NO THIRD-PARTY HEALTH CARE PAYER AND (II) UNDER ARRANGEMENTS THAT DO NOT INVOLVE FEE-FOR-SERVICE PAYMENT.

(F) PHASED-IN IMPLEMENTATION OF THE SYSTEM.

3. THE COMMISSIONER MAY PROVIDE THAT THE SYSTEM MAY PARTICIPATE IN OR COOPERATE WITH A SIMILAR SYSTEM OPERATED BY, OR RECEIVE INFORMATION FROM OR PROVIDE INFORMATION TO, A REGIONAL OR NATIONAL ENTITY OR ANOTHER JURISDICTION, INCLUDING MAKING APPROPRIATE AGREEMENTS AND APPLYING FOR APPROVALS, PROVIDED THAT THE PROTECTIONS FOR HEALTH CARE PROVIDERS, PATIENTS, AND THIRD-PARTY HEALTH CARE PAYERS IN THIS SECTION ARE PRESERVED AND COMPARABLE PROVISIONS ARE INCLUDED IN THE OTHER SYSTEM.

4. THE COMMISSIONER MAY PROVIDE FOR ACCESS TO DATA IN THE SYSTEM BY A HEALTH CARE PROVIDER RELATING TO A PATIENT BEING TREATED BY THE HEALTH CARE PROVIDER, SUBJECT TO THIS SECTION AND APPLICABLE STATE AND FEDERAL LAW.

5. IN OPERATING THE SYSTEM, THE COMMISSIONER SHALL CONSIDER NATIONAL STANDARDS, INCLUDING BUT NOT LIMITED TO THOSE APPROVED BY THE NATIONAL UNIFORM BILLING COMMITTEE (NUBC) OR REQUIRED UNDER NATIONAL ELECTRONIC

DATA INTERCHANGE (EDI) STANDARDS FOR HEALTH CARE TRANSACTIONS. THE COMMISSIONER SHALL ALSO CONSIDER THE USE OF THE STATEWIDE HEALTH INFORMATION NETWORK FOR NEW YORK IN RELATION TO THE SYSTEM.

6. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW TO THE CONTRARY, INCLUDING BUT NOT LIMITED TO SECTION ONE HUNDRED TWO OF THE EXECUTIVE LAW, SUCH RULES AND REGULATIONS MAY DESCRIBE DATA ELEMENTS BY REFERENCE TO INFORMATION REASONABLY AVAILABLE TO REGULATED PARTIES, AS SUCH MATERIAL MAY BE AMENDED IN THE FUTURE, EVEN THOUGH SUCH MATERIAL CANNOT BE PRECISELY IDENTIFIED TO THE EXTENT THAT IT IS AMENDED IN THE FUTURE; PROVIDED, HOWEVER, THAT THE COMMISSIONER SHALL PRECISELY IDENTIFY AND PUBLISH SUCH DATA ELEMENTS.

7. THE COMMISSIONER MAY CONTRACT WITH ONE OR MORE ENTITIES TO OPERATE ANY PART OF THE SYSTEM SUBJECT TO THIS SECTION.

8. THE COMMISSIONER MAY ACCEPT GRANTS AND ENTER INTO CONTRACTS AS MAY BE NECESSARY TO PROVIDE FUNDING FOR THE SYSTEM.

9. THE COMMISSIONER SHALL PUBLISH AN ANNUAL REPORT RELATING TO HEALTH CARE UTILIZATION, COST, QUALITY, AND SAFETY, INCLUDING DATA ON HEALTH DISPARITIES.

S 38-a. Paragraph (b) of subdivision 18-a of section 206 of the public health law, as added by section 11 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

(b) The commissioner shall make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a statewide health information network of New York (SHIN-NY) to enable widespread interoperability among disparate health information systems, including electronic health records, personal health records, HEALTH CARE CLAIMS AND OTHER ADMINISTRATIVE DATA, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY.

S 39. The social services law is amended by adding a new section 363-e to read as follows:

S 363-E. MEDICAID PLAN, APPLICATIONS FOR WAIVERS AND PLAN AMENDMENTS; PUBLIC DISCLOSURE. 1. THE COMMISSIONER OF HEALTH SHALL POST ON THE DEPARTMENT OF HEALTH INTERNET WEBSITE IN AS TIMELY A MANNER AS PRACTICAL THE ENTIRETY OF THE STATE'S PLAN FOR MEDICAL ASSISTANCE AS REQUIRED BY TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT, OR ITS SUCCESSOR, AND EVERY APPROVED AMENDMENT AND CHANGE TO THE PLAN.

2. THE COMMISSIONER OF HEALTH SHALL POST ON THE DEPARTMENT OF HEALTH INTERNET WEBSITE IN AS TIMELY A MANNER AS PRACTICAL: EVERY APPLICATION FOR A FEDERAL WAIVER AND EVERY PROPOSED STATE PLAN AMENDMENT, RELATING TO THE STATE'S PLAN FOR MEDICAL ASSISTANCE, SUBMITTED TO THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR ANY SUCCESSOR AGENCY OR PART THEREOF.

S 40. Paragraph (u) of subdivision 2 of section 365-a of the social services law, as amended by section 42 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(u) screening, brief intervention, and referral to treatment [in hospital outpatient and emergency departments and free-standing diagnostic and treatment centers] of individuals at risk for substance abuse including referral to the appropriate level of intervention and treatment in a community setting; provided, however, that the provisions of this paragraph relating to screening, brief intervention, and referral to treatment services shall not take effect unless all necessary

approvals under federal law and regulation have been obtained to receive federal financial participation in such costs.

S 41. Paragraphs (d) and (e) of subdivision 1 and paragraphs (c) and (d) of subdivision 2 of section 4403-f of the public health law, paragraph (d) of subdivision 1 as amended by section 6 of part C of chapter 58 of the laws of 2007, paragraph (e) of subdivision 1 as amended by section 65-d of part A of chapter 57 of the laws of 2006, paragraph (c) of subdivision 2 as added by chapter 659 of the laws of 1997 and paragraph (d) of subdivision 2 as amended by section 9 of part C of chapter 58 of the laws of 2007, and paragraphs (d) and (e) of subdivision 1 as relettered by section 7 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

(d) ["Approved managed long term care demonstration" means the sites approved by the commissioner to participate in the "Evaluated Medicaid Long Term Care Capitation Program".

(e)] "Health and long term care services" means services including, but not limited to [primary care, acute care,] home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. THE MANAGED LONG TERM CARE PLAN MAY ALSO COVER PRIMARY CARE AND ACUTE CARE IF SO AUTHORIZED.

(c) [a description that demonstrates the cost-effectiveness of the program as compared to the cost of services clients would otherwise have received;

(d)] adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section.

S 41-a. Subdivision 3 of section 4403-f of the public health law, as amended by chapter 627 of the laws of 2008, is amended to read as follows:

3. Certificate of authority; approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

(a) [the relative cost effectiveness to the medical assistance program when compared to other managed long term care plans proposing to serve, or serving, comparable populations;

(b)] that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

[(c)] (B) that it will include an enrollment process which shall ensure that enrollment in the plan is informed [and voluntary by enrollees or their representatives and a voluntary disenrollment process]. The application shall [include the specific grounds that would warrant involuntary disenrollment provided, however,] DESCRIBE THE DISENROLLMENT PROCESS, WHICH SHALL PROVIDE THAT an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

[(d)] (C) satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

[(e)] (D) sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

[(f)] (E) readiness and capability to [achieve full capitation for services reimbursed pursuant to title XVIII of the federal social security act or, for an applicant designated as an eligible applicant prior to April first, two thousand seven pursuant to paragraph (d) of subdivision six of this section that has its principal place of business in Bronx county and is unable to achieve such full capitation, readiness and capability to achieve full capitation on a scheduled basis for] MAXIMIZE REIMBURSEMENT OF AND COORDINATE services reimbursed pursuant to title XVIII of the federal social security act [or capability and protocols for benefit coordination for services reimbursed pursuant to such title] and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

[(g)] (F) readiness and capability to [achieve full capitation for] ARRANGE AND MANAGE COVERED SERVICES AND COORDINATE NON-COVERED SERVICES WHICH COULD INCLUDE PRIMARY, SPECIALTY, AND ACUTE CARE services reimbursed pursuant to title XIX of the federal social security act;

[(h)] (G) willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

[(i)] (H) that the CONTRACTUAL arrangements for PROVIDERS OF health and long term care services IN THE BENEFIT PACKAGE ARE SUFFICIENT TO ensure the availability and accessibility of such services to the proposed enrolled population CONSISTENT WITH GUIDELINES ESTABLISHED BY THE COMMISSIONER; WITH RESPECT TO INDIVIDUALS IN RECEIPT OF SUCH SERVICES PRIOR TO ENROLLMENT, SUCH GUIDELINES SHALL REQUIRE THE MANAGED LONG TERM CARE PLAN TO CONTRACT WITH AGENCIES CURRENTLY PROVIDING SUCH SERVICES, IN ORDER TO PROMOTE CONTINUITY OF CARE. IN ADDITION, SUCH GUIDELINES SHALL REQUIRE MANAGED LONG TERM CARE PLANS TO OFFER AND COVER CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES FOR ELIGIBLE INDIVIDUALS WHO ELECT SUCH SERVICES PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW; and

[(j)] (I) that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

S 41-b. Subdivisions 5, 6, 7 and 10 of section 4403-f of the public health law, subdivision 5 as amended by section 15 of part C of chapter 58 of the laws of 2007, subdivisions 6 and 7 as added by chapter 659 of the laws of 1997, paragraphs (a), (b) and (c) of subdivision 6 as amended by section 6 of part C of chapter 58 of the laws of 2010, paragraph (d) of subdivision 6 as amended by section 17 of part C of chapter 58 of the laws of 2007, paragraphs (c) and (d) of subdivision 7 as amended by section 18 of part C of chapter 58 of the laws of 2007, paragraphs (e) and (g) of subdivision 7 as relettered by section 20 of part C of chapter 58 of the laws of 2007, paragraph (h) of subdivision 7 as added by section 65-c of part A of chapter 57 of the laws of 2006, paragraph (i) as added by section 65-f of part A of chapter 57 of the laws of 2006, and such paragraphs (h) and (i) as relettered by section 20 of part C of chapter 58 of the laws of 2007, paragraph (f) of subdivision 7

as amended by section 7 of part C of chapter 58 of the laws of 2010, subparagraph (iii) of paragraph (h) of subdivision 7 as amended by section 19 of part C of chapter 58 of the laws of 2007, subdivision 10 as amended by chapter 192 of the laws of 2006 and renumbered by section 22 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

5. Applicability of other laws. A managed long term care plan [or approved managed long term care demonstration] shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

6. Approval authority. (a) An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section. The commissioner shall issue no more than [fifty] SEVENTY-FIVE certificates of authority to managed long term care plans pursuant to this section. [For purposes of issuance of no more than fifty certificates of authority, such certificates shall include those certificates issued pursuant to paragraphs (b) and (c) of this subdivision.]

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. [Except as otherwise expressly provided in paragraphs (d) and (e) of subdivision seven of this section, nothing] NOTHING in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) [An approved managed long term care demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Notwithstanding any inconsistent provision of law to the contrary, all authority for the operation of approved managed long term care demonstrations which have not been issued a certificate of authority as a managed long term care plan, shall expire one year after the adoption of regulations implementing managed long term care plans.

(d) The majority leader of the senate and the speaker of the assembly may each designate in writing up to fifteen eligible applicants to apply to be approved managed long term care demonstrations or plans. The commissioner may designate in writing up to eleven eligible applicants to apply to be approved managed long term care demonstrations or plans.] FOR THE PERIOD BEGINNING APRIL FIRST, TWO THOUSAND TWELVE AND ENDING MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, THE MAJORITY LEADER OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY MAY EACH RECOMMEND TO THE COMMISSIONER, IN WRITING, UP TO FOUR ELIGIBLE APPLICANTS TO CONVERT TO BE APPROVED MANAGED LONG TERM CARE PLANS. AN APPLICANT SHALL ONLY BE APPROVED AND ISSUED A CERTIFICATE OF AUTHORITY IF THE COMMISSIONER DETERMINES THAT THE APPLICANT MEETS THE REQUIREMENTS OF SUBDIVISION THREE OF THIS SECTION. THE MAJORITY LEADER OF THE SENATE OR THE SPEAKER OF THE ASSEMBLY MAY ASSIGN THEIR AUTHORITY TO RECOMMEND ONE OR MORE APPLICANTS UNDER THIS SECTION TO THE COMMISSIONER.

7. Program oversight and administration. (a)(i) The commissioner shall promulgate regulations to implement this section and to ensure the qual-

ity, appropriateness and cost-effectiveness of the services provided by managed long term care plans. The commissioner may waive rules and regulations of the department, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver will promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of enrollees will not be impaired as a result of such waiver. In order to achieve managed long term care plan system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioner may establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet component quality requirements, and require a uniform cost report. The commissioner shall require managed long term care plans to utilize quality improvement measures, based on health outcomes data, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation.

(b) (I) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. IN ADDITION, THE COMMISSIONER IS AUTHORIZED TO SUBMIT THE APPROPRIATE WAIVERS, INCLUDING BUT NOT LIMITED TO THOSE AUTHORIZED PURSUANT TO SECTIONS ELEVEN HUNDRED FIFTEEN AND NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT OR SUCCESSOR PROVISIONS, AND ANY OTHER WAIVERS NECESSARY TO REQUIRE ON OR AFTER APRIL FIRST, TWO THOUSAND TWELVE, MEDICAL ASSISTANCE RECIPIENTS WHO ARE TWENTY-ONE YEARS OF AGE OR OLDER AND WHO REQUIRE COMMUNITY-BASED LONG TERM CARE SERVICES, AS SPECIFIED BY THE COMMISSIONER, FOR MORE THAN ONE HUNDRED AND TWENTY DAYS, TO RECEIVE SUCH SERVICES THROUGH AN AVAILABLE PLAN CERTIFIED PURSUANT TO THIS SECTION OR OTHER PROGRAM MODEL THAT MEETS GUIDELINES SPECIFIED BY THE COMMISSIONER THAT SUPPORT COORDINATION AND INTEGRATION OF SERVICES. SUCH GUIDELINES SHALL ADDRESS THE REQUIREMENTS OF PARAGRAPHS (A), (B), (C), (D), (E), (F), (G), (H), AND (I) OF SUBDIVISION THREE OF THIS SECTION AS WELL AS PAYMENT METHODS THAT ENSURE PROVIDER ACCOUNTABILITY FOR COST EFFECTIVE QUALITY OUTCOMES. SUCH OTHER PROGRAM MODELS MAY INCLUDE LONG TERM HOME HEALTH CARE PROGRAMS THAT COMPLY WITH SUCH GUIDELINES. Copies of such original waiver applications AND AMENDMENTS THERETO shall be provided to the [chairman] CHAIRS of the senate finance committee [and the chairman of], the assembly ways and

means committee AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES simultaneously with their submission to the federal government.

(II) THE COMMISSIONER, SHALL SEEK INPUT FROM REPRESENTATIVES OF HOME AND COMMUNITY-BASED LONG TERM CARE SERVICES PROVIDERS, RECIPIENTS, AND THE MEDICAID MANAGED CARE ADVISORY REVIEW PANEL, AMONG OTHERS, TO FURTHER EVALUATE AND PROMOTE THE TRANSITION OF PERSONS IN RECEIPT OF HOME AND COMMUNITY-BASED LONG TERM CARE SERVICES INTO MANAGED LONG TERM CARE PLANS AND OTHER CARE COORDINATION MODELS AND TO DEVELOP GUIDELINES FOR SUCH CARE COORDINATION MODELS. THE GUIDELINES SHALL BE FINALIZED AND POSTED ON THE DEPARTMENT'S WEBSITE NO LATER THAN NOVEMBER FIFTEEN, TWO THOUSAND ELEVEN.

(III) MEDICAL ASSISTANCE RECIPIENTS WHO ARE NATIVE AMERICANS SHALL NOT BE REQUIRED TO ENROLL IN A MANAGED LONG TERM CARE PLAN OR OTHER CARE COORDINATION MODEL PURSUANT TO THIS PARAGRAPH.

(IV) THE FOLLOWING MEDICAL ASSISTANCE RECIPIENTS SHALL NOT BE ELIGIBLE TO PARTICIPATE IN A MANAGED LONG TERM CARE PROGRAM OR OTHER CARE COORDINATION MODEL ESTABLISHED PURSUANT TO THIS PARAGRAPH:

(1) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR LESS THAN SIX MONTHS, FOR A REASON OTHER THAN THAT THE PERSON IS ELIGIBLE FOR MEDICAL ASSISTANCE ONLY THROUGH THE APPLICATION OF EXCESS INCOME TOWARD THE COST OF MEDICAL CARE AND SERVICES;

(2) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(3) A PERSON RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;

(4) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAILABLE FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY PAYMENT, OR PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN PAYMENT OF SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE, AS DETERMINED BY THE SOCIAL SERVICES DISTRICT;

(5) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARAGRAPH ELEVEN OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW;

(6) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO PARAGRAPH (V) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW.

(V) THE FOLLOWING MEDICAL ASSISTANCE RECIPIENTS SHALL NOT BE ELIGIBLE TO PARTICIPATE IN A MANAGED LONG TERM CARE PROGRAM OR OTHER CARE COORDINATION MODEL ESTABLISHED PURSUANT TO THIS PARAGRAPH UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND, AS APPLICABLE, THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES:

(1) A PERSON ENROLLED IN A MANAGED CARE PLAN PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW;

(2) A PARTICIPANT IN THE TRAUMATIC BRAIN INJURY WAIVER PROGRAM;

(3) A PARTICIPANT IN THE NURSING HOME TRANSITION AND DIVERSION WAIVER PROGRAM;

(4) A PERSON ENROLLED IN THE ASSISTED LIVING PROGRAM;

(5) A PERSON ENROLLED IN HOME AND COMMUNITY BASED WAIVER PROGRAMS ADMINISTERED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.

(VI) PERSONS REQUIRED TO ENROLL IN THE MANAGED LONG TERM CARE PROGRAM OR OTHER CARE COORDINATION MODEL ESTABLISHED PURSUANT TO THIS PARAGRAPH SHALL HAVE NO LESS THAN THIRTY DAYS TO SELECT A MANAGED LONG TERM CARE PROVIDER, AND SHALL BE PROVIDED WITH INFORMATION TO MAKE AN INFORMED CHOICE. WHERE A PARTICIPANT HAS NOT SELECTED SUCH A PROVIDER, THE COMMISSIONER SHALL ASSIGN SUCH PARTICIPANT TO A MANAGED LONG TERM CARE PROVIDER, TAKING INTO ACCOUNT QUALITY, CAPACITY AND GEOGRAPHIC ACCESSIBILITY.

(VII) MANAGED LONG TERM CARE PROVIDED AND PLANS CERTIFIED OR OTHER CARE COORDINATION MODEL ESTABLISHED PURSUANT TO THIS PARAGRAPH SHALL COMPLY WITH THE PROVISIONS OF PARAGRAPHS (D), (I), AND (T) AND SUBPARAGRAPH (III) OF PARAGRAPH (A) AND SUBPARAGRAPH (IV) OF PARAGRAPH (E) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW.

(c)(i) A managed long term care plan shall not use deceptive or coercive marketing methods to encourage participants to enroll. A managed long term care plan shall not distribute marketing materials to potential enrollees before such materials have been approved by the commissioner.

(ii) The commissioner shall ensure, through periodic reviews of managed long term care plans, that enrollment was [a voluntary and] AN informed choice; such plan has only enrolled persons whom it is authorized to enroll, and plan services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioner in regulations.

(d) Notwithstanding any provision of law, rule or regulation to the contrary, the commissioner may issue a request for proposals to carry out reviews of enrollment and assessment activities in managed long term care plans and operating demonstrations with respect to enrollees eligible to receive services under title XIX of the federal social security act to determine if enrollment meets the requirements of subparagraph (ii) of paragraph (c) of this subdivision; and that assessments of such enrollees' health, functional and other status, for the purpose of adjusting premiums, were accurate. [Evaluations shall address each bidder's ability to ensure that enrollments in such plans are promptly reviewed and that medical assistance required to be furnished pursuant to title eleven of article five of the social services law will be appropriately furnished to the recipients for whom the local commissioners are responsible pursuant to section three hundred sixty-five of such title and that plan implementation will be consistent with the proper and efficient administration of the medical assistance program and managed long term care plans.]

(e) The commissioner may, in his or her discretion for the purpose of protection of enrollees, impose measures including, but not limited to, bans on further enrollments and requirements for use of enrollment brokers until any identified problems are resolved to the satisfaction of the commissioner.

(f) Continuation of a certificate of authority issued under this section shall be contingent upon satisfactory performance by the managed long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf of enrollees who are eligible to receive services under title XIX of the federal social security act.

(g) [The commissioner shall ensure that (i) a process exists for the resolution of disputes concerning the accuracy of assessments performed pursuant to paragraphs (d) and (e) of this subdivision; and (ii) the tasks described in paragraphs (d) and (e) of this subdivision are consistently administered.

(h)] (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an

evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the [prospective] enrollee. UPON APPROVAL OF FEDERAL WAIVERS PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION WHICH REQUIRE MEDICAL ASSISTANCE RECIPIENTS WHO REQUIRE COMMUNITY-BASED LONG TERM CARE SERVICES TO ENROLL IN A PLAN, AND UPON APPROVAL OF THE COMMISSIONER, A PLAN MAY ENROLL AN APPLICANT WHO IS CURRENTLY RECEIVING HOME AND COMMUNITY-BASED SERVICES AND COMPLETE THE COMPREHENSIVE ASSESSMENT WITHIN THIRTY DAYS OF ENROLLMENT PROVIDED THAT THE PLAN CONTINUES TO COVER TRANSITIONAL CARE UNTIL SUCH TIME AS THE ASSESSMENT IS COMPLETED.

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner AS NECESSARY. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The [completed assessment and documentation of the] enrollment APPLICATION shall be submitted by the managed long term care plan or demonstration to the [local department of social services, or to a contractor selected pursuant to paragraph (d) of this subdivision,] ENTITY DESIGNATED BY THE DEPARTMENT prior to the commencement of services under the managed long term care plan or demonstration. For purposes of reimbursement of the managed long term care plan or demonstration, if the [completed assessment and documentation are] ENROLLMENT APPLICATION IS submitted on or before the twentieth day of the month, the enrollment shall commence on the first day of the month following the completion and submission and if the [completed assessment and documentation are] ENROLLMENT APPLICATION IS submitted after the twentieth day of the month, the enrollment shall commence on the first day of the second month following submission. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department [and by the local social services district] or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least [annually] EVERY SIX MONTHS by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

[(i)] (H) The commissioner shall, upon request by a managed long term care plan[, approved managed long term care demonstration,] or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

(i) information concerning utilization of services and providers by each of its enrollees prior to and during enrollment, including but not limited to utilization of emergency department services, prescription drugs, and hospital and nursing facility admissions.

(ii) aggregate data concerning utilization and costs for enrollees and for comparable cohorts served through the Medicaid fee-for-service program.

10. [The] NOTWITHSTANDING ANY INCONSISTENT PROVISION TO THE CONTRARY, THE ENROLLMENT AND DISENROLLMENT PROCESS AND services provided or arranged by all operating demonstrations or any program that receives

designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, MUST MEET ALL APPLICABLE FEDERAL REQUIREMENTS. SERVICES may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services.

S 42. Section 4401 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. "SPECIAL NEEDS MANAGED CARE PLAN" OR "SPECIALIZED MANAGED CARE PLAN" SHALL MEAN A COMBINATION OF PERSONS NATURAL OR CORPORATE, OR ANY GROUPS OF SUCH PERSONS, OR A COUNTY OR COUNTIES, WHO ENTER INTO AN ARRANGEMENT, AGREEMENT OR PLAN, OR COMBINATION OF ARRANGEMENTS, AGREEMENTS OR PLANS, TO PROVIDE HEALTH AND BEHAVIORAL HEALTH SERVICES TO ENROLLEES WITH SIGNIFICANT BEHAVIORAL HEALTH NEEDS.

S 42-a. The public health law is amended by adding a new section 4403-d to read as follows:

S 4403-D. SPECIAL NEEDS MANAGED CARE PLANS AND SPECIALIZED MANAGED CARE PLANS. NO PERSON, GROUP OF PERSONS, COUNTY OR COUNTIES MAY OPERATE A SPECIAL NEEDS MANAGED CARE PLAN OR SPECIALIZED MANAGED CARE PLAN WITHOUT FIRST OBTAINING A CERTIFICATE OF AUTHORITY FROM THE COMMISSIONER, ISSUED JOINTLY WITH THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

S 42-b. Paragraph (m) of subdivision 1 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, is amended to read as follows:

(m) "[Mental health special] SPECIAL needs MANAGED CARE plan" AND "SPECIALIZED MANAGED CARE PLAN" shall have the same meaning as in section forty-four hundred [three-d] ONE of the public health law.

S 42-c. Subdivision 2 of section 364-j of the social services law is amended by adding a new paragraph (c) to read as follows:

(C) THE COMMISSIONER OF HEALTH, JOINTLY WITH THE COMMISSIONER OF MENTAL HEALTH AND THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL BE AUTHORIZED TO ESTABLISH SPECIAL NEEDS MANAGED CARE AND SPECIALIZED MANAGED CARE PLANS, UNDER THE MEDICAL ASSISTANCE PROGRAM, IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS. THE COMMISSIONER OF HEALTH, IN COOPERATION WITH SUCH COMMISSIONERS, IS AUTHORIZED, SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, TO APPLY FOR FEDERAL WAIVERS WHEN SUCH ACTION WOULD BE NECESSARY TO ASSIST IN PROMOTING THE OBJECTIVES OF THIS SECTION.

S 42-d. The social services law is amended by adding a new section 365-m to read as follows:

S 365-M. ADMINISTRATION AND MANAGEMENT OF BEHAVIORAL HEALTH SERVICES. 1. THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, THE IMPACTED LOCAL GOVERNMENTAL UNITS AND WITH THE APPROVAL OF THE DIVISION OF THE BUDGET, SHALL HAVE RESPONSIBILITY FOR JOINTLY DESIGNATING REGIONAL ENTITIES TO PROVIDE ADMINISTRATIVE AND

MANAGEMENT SERVICES FOR THE PURPOSES OF PRIOR APPROVING AND COORDINATING THE PROVISION OF BEHAVIORAL HEALTH SERVICES, FACILITATING THE CONTINUITY OF POST-HOSPITALIZATION BEHAVIORAL HEALTH AND THE INTEGRATION OF BEHAVIORAL HEALTH SERVICES WITH OTHER SERVICES AVAILABLE UNDER THIS TITLE, FOR RECIPIENTS OF MEDICAL ASSISTANCE WHO ARE NOT ENROLLED IN MANAGED CARE, AND FOR SUCH APPROVAL, COORDINATION, FACILITATING CONTINUITY AND INTEGRATION OF BEHAVIORAL HEALTH SERVICES THAT ARE NOT PROVIDED THROUGH MANAGED CARE PROGRAMS UNDER THIS TITLE FOR INDIVIDUALS REGARDLESS OF WHETHER OR NOT SUCH INDIVIDUALS ARE ENROLLED IN MANAGED CARE PROGRAMS. SUCH REGIONAL ENTITIES SHALL ALSO BE RESPONSIBLE FOR PROMOTING APPROPRIATE CARE AND SERVICE UTILIZATION WHILE SAFEGUARDING AGAINST UNNECESSARY UTILIZATION OF SUCH CARE AND SERVICES AND ASSURING THAT PAYMENTS ARE CONSISTENT WITH THE EFFICIENT AND ECONOMICAL DELIVERY OF QUALITY CARE.

2. IN EXERCISING THIS RESPONSIBILITY, THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO CONTRACT, AFTER CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE IMPACTED LOCAL GOVERNMENTAL UNITS, WITH REGIONAL BEHAVIORAL HEALTH ORGANIZATIONS OR OTHER ENTITIES. SUCH CONTRACTS MAY INCLUDE RESPONSIBILITY FOR RECEIPT, REVIEW, AND DETERMINATION OF PRIOR AUTHORIZATION REQUESTS FOR BEHAVIORAL HEALTH CARE AND SERVICES UNDER SUBDIVISION ONE OF THIS SECTION, CONSISTENT WITH CRITERIA ESTABLISHED OR APPROVED BY THE COMMISSIONERS OF MENTAL HEALTH AND ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AND AUTHORIZATION OF APPROPRIATE CARE AND SERVICES BASED ON DOCUMENTED PATIENT MEDICAL NEED.

3. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER SUBDIVISIONS ONE AND TWO OF THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(A) THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL POST ON THEIR WEBSITES, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACTOR CONTRACTS;

(II) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONERS; AND

(C) THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE IMPACTED LOCAL GOVERNMENTAL UNITS, SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY, AND ECONOMICALLY INTEGRATE BEHAVIORAL HEALTH AND HEALTH SERVICES; HAVE THE REQUISITE EXPERTISE AND FINANCIAL RESOURCES; HAVE DEMONSTRATED THAT THEIR DIRECTORS, SPONSORS, MEMBERS, MANAGERS, PARTNERS OR OPERATORS HAVE THE REQUISITE CHARACTER, COMPETENCE AND STANDING IN THE COMMUNITY, AND ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

4. THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE DEPARTMENT OF HEALTH, SHALL HAVE THE RESPONSIBILITY FOR JOINTLY DESIGNATING ON A REGIONAL BASIS, AFTER CONSULTATION WITH THE LOCAL SOCIAL SERVICES DISTRICT AND LOCAL GOVERNMENTAL UNIT, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW, OF A CITY WITH A POPULATION OF OVER ONE MILLION PERSONS, AND AFTER CONSULTATION OF OTHER AFFECTED COUNTIES, A LIMITED NUMBER OF SPECIALIZED MANAGED CARE PLANS UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE, SPECIAL NEED MANAGED CARE PLANS UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE, AND/OR INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH PROVIDER SYSTEMS CERTIFIED UNDER ARTICLE TWENTY-NINE-E OF THE PUBLIC HEALTH LAW CAPABLE OF MANAGING THE BEHAVIORAL AND PHYSICAL HEALTH NEEDS OF MEDICAL ASSISTANCE ENROLLEES WITH SIGNIFICANT BEHAVIORAL HEALTH NEEDS. INITIAL DESIGNATIONS OF SUCH PLANS OR PROVIDER SYSTEMS SHOULD BE MADE NO LATER THAN APRIL FIRST, TWO THOUSAND THIRTEEN, PROVIDED, HOWEVER, SUCH DESIGNATIONS SHALL BE CONTINGENT UPON A DETERMINATION BY SUCH STATE COMMISSIONERS THAT THE ENTITIES TO BE DESIGNATED HAVE THE CAPACITY AND FINANCIAL ABILITY TO PROVIDE SERVICES IN SUCH PLANS OR PROVIDER SYSTEMS, AND THAT THE REGION HAS A SUFFICIENT POPULATION AND SERVICE BASE TO SUPPORT SUCH PLANS AND SYSTEMS. ONCE DESIGNATED, THE COMMISSIONER OF HEALTH SHALL MAKE ARRANGEMENTS TO ENROLL SUCH ENROLLEES IN SUCH PLANS OR INTEGRATED PROVIDER SYSTEMS AND TO PAY SUCH PLANS OR PROVIDER SYSTEMS ON A CAPITATED OR OTHER BASIS TO MANAGE, COORDINATE, AND PAY FOR BEHAVIORAL AND PHYSICAL HEALTH MEDICAL ASSISTANCE SERVICES FOR SUCH ENROLLEES. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTION ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, AND SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE DESIGNATIONS OF SUCH PLANS AND PROVIDER SYSTEMS, AND ANY RESULTING CONTRACTS WITH SUCH PLANS, PROVIDERS OR PROVIDER SYSTEMS ARE AUTHORIZED TO BE ENTERED INTO BY SUCH STATE COMMISSIONERS WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED HOWEVER THAT:

(A) THE DEPARTMENT OF HEALTH, THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL POST ON THEIR WEBSITES, FOR A PERIOD OF NOT LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED BY THE PLANS OR SYSTEMS;

(II) THE CRITERIA FOR SELECTION OF A PLAN OR SYSTEM;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE PLAN OR SYSTEM MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE PLAN OR SYSTEM MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE PLANS OR SYSTEMS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONERS; AND

(C) THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, SHALL SELECT SUCH PLANS OR SYSTEMS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY, AND ECONOMICALLY MANAGE THE BEHAVIORAL AND PHYSICAL HEALTH NEEDS OF MEDICAL ASSISTANCE ENROLLEES WITH SIGNIFICANT BEHAVIORAL HEALTH NEEDS; HAVE THE REQUISITE EXPERTISE AND FINANCIAL RESOURCES; HAVE DEMONSTRATED THAT THEIR DIRECTORS, SPONSORS, MEMBERS, MANAGERS, PARTNERS OR OPERATORS HAVE THE REQUISITE CHARACTER, COMPETENCE AND STANDING IN THE COMMUNITY, AND ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

OVERSIGHT OF SUCH CONTRACTS WITH SUCH PLANS, PROVIDERS OR PROVIDER SYSTEMS SHALL BE THE JOINT RESPONSIBILITY OF SUCH STATE COMMISSIONERS, AND FOR CONTRACTS AFFECTING A CITY WITH A POPULATION OF OVER ONE MILLION PERSONS, ALSO WITH THE CITY'S LOCAL SOCIAL SERVICES DISTRICT AND LOCAL GOVERNMENTAL UNIT, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW.

S 43. Intentionally omitted.

S 44. Intentionally omitted.

S 45. Intentionally omitted.

S 46. Intentionally omitted.

S 47. Intentionally omitted.

S 47-a. Subdivision 8 of section 2511 of the public health law is amended by adding two new paragraphs (f) and (g) to read as follows:

(F) THE COMMISSIONER SHALL ADJUST SUBSIDY PAYMENTS MADE TO APPROVED ORGANIZATIONS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, SO THAT THE AMOUNT OF EACH SUCH PAYMENT IS REDUCED BY ONE AND SEVEN-TENTHS PERCENT.

(G) THE COMMISSIONER MAY INCREASE SUBSIDY PAYMENTS MADE TO APPROVED ORGANIZATIONS THAT VOLUNTARILY PARTICIPATE IN THE MULTI-PAYOR PATIENT CENTERED MEDICAL HOME PROGRAM TO REFLECT ADDITIONAL COSTS ASSOCIATED WITH ENHANCED PAYMENTS MADE TO CERTIFIED MEDICAL HOMES BY APPROVED ORGANIZATIONS AS REQUIRED BY ARTICLE TWENTY-NINE-AA OF THIS CHAPTER.

S 48. The public health law is amended by adding a new section 2997-d to read as follows:

S 2997-D. HOSPITAL, NURSING HOME, HOME CARE, SPECIAL NEEDS ASSISTED LIVING RESIDENCES AND ENHANCED ASSISTED LIVING RESIDENCES PALLIATIVE CARE SUPPORT. 1. (A) "PALLIATIVE CARE" MEANS HEALTH CARE TREATMENT, INCLUDING INTERDISCIPLINARY END-OF-LIFE CARE, AND CONSULTATION WITH PATIENTS AND FAMILY MEMBERS, TO PREVENT OR RELIEVE PAIN AND SUFFERING AND TO ENHANCE THE PATIENT'S QUALITY OF LIFE, INCLUDING HOSPICE CARE UNDER ARTICLE FORTY OF THIS CHAPTER.

(B) "APPROPRIATE" HAS THE SAME MEANING AS PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION TWENTY-NINE HUNDRED NINETY-SEVEN-C OF THIS TITLE.

2. GENERAL HOSPITALS, NURSING HOMES, ORGANIZATIONS LICENSED OR CERTIFIED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, AND ORGANIZATIONS LICENSED AS SPECIAL NEEDS ASSISTED LIVING RESIDENCES OR ENHANCED ASSISTED LIVING RESIDENCES PURSUANT TO ARTICLE FORTY-SIX-B OF THIS CHAPTER SHALL ESTABLISH POLICIES AND PROCEDURES TO PROVIDE PATIENTS WITH ADVANCED LIFE LIMITING CONDITIONS AND ILLNESSES WHO MIGHT BENEFIT FROM PALLIATIVE CARE, INCLUDING ASSOCIATED PAIN MANAGEMENT, SERVICES WITH ACCESS TO INFORMATION AND COUNSELING REGARDING SUCH OPTIONS APPROPRIATE TO THE PATIENT. POLICIES MUST INCLUDE PROVISION FOR PATIENTS WHO LACK CAPACITY TO MAKE MEDICAL DECISIONS, SO THAT ACCESS TO SUCH INFORMATION AND COUNSELING SHALL BE PROVIDED TO THE PERSONS WHO ARE LEGALLY AUTHORIZED TO MAKE MEDICAL DECISIONS ON BEHALF OF SUCH PATIENTS.

3. GENERAL HOSPITALS, NURSING HOMES, ORGANIZATIONS LICENSED OR CERTIFIED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, AND ORGANIZATIONS LICENSED AS SPECIAL NEEDS ASSISTED LIVING RESIDENCES OR ENHANCED ASSISTED LIVING RESIDENCES PURSUANT TO ARTICLE FORTY-SIX-B OF THIS CHAPTER SHALL FACILITATE ACCESS TO APPROPRIATE PALLIATIVE CARE CONSULTATIONS AND SERVICES, INCLUDING ASSOCIATED PAIN MANAGEMENT CONSULTATIONS AND SERVICES, INCLUDING BUT NOT LIMITED TO REFERRALS CONSISTENT WITH PATIENT NEEDS AND PREFERENCES. THE DEPARTMENT SHALL TAKE INTO ACCOUNT ACCESS AND PROXIMITY OF PALLIATIVE CARE SERVICES, INCLUDING THE AVAILABILITY OF HOSPICE AND PALLIATIVE CARE BOARD CERTIFIED PRACTITIONERS AND OTHER RELATED WORKFORCE STAFF, GEOGRAPHIC FACTORS, AND FACILITY SIZE THAT MAY IMPACT DEVELOPMENT OF PALLIATIVE CARE SERVICES.

S 49. Intentionally omitted.

S 50. Legislative findings. The legislature finds that integration and coordination of health care services is essential to the improvement of health care quality, efficiency, access and outcomes. The federal Patient Protection and Affordable Care Act creates several health system demonstration and pilot programs, intended to promote and assess delivery system and payment reforms, that require integration of services, coordination among providers, or a combination of the two. In addition, collaborative arrangements among, or consolidation, mergers or acquisition, of providers may be necessary to preserve access to essential services in some communities, and improve the quality of the services they provide and the efficiency of their operations, as well as minimize unnecessary increases in the cost of care.

Federal and state antitrust laws may prohibit or discourage such collaboration or consolidation beneficial to residents of New York state, given their potential for, or actual, reduction in competition. The legislature finds that such agreements where they meet the standards of this section, should be permitted and encouraged. Under these circumstances, competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage mergers, acquisitions, and cooperative, collaborative and integrative agreements among health care providers, and others, that are beneficial to New York residents when the benefits of such agreements outweigh any disadvantages caused by their potential or actual adverse effects on competition. Regulatory oversight of such arrangements should be provided to ensure that the benefits of such agreements outweigh any disadvantages attributable to any reduction in competition that may result from the agreements. Accordingly, the legislature intends to authorize a regulatory program to permit and oversee merger, acquisition, integration, consolidation, collaboration, and coordination among providers, where necessary to assure access to essential health care services, to improve health care quality and outcomes, to enhance efficiency, or to minimize the cost of health care.

S 51. The public health law is amended by adding a new article 29-F to read as follows:

ARTICLE 29-F

IMPROVED INTEGRATION OF HEALTH CARE AND FINANCING

SECTION 2999-AA. ANTITRUST PROVISIONS, STATE OVERSIGHT.

2999-BB. DEPARTMENT AUTHORITY.

S 2999-AA. ANTITRUST PROVISIONS, STATE OVERSIGHT. 1. IN ORDER TO PROMOTE IMPROVED QUALITY AND EFFICIENCY OF, AND ACCESS TO, HEALTH CARE SERVICES AND TO PROMOTE IMPROVED CLINICAL OUTCOMES TO THE RESIDENTS OF NEW YORK, IT SHALL BE THE POLICY OF THE STATE TO ENCOURAGE, WHERE APPROPRIATE, COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS INCLUDING BUT NOT LIMITED TO, MERGERS AND ACQUISITIONS AMONG HEALTH CARE PROVIDERS OR AMONG OTHERS WHO MIGHT OTHERWISE BE COMPETITORS, UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. TO THE EXTENT SUCH ARRANGEMENTS, OR THE PLANNING AND NEGOTIATIONS THAT PRECEDE THEM, MIGHT BE ANTI-COMPETITIVE WITHIN THE MEANING AND INTENT OF THE STATE AND FEDERAL ANTITRUST LAWS, THE INTENT OF THE STATE IS TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENTS UNDER THE ACTIVE SUPERVISION AND RELATED ADMINISTRATIVE ACTIONS OF THE COMMISSIONER AS NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS ARTICLE, AND TO PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS WITH RESPECT TO ACTIVITIES UNDERTAKEN BY HEALTH CARE PROVIDERS AND OTHERS PURSUANT TO THIS ARTICLE, WHERE THE BENEFITS OF SUCH ACTIVE SUPERVISION, ARRANGEMENTS AND ACTIONS OF THE COMMISSIONER

OUTWEIGH ANY DISADVANTAGES LIKELY TO RESULT FROM A REDUCTION OF COMPETITION. THE COMMISSIONER SHALL NOT APPROVE AN ARRANGEMENT FOR WHICH STATE ACTION IMMUNITY IS SOUGHT UNDER THIS ARTICLE WITHOUT FIRST CONSULTING WITH, AND RECEIVING A RECOMMENDATION FROM, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL. NO ARRANGEMENT UNDER THIS ARTICLE SHALL BE APPROVED AFTER DECEMBER THIRTY-FIRST, TWO THOUSAND SIXTEEN.

2. THE COMMISSIONER OR HIS OR HER DULY AUTHORIZED REPRESENTATIVE MAY ENGAGE IN APPROPRIATE STATE SUPERVISION NECESSARY TO PROMOTE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS.

S 2999-BB. DEPARTMENT AUTHORITY. THE DEPARTMENT SHALL PROMULGATE REGULATIONS TO IMPLEMENT THIS ARTICLE. SUCH REGULATIONS SHALL PROVIDE STANDARDS FOR DETERMINING WHICH PROPOSED COLLABORATIONS, INTEGRATIONS, MERGERS OR ACQUISITIONS SHALL BE COVERED BY THIS ARTICLE AND THE MANNER BY WHICH THE INTERESTS SET FORTH IN THE LEGISLATIVE FINDINGS SHALL BE ADVANCED THROUGH REGULATORY OVERSIGHT. THE DEPARTMENT SHALL FURTHER BE AUTHORIZED TO IMPOSE FEES AS APPROPRIATE TO FACILITATE THE IMPLEMENTATION OF THIS ARTICLE. THIS ARTICLE IS NOT INTENDED TO LIMIT THE AUTHORITY OF THE ATTORNEY GENERAL OF THE STATE OF NEW YORK.

S 52. Article 29-D of the public health law is amended by adding a new title 4 to read as follows:

TITLE 4

NEW YORK STATE MEDICAL INDEMNITY FUND

SECTION 2999-G. PURPOSE OF THIS TITLE.
2999-H. DEFINITIONS.
2999-I. CUSTODY AND ADMINISTRATION OF THE FUND.
2999-J. PAYMENTS FROM THE FUND.

S 2999-G. PURPOSE OF THIS TITLE. CREATION OF THE NEW YORK STATE MEDICAL INDEMNITY FUND. THERE IS HEREBY CREATED THE NEW YORK STATE MEDICAL INDEMNITY FUND (THE "FUND"). THE PURPOSE OF THE FUND IS TO PROVIDE A FUNDING SOURCE FOR FUTURE HEALTH CARE COSTS ASSOCIATED WITH BIRTH RELATED NEUROLOGICAL INJURIES, IN ORDER TO REDUCE PREMIUM COSTS FOR MEDICAL MALPRACTICE INSURANCE COVERAGE.

S 2999-H. DEFINITIONS. AS USED IN THIS TITLE, UNLESS THE CONTEXT OR SUBJECT MATTER REQUIRES OTHERWISE:

1. "BIRTH-RELATED NEUROLOGICAL INJURY" MEANS AN INJURY TO THE BRAIN OR SPINAL CORD OF A LIVE INFANT CAUSED BY THE DEPRIVATION OF OXYGEN OR MECHANICAL INJURY OCCURRING IN THE COURSE OF LABOR, DELIVERY OR RESUSCITATION OR BY OTHER MEDICAL SERVICES PROVIDED OR NOT PROVIDED DURING DELIVERY ADMISSION THAT RENDERED THE INFANT WITH A PERMANENT AND SUBSTANTIAL MOTOR IMPAIRMENT OR WITH A DEVELOPMENTAL DISABILITY AS THAT TERM IS DEFINED BY SECTION 1.03 OF THE MENTAL HYGIENE LAW, OR BOTH. THIS DEFINITION SHALL APPLY TO LIVE BIRTHS ONLY.

2. "FUND" MEANS THE NEW YORK STATE MEDICAL INDEMNITY FUND.

3. "QUALIFYING HEALTH CARE COSTS" MEANS THE FUTURE MEDICAL, HOSPITAL, SURGICAL, NURSING, DENTAL, REHABILITATION, CUSTODIAL, DURABLE MEDICAL EQUIPMENT, HOME MODIFICATIONS, ASSISTIVE TECHNOLOGY, VEHICLE MODIFICATIONS, PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS, AND OTHER HEALTH CARE COSTS ACTUALLY INCURRED FOR SERVICES RENDERED TO AND SUPPLIES UTILIZED BY QUALIFIED PLAINTIFFS, WHICH ARE NECESSARY TO MEET THEIR HEALTH CARE NEEDS AS DETERMINED BY THEIR TREATING PHYSICIANS, PHYSICIAN ASSISTANTS, OR NURSE PRACTITIONERS AND AS OTHERWISE DEFINED BY THE COMMISSIONER IN REGULATION.

4. "QUALIFIED PLAINTIFF" MEANS EVERY PLAINTIFF OR CLAIMANT WHO (I) HAS BEEN FOUND BY A JURY OR COURT TO HAVE SUSTAINED A BIRTH-RELATED NEUROLOGICAL INJURY AS THE RESULT OF MEDICAL MALPRACTICE, OR (II) HAS SUSTAINED A BIRTH-RELATED NEUROLOGICAL INJURY AS THE RESULT OF ALLEGED

MEDICAL MALPRACTICE, AND HAS SETTLED HIS OR HER LAWSUIT OR CLAIM THEREFOR.

5. ANY REFERENCE TO THE "DEPARTMENT OF FINANCIAL SERVICES" AND THE "SUPERINTENDENT OF FINANCIAL SERVICES" IN THIS TITLE SHALL MEAN, PRIOR TO OCTOBER THIRD, TWO THOUSAND ELEVEN, RESPECTIVELY, THE "DEPARTMENT OF INSURANCE" AND "SUPERINTENDENT OF INSURANCE."

S 2999-I. CUSTODY AND ADMINISTRATION OF THE FUND. 1. THE COMMISSIONER OF TAXATION AND FINANCE SHALL BE THE CUSTODIAN OF THE FUND AND THE SPECIAL ACCOUNT ESTABLISHED PURSUANT TO SECTION NINETY-NINE-T OF THE STATE FINANCE LAW. ALL PAYMENTS FROM THE FUND SHALL BE MADE BY THE COMMISSIONER OF TAXATION AND FINANCE UPON CERTIFICATES SIGNED BY THE SUPERINTENDENT OF FINANCIAL SERVICES, OR HIS OR HER DESIGNEE, AS HEREINAFTER PROVIDED. THE FUND SHALL BE SEPARATE AND APART FROM ANY OTHER FUND AND FROM ALL OTHER STATE MONIES. NO MONIES FROM THE FUND SHALL BE TRANSFERRED TO ANY OTHER FUND, NOR SHALL ANY SUCH MONIES BE APPLIED TO THE MAKING OF ANY PAYMENT FOR ANY PURPOSE OTHER THAN THE PURPOSE SET FORTH IN THIS TITLE.

2. (A) THE FUND SHALL BE ADMINISTERED BY THE SUPERINTENDENT OF FINANCIAL SERVICES OR HIS OR HER DESIGNEE IN ACCORDANCE WITH THE PROVISIONS OF THIS ARTICLE.

(B) THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL HAVE ALL POWERS NECESSARY AND PROPER TO CARRY OUT THE PURPOSES OF THE FUND.

(C) 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, THE SUPERINTENDENT OF FINANCIAL SERVICES IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS FOR PURPOSES OF ADMINISTERING THE FUND FOR THE FIRST YEAR OF ITS OPERATION AND IN PREPARATION THEREFOR.

(D) THE DEPARTMENT OF FINANCIAL SERVICES AND THE DEPARTMENT SHALL POST ON THEIR WEBSITES INFORMATION ABOUT THE FUND, ELIGIBILITY FOR ENROLLMENT IN THE FUND, AND THE PROCESS FOR ENROLLMENT IN THE FUND.

3. THE EXPENSE OF ADMINISTERING THE FUND, INCLUDING THE EXPENSES INCURRED BY THE DEPARTMENT, SHALL BE PAID FROM THE FUND.

4. MONIES FOR THE FUND WILL BE PROVIDED PURSUANT TO THIS CHAPTER.

5. FOR THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND ELEVEN AND ENDING MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND TWELVE AND ENDING MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND THIRTEEN AND ENDING MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN, THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL CAUSE TO BE DEPOSITED INTO THE FUND FOR EACH SUCH FISCAL YEAR THE AMOUNT APPROPRIATED FOR SUCH PURPOSE. BEGINNING APRIL FIRST, TWO THOUSAND FOURTEEN AND ANNUALLY THEREAFTER, THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL CAUSE TO BE DEPOSITED INTO THE FUND, SUBJECT TO AVAILABLE APPROPRIATIONS, AN AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE AMOUNT APPROPRIATED TO THE FUND IN THE PRECEDING FISCAL YEAR, AS INCREASED BY THE ADJUSTMENT FACTOR DEFINED IN SUBDIVISION SEVEN OF THIS SECTION, AND THE ASSETS OF THE FUND AT THE CONCLUSION OF THAT FISCAL YEAR.

6. (A) FOLLOWING THE DEPOSIT REFERENCED IN SUBDIVISION FIVE OF THIS SECTION, THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL CONDUCT AN ACTUARIAL CALCULATION OF THE ESTIMATED LIABILITIES OF THE FUND FOR THE COMING YEAR RESULTING FROM THE QUALIFIED PLAINTIFFS ENROLLED IN THE FUND. THE ADMINISTRATOR SHALL FROM TIME TO TIME ADJUST SUCH CALCULATION. IF THE TOTAL OF ALL ESTIMATES OF CURRENT LIABILITIES EQUALS OR EXCEEDS EIGHTY PERCENT OF THE FUND'S ASSETS, THEN THE FUND SHALL NOT ACCEPT ANY

NEW ENROLLMENTS UNTIL A NEW DEPOSIT HAS BEEN MADE PURSUANT TO SUBDIVISION FIVE OF THIS SECTION. WHEN, AS A RESULT OF SUCH NEW DEPOSIT, THE FUND'S LIABILITIES NO LONGER EXCEED EIGHTY PERCENT OF THE FUND'S ASSETS, THE FUND ADMINISTRATOR SHALL ENROLL NEW QUALIFIED PLAINTIFFS IN THE ORDER THAT AN APPLICATION FOR ENROLLMENT HAS BEEN SUBMITTED IN ACCORDANCE WITH SUBDIVISION SEVEN OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-J OF THIS TITLE.

(B) WHENEVER ENROLLMENT IS SUSPENDED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION AND UNTIL SUCH TIME AS ENROLLMENT RESUMES PURSUANT TO SUCH PARAGRAPH: (I) NOTICE OF SUCH SUSPENSION SHALL BE PROMPTLY POSTED ON THE DEPARTMENT'S WEBSITE AND ON THE WEBSITE OF THE DEPARTMENT OF FINANCIAL SERVICES; (II) THE FUND ADMINISTRATOR SHALL DENY EACH APPLICATION FOR ENROLLMENT THAT HAD BEEN RECEIVED BUT NOT ACCEPTED PRIOR TO THE DATE OF SUSPENSION AND EACH APPLICATION FOR ENROLLMENT RECEIVED AFTER THE DATE OF SUCH SUSPENSION; AND (III) NOTIFICATION OF EACH SUCH DENIAL SHALL BE MADE TO THE PLAINTIFF OR CLAIMANT OR PERSONS AUTHORIZED TO ACT ON BEHALF OF SUCH PLAINTIFF OR CLAIMANT AND ALL DEFENDANTS IN REGARD TO SUCH PLAINTIFF OR CLAIMANT, TO THE EXTENT THEY ARE KNOWN TO THE FUND ADMINISTRATOR. JUDGMENTS AND SETTLEMENTS FOR PLAINTIFFS OR CLAIMANTS FOR WHOM APPLICATIONS ARE DENIED UNDER THIS PARAGRAPH OR WHO ARE NOT ELIGIBLE FOR ENROLLMENT DUE TO SUSPENSION PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE SATISFIED AS IF THIS TITLE HAD NOT BEEN ENACTED.

(C) FOLLOWING A SUSPENSION, WHENEVER ENROLLMENT RESUMES PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, NOTICE THAT ENROLLMENT HAS RESUMED SHALL BE PROMPTLY POSTED ON THE DEPARTMENT'S WEBSITE AND ON THE WEBSITE OF THE DEPARTMENT OF FINANCIAL SERVICES.

(D) THE SUSPENSION OF ENROLLMENT PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL NOT IMPACT PAYMENT UNDER THE FUND FOR ANY QUALIFIED PLAINTIFFS ALREADY ENROLLED IN THE FUND.

7. FOR PURPOSES OF THIS SECTION, THE ADJUSTMENT FACTOR REFERENCED IN THIS SECTION SHALL BE THE TEN YEAR ROLLING AVERAGE MEDICAL COMPONENT OF THE CONSUMER PRICE INDEX AS PUBLISHED BY THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, FOR THE PRECEDING TEN YEARS.

S 2999-J. PAYMENTS FROM THE FUND. 1. THE FUND SHALL BE USED TO PAY THE QUALIFYING HEALTH CARE COSTS OF QUALIFIED PLAINTIFFS.

2. THE PROVISION OF QUALIFYING HEALTH CARE COSTS TO QUALIFIED PLAINTIFFS SHALL NOT BE SUBJECT TO PRIOR AUTHORIZATION, EXCEPT AS DESCRIBED BY THE COMMISSIONER IN REGULATION; PROVIDED, HOWEVER, THAT SUCH REGULATION SHALL NOT PREVENT QUALIFIED PLAINTIFFS FROM RECEIVING CARE OR ASSISTANCE THAT WOULD, AT A MINIMUM, BE AUTHORIZED UNDER THE MEDICAID PROGRAM; AND PROVIDED, FURTHER, THAT IF ANY PRIOR AUTHORIZATION IS REQUIRED BY SUCH REGULATION, THE REGULATION SHALL REQUIRE THAT REQUESTS FOR PRIOR AUTHORIZATION BE PROCESSED WITHIN A REASONABLY PROMPT PERIOD OF TIME AND SHALL IDENTIFY A PROCESS FOR PROMPT ADMINISTRATIVE REVIEW OF ANY DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION.

3. IN DETERMINING THE AMOUNT OF QUALIFYING HEALTH CARE COSTS TO BE PAID FROM THE FUND, ANY SUCH COST OR EXPENSE THAT WAS OR WILL, WITH REASONABLE CERTAINTY, BE PAID, REPLACED OR INDEMNIFIED FROM ANY COLLATERAL SOURCE AS PROVIDED BY SUBDIVISION (A) OF SECTION FORTY-FIVE HUNDRED FORTY-FIVE OF THE CIVIL PRACTICE LAW AND RULES SHALL NOT CONSTITUTE A QUALIFYING HEALTH CARE COST AND SHALL NOT BE PAID FROM THE FUND. FOR PURPOSES OF THIS TITLE, "COLLATERAL SOURCE" SHALL NOT INCLUDE MEDICARE OR MEDICAID.

4. THE AMOUNT OF QUALIFYING HEALTH CARE COSTS TO BE PAID FROM THE FUND SHALL BE CALCULATED: (A) WITH RESPECT TO SERVICES PROVIDED IN PRIVATE PHYSICIAN PRACTICES ON THE BASIS OF ONE HUNDRED PERCENT OF THE USUAL AND

CUSTOMARY RATES, AS DEFINED BY THE COMMISSIONER IN REGULATION; OR (B) WITH RESPECT TO ALL OTHER SERVICES, ON THE BASIS OF MEDICAID RATES OF REIMBURSEMENT OR, WHERE NO SUCH RATES ARE AVAILABLE, AS DEFINED BY THE COMMISSIONER IN REGULATION.

5. CLAIMS FOR THE PAYMENT OR REIMBURSEMENT FROM THE FUND OF QUALIFYING HEALTH CARE COSTS SHALL BE MADE UPON FORMS PRESCRIBED AND FURNISHED BY THE FUND ADMINISTRATOR IN CONSULTATION WITH THE COMMISSIONER AND IN CONJUNCTION WITH REGULATIONS ESTABLISHING A MECHANISM FOR SUBMISSION OF CLAIMS BY HEALTH CARE PROVIDERS DIRECTLY TO THE FUND, WHERE PRACTICABLE.

6. (A) EVERY SETTLEMENT AGREEMENT FOR CLAIMS ARISING OUT OF A PLAINTIFF'S OR CLAIMANT'S BIRTH RELATED NEUROLOGICAL INJURY SUBJECT TO THIS TITLE, AND THAT PROVIDES FOR THE PAYMENT OF FUTURE MEDICAL EXPENSES FOR THE PLAINTIFF OR CLAIMANT, SHALL PROVIDE THAT IN THE EVENT THE ADMINISTRATOR OF THE FUND DETERMINES THAT THE PLAINTIFF OR CLAIMANT IS A QUALIFIED PLAINTIFF, ALL PAYMENTS FOR FUTURE MEDICAL EXPENSES SHALL BE PAID IN ACCORDANCE WITH THIS TITLE, IN LIEU OF THAT PORTION OF THE SETTLEMENT AGREEMENT THAT PROVIDES FOR PAYMENT OF SUCH EXPENSES. THE PLAINTIFF'S OR CLAIMANT'S FUTURE MEDICAL EXPENSES SHALL BE PAID IN ACCORDANCE WITH THIS TITLE. WHEN SUCH A SETTLEMENT AGREEMENT DOES NOT SO PROVIDE, THE COURT SHALL DIRECT THE MODIFICATION OF THE AGREEMENT TO INCLUDE SUCH TERM AS A CONDITION OF COURT APPROVAL.

(B) IN ANY CASE WHERE THE JURY OR COURT HAS MADE AN AWARD FOR FUTURE MEDICAL EXPENSES ARISING OUT OF A BIRTH RELATED NEUROLOGICAL INJURY, ANY PARTY TO SUCH ACTION OR PERSON AUTHORIZED TO ACT ON BEHALF OF SUCH PARTY MAY MAKE APPLICATION TO THE COURT THAT THE JUDGMENT REFLECT THAT, IN LIEU OF THAT PORTION OF THE AWARD THAT PROVIDES FOR PAYMENT OF SUCH EXPENSES, AND UPON A DETERMINATION BY THE FUND ADMINISTRATOR THAT THE PLAINTIFF IS A QUALIFIED PLAINTIFF, THE FUTURE MEDICAL EXPENSES OF THE PLAINTIFF SHALL BE PAID OUT OF THE FUND IN ACCORDANCE WITH THIS TITLE. UPON A FINDING BY THE COURT THAT THE APPLICANT HAS MADE A PRIMA FACIE SHOWING THAT THE PLAINTIFF IS A QUALIFIED PLAINTIFF, THE COURT SHALL ENSURE THAT THE JUDGMENT SO PROVIDES.

7. A QUALIFIED PLAINTIFF SHALL BE ENROLLED WHEN (A) SUCH PLAINTIFF OR PERSON AUTHORIZED TO ACT ON BEHALF OF SUCH PERSON, UPON NOTICE TO ALL DEFENDANTS, OR ANY OF THE DEFENDANTS IN REGARD TO THE PLAINTIFF'S CLAIM, UPON NOTICE TO SUCH PLAINTIFF, MAKES AN APPLICATION FOR ENROLLMENT BY PROVIDING THE FUND ADMINISTRATOR WITH A CERTIFIED COPY OF THE JUDGMENT OR OF THE COURT APPROVED SETTLEMENT AGREEMENT; AND (B) THE FUND ADMINISTRATOR DETERMINES UPON THE BASIS OF SUCH JUDGMENT OR SETTLEMENT AGREEMENT AND ANY ADDITIONAL INFORMATION THE FUND ADMINISTRATOR SHALL REQUEST THAT THE RELEVANT PROVISIONS OF SUBDIVISION SIX OF THIS SECTION HAVE BEEN MET AND THAT THE PLAINTIFF IS A QUALIFIED PLAINTIFF; PROVIDED THAT NO ENROLLMENT SHALL OCCUR WHEN THE FUND IS CLOSED TO ENROLLMENT PURSUANT TO SUBDIVISION SIX OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-I OF THIS TITLE.

8. AS TO ALL CLAIMS, THE FUND ADMINISTRATOR SHALL:

(A) DETERMINE WHICH OF SUCH COSTS ARE QUALIFYING HEALTH CARE COSTS TO BE PAID FROM THE FUND; AND

(B) THEREUPON CERTIFY TO THE COMMISSIONER OF TAXATION AND FINANCE THOSE COSTS THAT HAVE BEEN DETERMINED TO BE QUALIFYING HEALTH CARE COSTS TO BE PAID FROM THE FUND.

9. PAYMENTS FROM THE FUND SHALL BE MADE BY THE COMMISSIONER OF TAXATION AND FINANCE ON THE SAID CERTIFICATE OF THE SUPERINTENDENT OF FINANCIAL SERVICES. NO PAYMENT SHALL BE MADE BY THE COMMISSIONER OF TAXATION AND FINANCE IN EXCESS OF THE AMOUNT CERTIFIED. PROMPTLY UPON RECEIPT OF THE SAID CERTIFICATE OF THE SUPERINTENDENT OF FINANCIAL SERVICES, THE

COMMISSIONER OF TAXATION AND FINANCE SHALL PAY THE QUALIFIED PLAINTIFF'S HEALTH CARE PROVIDER OR REIMBURSE THE QUALIFIED PLAINTIFF THE AMOUNT SO CERTIFIED FOR PAYMENT.

10. PAYMENT FROM THE FUND SHALL NOT GIVE THE FUND ANY RIGHT OF RECOVERY AGAINST ANY QUALIFIED PLAINTIFF OR SUCH QUALIFIED PLAINTIFF'S ATTORNEY EXCEPT IN THE CASE OF FRAUD OR MISTAKE.

11. ALL HEALTH CARE PROVIDERS SHALL ACCEPT FROM QUALIFIED PLAINTIFF'S OR PERSONS AUTHORIZED TO ACT ON BEHALF OF SUCH PLAINTIFF'S ASSIGNMENTS OF THE RIGHT TO RECEIVE PAYMENTS FROM THE FUND FOR QUALIFYING HEALTH CARE COSTS.

12. HEALTH INSURERS (OTHER THAN MEDICARE AND MEDICAID) SHALL BE THE PRIMARY PAYERS OF QUALIFYING HEALTH CARE COSTS OF QUALIFIED PLAINTIFFS. SUCH COSTS SHALL BE PAID FROM THE FUND ONLY TO THE EXTENT THAT HEALTH INSURERS OR OTHER COLLATERAL SOURCES OR OTHER PERSONS ARE NOT OTHERWISE OBLIGATED TO MAKE PAYMENTS THEREFOR. HEALTH INSURERS THAT MAKE PAYMENTS FOR QUALIFYING HEALTH CARE COSTS TO OR ON BEHALF OF QUALIFIED PLAINTIFFS SHALL HAVE NO RIGHT OF RECOVERY AGAINST AND SHALL HAVE NO LIEN UPON THE FUND OR ANY PERSON OR ENTITY NOR SHALL THE FUND CONSTITUTE AN ADDITIONAL PAYMENT SOURCE TO OFFSET THE PAYMENTS OTHERWISE CONTRACTUALLY REQUIRED TO BE MADE BY SUCH HEALTH INSURERS. THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL HAVE THE AUTHORITY TO ENFORCE THE PROVISIONS OF THIS SUBDIVISION.

13. EXCEPT AS PROVIDED FOR BY THIS TITLE, WITH RESPECT TO A QUALIFIED PLAINTIFF, NO PAYMENT SHALL BE REQUIRED TO BE MADE BY ANY DEFENDANT OR SUCH DEFENDANT'S INSURER FOR QUALIFYING HEALTH CARE COSTS AND NO JUDGMENT SHALL BE MADE OR ENTERED REQUIRING THAT ANY SUCH PAYMENT BE MADE BY ANY DEFENDANT OR SUCH DEFENDANT'S INSURER FOR SUCH HEALTH CARE COSTS.

14. THE DETERMINATION OF THE QUALIFIED PLAINTIFF'S ATTORNEY'S FEE SHALL BE BASED UPON THE ENTIRE SUM AWARDED BY THE JURY OR THE COURT OR THE FULL SUM OF THE SETTLEMENT, AS THE CASE MAY BE. THE QUALIFIED PLAINTIFF'S ATTORNEY'S FEE SHALL BE PAID IN A LUMP SUM BY THE DEFENDANTS AND THEIR INSURERS PURSUANT TO SECTION FOUR HUNDRED SEVENTY-FOUR-A OF THE JUDICIARY LAW; PROVIDED HOWEVER THAT THE PORTION OF THE ATTORNEY FEE THAT IS ALLOCATED TO THE NON-FUND ELEMENTS OF DAMAGES SHALL BE DEDUCTED FROM THE NON-FUND PORTION OF THE AWARD IN A PROPORTIONAL MANNER.

15. THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, SHALL PROMULGATE, AMEND AND ENFORCE ALL RULES AND REGULATIONS NECESSARY FOR THE PROPER ADMINISTRATION OF THE FUND IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION, INCLUDING, BUT NOT LIMITED TO, THOSE CONCERNING THE PAYMENT OF CLAIMS AND CONCERNING THE ACTUARIAL CALCULATIONS NECESSARY TO DETERMINE, ANNUALLY, THE TOTAL AMOUNT TO BE PAID INTO THE FUND AS PROVIDED HEREIN, AND AS OTHERWISE NEEDED TO IMPLEMENT THIS TITLE.

16. THE COMMISSIONER SHALL CONVENE A CONSUMER ADVISORY COMMITTEE FOR THE PURPOSE OF PROVIDING INFORMATION, AS REQUESTED BY THE COMMISSIONER, IN THE DEVELOPMENT OF THE REGULATIONS AUTHORIZED BY SUBDIVISION FIFTEEN OF THIS SECTION.

S 52-a. Article 29-D of the public health law is amended by adding a new title 5 to read as follows:

TITLE 5

NEW YORK STATE HOSPITAL QUALITY INITIATIVE

SECTION 2999-M. NEW YORK STATE HOSPITAL QUALITY INITIATIVE.

S 2999-M. NEW YORK STATE HOSPITAL QUALITY INITIATIVE. THE NEW YORK STATE HOSPITAL QUALITY INITIATIVE, INCLUDING THE NEW YORK STATE OBSTETRICAL PATIENT SAFETY WORKGROUP, WILL BE CREATED IN THE DEPARTMENT OF

HEALTH TO BE COMPRISED OF MEDICAL, HOSPITAL AND ACADEMIC EXPERTS AND OTHER STAKEHOLDERS CHOSEN BY THE COMMISSIONER.

THE NEW YORK STATE QUALITY INITIATIVE WILL OVERSEE THE GENERAL DISSEMINATION OF INITIATIVES, GUIDANCE, AND BEST PRACTICES TO GENERAL HOSPITALS. ACTIVITIES WILL INCLUDE BUT NOT BE LIMITED TO: BUILDING CULTURES OF PATIENT SAFETY AND IMPLEMENTING EVIDENCE BASED CARE IN TARGET AREAS. THE WORKGROUP WILL UNDERTAKE COLLABORATIVE WORK TO IMPROVE OBSTETRICAL CARE OUTCOMES AND QUALITY OF CARE, BASED ON IDENTIFYING AND IMPLEMENTING EVIDENCE BASED PRACTICES, AND CLINICAL PROTOCOLS THAT CAN BE STANDARDIZED AND ADOPTED BY HOSPITALS INCLUDING BUT NOT LIMITED TO:

(A) SURVEYING, REVIEWING AND ANALYZING CURRENT "BEST" PRACTICES EMPLOYED IN OBSTETRICAL CASES, INCLUDING EXPLORING THE USE OF "VIRTUAL GRAND ROUNDS";

(B) UNDERTAKING A REVIEW OF CLAIMS IN AN EFFORT TO DEVELOP A SET OF "STANDARD BEST PRACTICES" FOR DELIVERIES IN NEW YORK STATE;

(C) FORMULATING AND RECOMMENDING TO THE COMMISSIONER BEST PRACTICE STANDARDS AND DESIGNING NEW PROGRAMS FOR IMPLEMENTATION AND IMPROVED OUTCOMES, INCLUDING BUT NOT LIMITED TO, CLINICAL BUNDLES FOR HIGH PRIORITY CONDITIONS, ELECTRONIC FETAL MONITORING TRAINING AND CERTIFICATION, AND TEAM TRAINING; AND

(D) ENGAGING THE EXISTING REGIONAL PERINATAL CENTER NETWORK IN DIALOGUES REGARDING THE ABOVE TOPICS AND MAKING RECOMMENDATIONS TO IMPROVE AND/OR UPGRADE ASSISTANCE AND COMMUNICATION TO SMALLER HOSPITALS.

S 52-b. Subdivision 1 of section 2807-v of the public health law is amended by adding a new paragraph (iii) to read as follows:

(III) FUNDS SHALL BE RESERVED AND SET ASIDE AND ACCUMULATED FROM YEAR TO YEAR AND SHALL BE MADE AVAILABLE, INCLUDING INCOME FROM INVESTMENT FUNDS, FOR THE PURPOSE OF SUPPORTING THE NEW YORK STATE MEDICAL INDEMNITY FUND AS AUTHORIZED PURSUANT TO TITLE FOUR OF ARTICLE TWENTY-NINE-D OF THIS CHAPTER, FOR THE FOLLOWING PERIODS AND IN THE FOLLOWING AMOUNTS, PROVIDED, HOWEVER, THAT THE COMMISSIONER IS AUTHORIZED TO SEEK WAIVER AUTHORITY FROM THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID FOR THE PURPOSE OF SECURING MEDICAID FEDERAL FINANCIAL PARTICIPATION FOR SUCH PROGRAM, IN WHICH CASE THE FUNDING AUTHORIZED PURSUANT TO THIS PARAGRAPH SHALL BE UTILIZED AS THE NON-FEDERAL SHARE FOR SUCH PAYMENTS:

THIRTY MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE.

S 52-c. The public health law is amended by adding a new section 2807-d-1 to read as follows:

S 2807-D-1. HOSPITAL QUALITY CONTRIBUTIONS. 1. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE RECEIPT OF ALL NECESSARY FEDERAL APPROVALS OR WAIVERS, FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND ELEVEN, A QUALITY CONTRIBUTION SHALL BE IMPOSED ON THE INPATIENT REVENUE OF EACH GENERAL HOSPITAL THAT IS RECEIVED FOR THE PROVISION OF INPATIENT OBSTETRICAL PATIENT CARE SERVICES IN AN AMOUNT EQUAL TO ONE AND SIX-TENTHS PERCENT OF SUCH REVENUE, AS DEFINED IN ACCORDANCE WITH PARAGRAPH (A) OF SUBDIVISION THREE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE, PROVIDED, HOWEVER, THAT IN THE EVENT THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, DETERMINES THAT SUCH QUALITY CONTRIBUTION SHALL RAISE LESS THAN OR MORE THAN THE TOTAL QUALITY COLLECTION AMOUNT SET FORTH IN SUBDIVISION TWO OF THIS SECTION, THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, MAY PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, INCREASING OR DECREASING SUCH QUALITY CONTRIB-

UTIONS BY AMOUNTS SUFFICIENT TO ENSURE THE COLLECTION OF SUCH ANNUAL QUALITY CONTRIBUTION AMOUNT.

2. THE ANNUAL QUALITY CONTRIBUTION AMOUNT REFERENCED IN SUBDIVISION ONE OF THIS SECTION SHALL BE THIRTY MILLION DOLLARS FOR THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND ELEVEN, AND FOR EACH SUBSEQUENT STATE FISCAL YEAR THEREAFTER IT SHALL BE THE AMOUNT OF THE PRECEDING YEAR AS INCREASED BY THE TEN YEAR ROLLING AVERAGE OF THE MEDICAL COMPONENT OF THE CONSUMER PRICE INDEX AS PUBLISHED BY THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, FOR THE PRECEDING TEN YEARS.

3. THE QUALITY CONTRIBUTIONS DESCRIBED IN THIS SECTION SHALL BE ADMINISTERED IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF SUBDIVISIONS FOUR, FIVE, SIX, SEVEN, EIGHT AND TWELVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE, PROVIDED, HOWEVER, THAT SUCH QUALITY CONTRIBUTIONS SHALL BE DEPOSITED IN THE HCRA RESOURCES FUND AS ESTABLISHED PURSUANT TO SECTION NINETY-TWO-DD OF THE STATE FINANCE LAW; AND PROVIDED FURTHER, HOWEVER, THAT SUCH CONTRIBUTIONS SHALL NOT BE AN ALLOWABLE COST IN THE DETERMINATION OF REIMBURSEMENT RATES OF PAYMENT COMPUTED PURSUANT TO THIS ARTICLE.

S 52-d. The civil practice law and rules is amended by adding a new rule 3409 to read as follows:

RULE 3409. SETTLEMENT CONFERENCE IN DENTAL, PODIATRIC AND MEDICAL MALPRACTICE ACTIONS. IN EVERY DENTAL, PODIATRIC OR MEDICAL MALPRACTICE ACTION, THE COURT SHALL HOLD A MANDATORY SETTLEMENT CONFERENCE WITHIN FORTY-FIVE DAYS AFTER THE FILING OF THE NOTE OF ISSUE AND CERTIFICATE OF READINESS OR, IF A PARTY MOVES TO VACATE THE NOTE OF ISSUE AND CERTIFICATE OF READINESS, WITHIN FORTY-FIVE DAYS AFTER THE DENIAL OF SUCH MOTION. WHERE PARTIES ARE REPRESENTED BY COUNSEL, ONLY ATTORNEYS FULLY FAMILIAR WITH THE ACTION AND AUTHORIZED TO DISPOSE OF THE CASE, OR ACCOMPANIED BY A PERSON EMPOWERED TO ACT ON BEHALF OF THE PARTY REPRESENTED, WILL BE PERMITTED TO APPEAR AT THE CONFERENCE. WHERE APPROPRIATE, THE COURT MAY ORDER PARTIES, REPRESENTATIVES OF PARTIES, REPRESENTATIVES OF INSURANCE CARRIERS OR PERSONS HAVING AN INTEREST IN ANY SETTLEMENT TO ALSO ATTEND IN PERSON OR TELEPHONICALLY AT THE SETTLEMENT CONFERENCE. THE CHIEF ADMINISTRATIVE JUDGE SHALL BY RULE ADOPT PROCEDURES TO IMPLEMENT SUCH SETTLEMENT CONFERENCE.

S 52-e. The state finance law is amended by adding a new section 99-t to read as follows:

S 99-T. NEW YORK STATE MEDICAL INDEMNITY FUND ACCOUNT. 1. THERE IS HEREBY ESTABLISHED IN THE CUSTODY OF THE COMMISSIONER OF TAXATION AND FINANCE A SPECIAL ACCOUNT TO BE KNOWN AS THE "NEW YORK STATE MEDICAL INDEMNITY FUND ACCOUNT".

2. ALL MONEYS RECEIVED BY THE NEW YORK STATE MEDICAL INDEMNITY FUND PURSUANT TO TITLE FOUR OF ARTICLE TWENTY-NINE-D OF THE PUBLIC HEALTH LAW FROM WHATEVER SOURCE DERIVED SHALL BE DEPOSITED TO THE EXCLUSIVE CREDIT OF SUCH FUND ACCOUNT. SAID MONEYS SHALL BE KEPT SEPARATE AND SHALL NOT BE COMMINGLED WITH ANY OTHER MONEYS IN THE CUSTODY OF THE COMMISSIONER OF TAXATION AND FINANCE.

3. THE MONEYS IN SAID ACCOUNT SHALL BE RETAINED BY THE FUND AND SHALL BE RELEASED BY THE COMMISSIONER OF TAXATION AND FINANCE ONLY UPON CERTIFICATES SIGNED BY THE SUPERINTENDENT OF FINANCIAL SERVICES OR THE HEAD OF ANY SUCCESSOR AGENCY TO THE DEPARTMENT OF INSURANCE OR HIS OR HER DESIGNEE AND ONLY FOR THE PURPOSES SET FORTH IN TITLE FOUR OF ARTICLE TWENTY-NINE-D OF THE PUBLIC HEALTH LAW.

S 52-f. Part C of chapter 58 of the laws of 2005, amending the public health law and other laws relating to authorizing reimbursements for

expenditures made by social services districts for medical assistance, is amended by adding a new section 5-a to read as follows:

S 5-A. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO APPROVE SOCIAL SERVICES DISTRICT DEMONSTRATION PROGRAMS FOR THE PURPOSE OF MAXIMIZING MEDICAID RECOVERIES. THE COMMISSIONER SHALL EVALUATE THE RESULTS OF ANY SUCH PROGRAMS, INCLUDING ANY SAVINGS RESULTING THEREFROM. TEN PERCENT OF ANY SUCH SAVINGS, AFTER CERTIFICATION BY THE DIRECTOR OF THE DIVISION OF THE BUDGET, SHALL BE SHARED WITH THE APPLICABLE SOCIAL SERVICES DISTRICT IN A MANNER TO BE DETERMINED JOINTLY BY THE COMMISSIONER OF HEALTH AND THE DIRECTOR OF THE DIVISION OF THE BUDGET.

S 52-g. Subdivision 1 of section 104-b of the social services law, as amended by chapter 271 of the laws of 1965, is amended to read as follows:

1. If a recipient of public assistance and care shall have a right of action, suit, claim, counterclaim or demand against another on account of any personal injuries suffered by such recipient, then the public welfare official for the public welfare district providing such assistance and care shall have a lien for such amount as may be fixed by the public welfare official not exceeding, however, the total amount of such assistance and care furnished by such public welfare official on and after the date when such injuries were incurred. IN ALL SUCH CASES, NOTICE OF THE COMMENCEMENT OF SUCH AN ACTION SHALL BE SERVED UPON THE PUBLIC WELFARE DISTRICT THAT HAS PROVIDED OR IS PROVIDING SUCH ASSISTANCE AND CARE, OR UPON THE DEPARTMENT OF HEALTH.

The [welfare] commissioner shall endeavor to ascertain whether such person, firm or corporation alleged to be responsible for such injuries is insured with a liability insurance company, as the case may be, and the name thereof.

S 52-h. The civil practice law and rules is amended by adding a new section 306-c to read as follows:

S 306-C. NOTICE OF COMMENCEMENT OF ACTION FOR PERSONAL INJURIES BY RECIPIENT OF MEDICAL ASSISTANCE. IN THE CASE OF AN INDIVIDUAL WHO HAS SUFFERED PERSONAL INJURIES AND HAS RECEIVED MEDICAL ASSISTANCE PURSUANT TO TITLES ELEVEN AND ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW ON OR AFTER THE DATE OF SUCH INJURY, NOTICE OF THE COMMENCEMENT OF AN ACTION BY OR ON BEHALF OF SUCH INDIVIDUAL FOR SUCH PERSONAL INJURIES SHALL BE SENT TO THE SOCIAL SERVICES DISTRICT IN THE COUNTY IN WHICH SUCH RECIPIENT RESIDES, OR TO THE DEPARTMENT OF HEALTH, BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED, OR ELECTRONICALLY IN ACCORD WITH REGULATIONS PROMULGATED BY THE COMMISSIONER OF THE DEPARTMENT OF HEALTH, WITHIN SIXTY DAYS OF THE COMPLETION OF SERVICE UPON ALL PARTIES TO SUCH ACTION. PROOF OF SENDING SUCH NOTICE SHALL BE FILED WITH THE COURT IN ACCORDANCE WITH RULE THREE HUNDRED SIX OF THIS ARTICLE. SENDING SUCH NOTICE SHALL NOT BE A JURISDICTIONAL REQUIREMENT TO COMMENCING AN ACTION.

S 52-i. Intentionally omitted.

S 52-j. Intentionally omitted.

S 52-k. Intentionally omitted.

S 52-l. Intentionally omitted.

S 52-m. Intentionally omitted.

S 53. Subdivision 6 of section 369 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

6. For purposes of this section, [the term] AN INDIVIDUAL'S "estate" [means] INCLUDES all OF THE INDIVIDUAL'S real and personal property and other assets [included within the individual's estate and] passing under

the terms of a valid will or by intestacy. PURSUANT TO REGULATIONS ADOPTED BY THE COMMISSIONER, WHICH MAY BE PROMULGATED ON AN EMERGENCY BASIS, AN INDIVIDUAL'S ESTATE ALSO INCLUDES ANY OTHER PROPERTY IN WHICH THE INDIVIDUAL HAS ANY LEGAL TITLE OR INTEREST AT THE TIME OF DEATH, INCLUDING JOINTLY HELD PROPERTY, RETAINED LIFE ESTATES, AND INTERESTS IN TRUSTS, TO THE EXTENT OF SUCH INTERESTS; PROVIDED, HOWEVER, THAT A CLAIM AGAINST A RECIPIENT OF SUCH PROPERTY BY DISTRIBUTION OR SURVIVAL SHALL BE LIMITED TO THE VALUE OF THE PROPERTY RECEIVED OR THE AMOUNT OF MEDICAL ASSISTANCE BENEFITS OTHERWISE RECOVERABLE PURSUANT TO THIS SECTION, WHICHEVER IS LESS. NOTHING IN THIS SUBDIVISION SHALL BE CONSTRUED AS AUTHORIZING THE DEPARTMENT OR A SOCIAL SERVICES DISTRICT TO IMPOSE LIENS OR MAKE RECOVERIES THAT ARE PROHIBITED BY FEDERAL LAWS GOVERNING THE MEDICAL ASSISTANCE PROGRAM.

S 54. Subparagraph 12 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 42-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(12) is a disabled person at least sixteen years of age, but under the age of sixty-five, who: would be eligible for benefits under the supplemental security income program but for earnings in excess of the allowable limit; has net available income that does not exceed two hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, for a one-person or two-person household, as defined by the commissioner in regulation; has household resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, OTHER THAN RETIREMENT ACCOUNTS, that do not exceed [the amount described in subparagraph four of paragraph (a) of subdivision two of this section] TWENTY THOUSAND DOLLARS for a one-person HOUSEHOLD or THIRTY THOUSAND DOLLARS FOR A two-person household, as defined by the commissioner in regulation; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, disabled means having a medically determinable impairment of sufficient severity and duration to qualify for benefits under section 1902(a)(10)(A)(ii)(xv) of the social security act; or

S 55. The mental hygiene law is amended by adding a new section 31.08 to read as follows:

S 31.08 COMPLIANCE WITH OPERATIONAL STANDARDS BY HOSPITALS.

(A) NOTWITHSTANDING THE PROVISIONS OF SECTION 31.07 OF THIS ARTICLE, WITH RESPECT TO A HOSPITAL AS DEFINED IN SECTION 1.03 OF THIS CHAPTER, WHICH IS A WARD, WING, UNIT, OR OTHER PART OF A HOSPITAL, AS DEFINED IN ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, WHICH PROVIDES SERVICES FOR PERSONS WITH MENTAL ILLNESS PURSUANT TO AN OPERATING CERTIFICATE ISSUED BY THE COMMISSIONER, THE REQUIREMENTS OF SECTION 31.07 OF THIS ARTICLE MAY BE DEEMED TO BE MET IF SUCH HOSPITAL HAS BEEN ACCREDITED BY THE JOINT COMMISSION, OR ANY OTHER HOSPITAL ACCREDITING ORGANIZATION TO WHICH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HAS GRANTED DEEMING STATUS, AND WHICH THE COMMISSIONER SHALL HAVE DETERMINED HAS ACCREDITING STANDARDS SUFFICIENT TO ASSURE THE COMMISSIONER THAT HOSPITALS SO ACCREDITED ARE IN COMPLIANCE WITH THE PROVISIONS OF THIS CHAPTER AND APPLICABLE LAWS, RULES AND REGULATIONS IN REGARD TO SERVICES PROVIDED AT SUCH WING, WARD, UNIT OR OTHER PART OF A HOSPITAL. SUCH ACCREDITATION SHALL HAVE THE SAME LEGAL EFFECT AS A DETERMINATION BY THE COMMISSIONER UNDER SECTION 31.07 OF THIS ARTICLE THAT THE HOSPITAL IS IN COMPLIANCE WITH SUCH PROVISIONS. THE COMMISSIONER MAY EXEMPT ANY SUCH HOSPITAL

FROM THE ANNUAL INSPECTION AND VISITATION REQUIREMENTS ESTABLISHED IN SECTION 31.07 OF THIS ARTICLE, PROVIDED THAT:

1. SUCH HOSPITAL HAS A HISTORY OF COMPLIANCE WITH SUCH PROVISIONS OF LAW, RULES AND REGULATIONS AND A RECORD OF PROVIDING GOOD QUALITY CARE, AS DETERMINED BY THE COMMISSIONER;

2. A COPY OF THE SURVEY REPORT AND THE CERTIFICATE OF ACCREDITATION OF THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION IS SUBMITTED BY THE ACCREDITING BODY OR THE HOSPITAL TO THE COMMISSIONER, WITHIN SEVEN DAYS OF ISSUANCE TO THE HOSPITAL;

3. THE JOINT COMMISSION OR OTHER ACCREDITING ORGANIZATION HAS AGREED TO AND DOES EVALUATE, AS PART OF ITS ACCREDITATION SURVEY, ANY MINIMAL OPERATIONAL STANDARDS ESTABLISHED BY THE COMMISSIONER WHICH ARE IN ADDITION TO THE MINIMAL OPERATIONAL STANDARDS OF ACCREDITATION OF THE JOINT COMMISSION OR OTHER ACCREDITING ORGANIZATION; AND

4. THERE ARE NO CONSTRAINTS PLACED UPON ACCESS BY THE COMMISSIONER TO THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION SURVEY REPORTS, PLANS OF CORRECTION, INTERIM SELF-EVALUATION REPORTS, NOTICES OF NONCOMPLIANCE, PROGRESS REPORTS ON CORRECTION OF AREAS OF NONCOMPLIANCE, OR ANY OTHER RELATED REPORTS, INFORMATION, COMMUNICATIONS OR MATERIALS REGARDING SUCH HOSPITAL.

(B) ANY HOSPITAL GOVERNED BY THE PROVISIONS OF SUBDIVISION (A) OF THIS SECTION SHALL AT ALL TIMES BE SUBJECT TO INSPECTION OR VISITATION BY THE COMMISSIONER TO DETERMINE COMPLIANCE WITH APPLICABLE LAW, REGULATIONS, STANDARDS OR CONDITIONS AS DEEMED NECESSARY BY THE COMMISSIONER. ANY SUCH HOSPITAL SHALL BE SUBJECT TO THE FULL RANGE OF LICENSING ENFORCEMENT AUTHORITY OF THE COMMISSIONER.

(C) ANY HOSPITAL GOVERNED BY THE PROVISIONS OF SUBDIVISION (A) OF THIS SECTION SHALL NOTIFY THE COMMISSIONER IMMEDIATELY UPON RECEIPT OF NOTICE BY THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION, OR ANY COMMUNICATION THE HOSPITAL MAY RECEIVE THAT SUCH ORGANIZATION WILL BE RECOMMENDING THAT SUCH HOSPITAL NOT BE ACCREDITED, NOT HAVE ITS ACCREDITATION RENEWED, OR HAVE ITS ACCREDITATION TERMINATED, OR UPON RECEIPT OF NOTICE OR OTHER COMMUNICATION FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES REGARDING A DETERMINATION THAT THE HOSPITAL WILL BE TERMINATED FROM PARTICIPATION IN THE MEDICARE PROGRAM BECAUSE IT IS NOT IN COMPLIANCE WITH ONE OR MORE CONDITIONS OF PARTICIPATION IN SUCH PROGRAM, OR HAS DEFICIENCIES THAT EITHER INDIVIDUALLY OR IN COMBINATION JEOPARDIZE THE HEALTH AND SAFETY OF PATIENTS OR ARE OF SUCH CHARACTER AS TO SERIOUSLY LIMIT THE PROVIDER'S CAPACITY TO RENDER ADEQUATE CARE.

S 56. The mental hygiene law is amended by adding a new section 32.14 to read as follows:

S 32.14 COMPLIANCE WITH OPERATIONAL STANDARDS BY PROVIDERS OF SERVICES IN HOSPITALS.

(A) NOTWITHSTANDING THE PROVISIONS OF SECTION 32.13 OF THIS ARTICLE, WITH RESPECT TO A PROVIDER OF SERVICES AS DEFINED IN SECTION 1.03 OF THIS CHAPTER THAT OCCUPIES A WARD, WING, UNIT, OR OTHER PART OF A HOSPITAL, AS DEFINED IN ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, WHICH PROVIDES SERVICES FOR PERSONS WITH MENTAL DISABILITIES PURSUANT TO AN OPERATING CERTIFICATE ISSUED BY THE COMMISSIONER, THE REQUIREMENTS OF SECTION 32.13 OF THIS ARTICLE MAY BE DEEMED TO BE MET IF SUCH HOSPITAL HAS BEEN ACCREDITED BY THE JOINT COMMISSION, OR ANY OTHER ACCREDITING ORGANIZATION TO WHICH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HAS GRANTED DEEMING STATUS, AND WHICH THE COMMISSIONER SHALL HAVE DETERMINED HAS ACCREDITING STANDARDS SUFFICIENT TO ASSURE THE COMMISSIONER THAT PROVIDERS OF SERVICES OCCUPYING A WARD, WING, UNIT OR OTHER PART OF SUCH HOSPITAL SO ACCREDITED ARE IN COMPLIANCE WITH THE PROVISIONS OF THIS

CHAPTER AND APPLICABLE LAWS, RULES AND REGULATIONS IN REGARD TO SERVICES PROVIDED AT SUCH WARD, WING, UNIT OR OTHER PART OF A HOSPITAL. SUCH ACCREDITATION SHALL HAVE THE SAME LEGAL EFFECT AS A DETERMINATION BY THE COMMISSIONER UNDER SECTION 32.13 OF THIS ARTICLE THAT THE PROVIDER OF SERVICES IS IN COMPLIANCE WITH SUCH PROVISIONS. THE COMMISSIONER MAY EXEMPT ANY SUCH PROVIDER OF SERVICES, IN REGARD TO SERVICES PROVIDED AT SUCH WARD, WING, UNIT OR OTHER PART OF A HOSPITAL, FROM THE ANNUAL INSPECTION AND VISITATION REQUIREMENTS ESTABLISHED IN SECTION 32.13 OF THIS ARTICLE, PROVIDED THAT:

1. SUCH PROVIDER OF SERVICES HAS A HISTORY OF COMPLIANCE WITH SUCH PROVISIONS OF LAW, RULES AND REGULATIONS AND A RECORD OF PROVIDING GOOD QUALITY CARE, AS DETERMINED BY THE COMMISSIONER;

2. A COPY OF THE SURVEY REPORT AND THE CERTIFICATE OF ACCREDITATION OF THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION IS SUBMITTED BY THE ACCREDITING BODY OR THE PROVIDER OF SERVICES TO THE COMMISSIONER, WITHIN SEVEN DAYS OF ISSUANCE TO SUCH PROVIDER OF SERVICES;

3. THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION HAS AGREED TO AND DOES EVALUATE, AS PART OF ITS ACCREDITATION SURVEY, ANY MINIMAL OPERATIONAL STANDARDS ESTABLISHED BY THE COMMISSIONER WHICH ARE IN ADDITION TO THE MINIMAL OPERATIONAL STANDARDS OF ACCREDITATION OF THE JOINT COMMISSION OR OTHER ACCREDITING ORGANIZATION; AND

4. THERE ARE NO CONSTRAINTS PLACED UPON ACCESS BY THE COMMISSIONER TO THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION SURVEY REPORTS, PLANS OF CORRECTION, INTERIM SELF-EVALUATION REPORTS, NOTICES OF NONCOMPLIANCE, PROGRESS REPORTS ON CORRECTION OF AREAS OF NONCOMPLIANCE, OR ANY OTHER RELATED REPORTS, INFORMATION, COMMUNICATIONS OR MATERIALS REGARDING SUCH PROVIDER OF SERVICES.

(B) ANY PROVIDER OF SERVICES GOVERNED BY THE PROVISIONS OF SUBDIVISION (A) OF THIS SECTION SHALL AT ALL TIMES BE SUBJECT TO INSPECTION OR VISITATION BY THE COMMISSIONER TO DETERMINE COMPLIANCE WITH APPLICABLE LAW, REGULATIONS, STANDARDS OR CONDITIONS AS DEEMED NECESSARY BY THE COMMISSIONER. ANY SUCH PROVIDER OF SERVICES SHALL BE SUBJECT TO THE FULL RANGE OF CERTIFICATION ENFORCEMENT AUTHORITY OF THE COMMISSIONER.

(C) ANY PROVIDER OF SERVICES GOVERNED BY THE PROVISIONS OF SUBDIVISION (A) OF THIS SECTION SHALL NOTIFY THE COMMISSIONER IMMEDIATELY UPON RECEIPT OF NOTICE BY THE JOINT COMMISSION OR OTHER APPROVED ACCREDITING ORGANIZATION, OR ANY COMMUNICATION THE PROVIDER OF SERVICES MAY RECEIVE THAT SUCH ORGANIZATION WILL BE RECOMMENDING THAT SUCH PROVIDER OF SERVICES NOT BE ACCREDITED, NOT HAVE ITS ACCREDITATION RENEWED, OR HAVE ITS ACCREDITATION TERMINATED, OR UPON RECEIPT OF NOTICE OR OTHER COMMUNICATION FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES REGARDING A DETERMINATION THAT THE PROVIDER OF SERVICES WILL BE TERMINATED FROM PARTICIPATION IN THE MEDICARE OR MEDICAID PROGRAM BECAUSE IT IS NOT IN COMPLIANCE WITH ONE OR MORE CONDITIONS OF PARTICIPATION IN SUCH PROGRAM, OR HAS DEFICIENCIES THAT EITHER INDIVIDUALLY OR IN COMBINATION JEOPARDIZE THE HEALTH AND SAFETY OF PATIENTS OR ARE OF SUCH CHARACTER AS TO SERIOUSLY LIMIT THE PROVIDER'S CAPACITY TO RENDER ADEQUATE CARE.

S 57. Intentionally omitted.

S 58. Section 2805-l of the public health law, as added by chapter 266 of the laws of 1986, subdivision 3 as amended by chapter 542 of the laws of 2000, subdivision 4 as added and subdivision 5 as renumbered by chapter 632 of the laws of 2006, is amended to read as follows:

S 2805-l. [Incident] ADVERSE EVENT reporting. 1. (A) All hospitals[, as defined in subdivision ten of section twenty-eight hundred one of this article,] shall be required to report [incidents] EVENTS described

by subdivision two of this section to the department in a manner and within time periods as may be specified by regulation of the department.

(B) FOR PURPOSES OF THIS SECTION, "HOSPITAL" MEANS ANY GENERAL HOSPITAL OR DIAGNOSTIC AND TREATMENT CENTER.

2. The following [incidents] ADVERSE EVENTS shall be reported to the department:

(a) patients' deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards;

(b) fires in the hospital which disrupt the provision of patient care services or cause harm to patients or staff;

(c) equipment malfunction during treatment or diagnosis of a patient which did or could have adversely affected a patient or hospital personnel;

(d) poisoning occurring within the hospital;

(e) strikes by hospital staff;

(f) disasters or other emergency situations external to the hospital environment which affect hospital operations; and

(g) termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.

3. NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, THE COMMISSIONER IS AUTHORIZED, AS APPROPRIATE IN THE INTEREST OF PROMOTING PATIENT SAFETY, AND AFTER CONSULTING WITH CLINICIANS, HOSPITAL ADMINISTRATORS, RESEARCHERS, AND CONSUMERS WITH EXPERTISE IN THE AREA OF PATIENT SAFETY AND QUALITY IMPROVEMENT, TO ADD, MODIFY OR ELIMINATE ONE OR MORE ADVERSE EVENTS SET FORTH IN SUBDIVISION TWO OF THIS SECTION, BY REGULATION, CONSISTENT WITH NATIONAL CONSENSUS STANDARDS ENDORSED BY THE CONSENSUS-BASED ENTITY SELECTED FOR THE PURPOSE OF PURSUING CERTAIN ACTIVITIES RELATING TO HEALTHCARE PERFORMANCE MEASUREMENT BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO THE MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT (PUB. L. 110-275).

4. The hospital shall conduct an investigation of [incidents] EVENTS described in paragraphs (a) through (d) of subdivision two of this section within thirty days of obtaining knowledge of any information which reasonably appears to show that such an [incident] EVENT has occurred, provided that, if the hospital reasonably expects such investigation to extend beyond such thirty day period, the hospital shall notify the department of such expectation and the reason therefor, and shall inform the department of the expected completion date of the investigation. The hospital shall provide to the department a copy of the investigation report within twenty-four hours of completion. Nothing herein shall limit the authority of the department to conduct an investigation of [incidents] EVENTS occurring in [general] hospitals.

5. THE DEPARTMENT SHALL:

(A) ANALYZE EVENT REPORTS, FINDINGS OF THE INVESTIGATIONS, THEIR ROOT CAUSE ANALYSES, AND CORRECTIVE ACTION PLANS TO DETERMINE PATTERNS OF SYSTEMIC FAILURE IN THE HEALTH CARE SYSTEM AND IDENTIFY SUCCESSFUL METHODS TO CORRECT THESE FAILURES; AND

(B) COMMUNICATE TO FACILITIES THE DEPARTMENT'S CONCLUSIONS, IF ANY, REGARDING EVENT REPORTS, PATTERNS OF SYSTEMIC FAILURE, AND RECOMMENDATIONS FOR CORRECTIVE ACTION RESULTING FROM THE ANALYSIS OF SUBMISSIONS FROM FACILITIES; AND MAY RELEASE, IN A FORMAT THAT DOES NOT IDENTIFY

SPECIFIC PATIENTS AND DOES NOT PROVIDE REASONABLE BASIS TO BELIEVE THAT THE INFORMATION CAN BE USED TO IDENTIFY A PATIENT; (I) ANALYSES AND FINDINGS DERIVED FROM THE ADVERSE EVENT DATA TO HOSPITALS OR THE PUBLIC AND (II) ADVERSE EVENT DATA TO RESEARCHERS FOR PATIENT SAFETY RESEARCH PROJECTS APPROVED BY THE COMMISSIONER, SUBJECT TO ANY TERMS AND CONDITIONS IMPOSED BY THE COMMISSIONER CONCERNING THE SECURITY AND CONFIDENTIALITY OF THE DATA AND THEIR USE; AND PROVIDED THAT NO SUCH DATA, RECORD, DOCUMENTATION OR ACTION SUBJECT TO SUBDIVISION TWO OF SECTION TWENTY-EIGHT HUNDRED FIVE-M OF THIS ARTICLE, SHALL BE SUBJECT TO DISCLOSURE UNDER ARTICLE SIX OF THE PUBLIC OFFICERS LAW NOR ARTICLE THIRTY-ONE OF THE CIVIL PRACTICE LAW AND RULES.

[4] 6. The commissioner shall establish protocols for hospital personnel where a patient under the age of eighteen years dies during transportation to the hospital or while at the hospital, under circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards. Such protocols shall address matters including, but not limited to, the following:

(a) medical and social history, and examination of the patient;

(b) preservation of evidence and chain of custody;

(c) questioning of the patient's family, guardian or person in parental authority;

(d) circumstances surrounding the injury resulting in death;

(e) determination of the cause of death;

(f) notification of law enforcement personnel; and

(g) reporting requirements under title six of article six of the social services law.

In developing such protocols, the commissioner shall consult with the office of children and family services, local departments of social services, coordinators of child fatality review teams established pursuant to section four hundred twenty-two-b of the social services law, law enforcement agencies, pediatricians preferably with expertise in the area of child abuse and maltreatment or forensic pediatrics, and such other persons as the commissioner deems necessary.

[5] 7. The commissioner shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate to effectuate the purposes of this section.

S 59. Intentionally omitted.

S 60. Intentionally omitted.

S 61. Intentionally omitted.

S 62. Intentionally omitted.

S 63. Subdivision 38 of section 2 of the social services law is amended by adding four new paragraphs (f), (g), (h) and (i) to read as follows:

(F) "VERIFICATION ORGANIZATION" MEANS AN ENTITY, OPERATING IN A MANNER CONSISTENT WITH APPLICABLE FEDERAL AND STATE CONFIDENTIALITY AND PRIVACY LAWS AND REGULATIONS, WHICH USES ELECTRONIC MEANS INCLUDING BUT NOT LIMITED TO CONTEMPORANEOUS TELEPHONE VERIFICATION OR CONTEMPORANEOUS VERIFIED ELECTRONIC DATA TO VERIFY WHETHER A SERVICE OR ITEM WAS PROVIDED TO AN ELIGIBLE MEDICAID RECIPIENT. FOR EACH SERVICE OR ITEM THE VERIFICATION ORGANIZATION SHALL CAPTURE:

(I) THE IDENTITY OF THE INDIVIDUAL PROVIDING SERVICES OR ITEMS TO THE MEDICAID RECIPIENT;

(II) THE IDENTITY OF THE MEDICAID RECIPIENT; AND

(III) THE DATE, TIME, DURATION, LOCATION AND TYPE OF SERVICE OR ITEM.

A LIST OF VERIFICATION ORGANIZATIONS SHALL BE JOINTLY DEVELOPED BY THE DEPARTMENT OF HEALTH AND THE OFFICE OF THE MEDICAID INSPECTOR GENERAL.

(G) "EXCEPTION REPORT" MEANS AN ELECTRONIC REPORT CONTAINING ALL THE DATA FIELDS IN PARAGRAPH (F) OF THIS SUBDIVISION FOR CONFLICTS BETWEEN SERVICES OR ITEMS ON THE BASIS OF THE IDENTITY OF THE PERSON PROVIDING THE SERVICE OR ITEM TO THE MEDICAID RECIPIENT, THE IDENTITY OF THE MEDICAID RECIPIENT, AND/OR TIME, DATE, DURATION OR LOCATION OF SERVICE;

(H) "CONFLICT REPORT" MEANS AN ELECTRONIC REPORT CONTAINING ALL OF THE DATA FIELDS IN PARAGRAPH (F) OF THIS SUBDIVISION DETAILING INCONGRUITIES IN SERVICES OR ITEMS BETWEEN SCHEDULING AND/OR LOCATION OF SERVICE WHEN COMPARED TO A DUTY ROSTER.

(I) "PARTICIPATING PROVIDER" MEANS A CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH AGENCY OR PERSONAL CARE PROVIDER WITH TOTAL MEDICAID REIMBURSEMENTS EXCEEDING FIFTEEN MILLION DOLLARS PER CALENDAR YEAR.

S 64. The social services law is amended by adding a new section 363-e to read as follows:

S 363-E. PRECLAIM REVIEW FOR PARTICIPATING PROVIDERS OF MEDICAL ASSISTANCE PROGRAM SERVICES AND ITEMS. EVERY SERVICE OR ITEM WITHIN A CLAIM SUBMITTED BY A PARTICIPATING PROVIDER SHALL BE REVIEWED AND VERIFIED BY A VERIFICATION ORGANIZATION PRIOR TO SUBMISSION OF A CLAIM TO THE DEPARTMENT OF HEALTH. THE VERIFICATION ORGANIZATION SHALL DECLARE EACH SERVICE OR ITEM TO BE VERIFIED OR UNVERIFIED. EACH PARTICIPATING PROVIDER SHALL RECEIVE AND MAINTAIN REPORTS FROM THE VERIFICATION ORGANIZATION WHICH SHALL CONTAIN DATA ON:

1. VERIFIED SERVICES OR ITEMS, INCLUDING WHETHER A SERVICE APPEARED ON A CONFLICT OR EXCEPTION REPORT BEFORE VERIFICATION AND HOW THAT CONFLICT OR EXCEPTION WAS RESOLVED; AND

2. SERVICES OR ITEMS THAT WERE NOT VERIFIED, INCLUDING CONFLICT AND EXCEPTION REPORT DATA FOR THESE SERVICES.

S 65. Subparagraph (iii) of paragraph (d) of subdivision 1 of section 367-a of the social services law, as amended by section 53 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

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

liability of such eligible persons or such qualified medicare beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

S 65-a. Subdivision 1 of section 367-a of the social services law is amended by adding a new paragraph (g) to read as follows:

(G) NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, AMOUNTS PAYABLE UNDER THIS TITLE FOR MEDICAL ASSISTANCE IN THE FORM OF HOSPITAL OUTPATIENT SERVICES OR DIAGNOSTIC AND TREATMENT CENTER SERVICES PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW PROVIDED TO ELIGIBLE PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL NOT EXCEED THE APPROVED MEDICAL ASSISTANCE PAYMENT LEVEL LESS THE AMOUNT PAYABLE UNDER PART B.

S 66. The public health law is amended by adding a new article 29-E to read as follows:

ARTICLE 29-E

ACCOUNTABLE CARE ORGANIZATIONS DEMONSTRATION PROGRAM

SECTION 2999-N. ACCOUNTABLE CARE ORGANIZATIONS; FINDINGS; PURPOSE.
2999-O. DEFINITIONS.
2999-P. ESTABLISHMENT OF ACO DEMONSTRATION PROGRAM.
2999-Q. ACCOUNTABLE CARE ORGANIZATIONS; REQUIREMENTS.
2999-R. OTHER LAWS.

S 2999-N. ACCOUNTABLE CARE ORGANIZATIONS; FINDINGS; PURPOSE. THE LEGISLATURE INTENDS TO TEST THE ABILITY OF ACCOUNTABLE CARE ORGANIZATIONS TO ASSUME A ROLE IN DELIVERING AN ARRAY OF HEALTH CARE SERVICES, FROM PRIMARY AND PREVENTIVE CARE THROUGH ACUTE INPATIENT HOSPITAL AND POST-HOSPITAL CARE. THE LEGISLATURE FINDS THAT THE FORMATION AND OPERATION OF ACCOUNTABLE CARE ORGANIZATIONS UNDER THIS ARTICLE, AND SUBJECT TO APPROPRIATE REGULATION, CAN BE CONSISTENT WITH THE PURPOSES OF FEDERAL AND STATE ANTI-TRUST, ANTI-REFERRAL, AND OTHER STATUTES, INCLUDING REDUCING OVER-UTILIZATION AND EXPENDITURES. THE LEGISLATURE FINDS THAT THE DEVELOPMENT OF ACCOUNTABLE CARE ORGANIZATIONS UNDER THIS ARTICLE WILL REDUCE HEALTH CARE COSTS, PROMOTE EFFECTIVE ALLOCATION OF HEALTH CARE RESOURCES, AND ENHANCE THE QUALITY AND ACCESSIBILITY OF HEALTH CARE. THE LEGISLATURE FINDS THAT THIS ARTICLE IS NECESSARY TO PROMOTE THE FORMATION OF ACCOUNTABLE CARE ORGANIZATIONS AND PROTECT THE PUBLIC INTEREST AND THE INTERESTS OF PATIENTS AND HEALTH CARE PROVIDERS.

S 2999-O. DEFINITIONS. AS USED IN THIS ARTICLE, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS, UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE:

1. "ACCOUNTABLE CARE ORGANIZATION" OR "ACO" MEANS AN ORGANIZATION OF CLINICALLY INTEGRATED HEALTH CARE PROVIDERS CERTIFIED BY THE COMMISSIONER UNDER THIS ARTICLE.

2. "CERTIFICATE OF AUTHORITY" OR "CERTIFICATE" MEANS A CERTIFICATE OF AUTHORITY ISSUED BY THE COMMISSIONER UNDER THIS ARTICLE.

3. "HEALTH CARE PROVIDER" INCLUDES BUT IS NOT LIMITED TO AN ENTITY LICENSED OR CERTIFIED UNDER ARTICLE TWENTY-EIGHT OR THIRTY-SIX OF THIS CHAPTER; AN ENTITY LICENSED OR CERTIFIED UNDER ARTICLE SIXTEEN, THIRTY-ONE OR THIRTY-TWO OF THE MENTAL HYGIENE LAW; OR A HEALTH CARE PRACTITIONER LICENSED OR CERTIFIED UNDER TITLE EIGHT OF THE EDUCATION LAW OR A LAWFUL COMBINATION OF SUCH HEALTH CARE PRACTITIONERS; AND MAY ALSO INCLUDE, TO THE EXTENT PROVIDED BY REGULATION OF THE COMMISSIONER, OTHER ENTITIES THAT PROVIDE TECHNICAL ASSISTANCE, INFORMATION SYSTEMS AND SERVICES, CARE COORDINATION AND OTHER SERVICES TO HEALTH CARE PROVIDERS AND PATIENTS PARTICIPATING IN AN ACO.

4. "PRIMARY CARE" MEANS THE HEALTH CARE FIELDS OF FAMILY PRACTICE, GENERAL PEDIATRICS, PRIMARY CARE INTERNAL MEDICINE, PRIMARY CARE OBSTETRICS, OR PRIMARY CARE GYNECOLOGY, WITHOUT REGARD TO BOARD CERTIFICATION, PROVIDED BY A HEALTH CARE PROVIDER ACTING WITHIN HIS, HER, OR ITS LAWFUL SCOPE OF PRACTICE.

5. "THIRD-PARTY HEALTH CARE PAYER" HAS ITS ORDINARY MEANINGS AND MAY INCLUDE ANY ENTITIES PROVIDED FOR BY REGULATION OF THE COMMISSIONER, WHICH MAY INCLUDE AN ENTITY SUCH AS A PHARMACY BENEFITS MANAGER, FISCAL ADMINISTRATOR, OR ADMINISTRATIVE SERVICES PROVIDER THAT PARTICIPATES IN THE ADMINISTRATION OF A THIRD-PARTY HEALTH CARE PAYER SYSTEM.

6. ANY REFERENCES TO THE "DEPARTMENT OF FINANCIAL SERVICES" AND THE "SUPERINTENDENT OF FINANCIAL SERVICES" IN THIS ARTICLE SHALL MEAN, PRIOR TO OCTOBER THIRD, TWO THOUSAND ELEVEN, RESPECTIVELY, THE "DEPARTMENT OF INSURANCE" AND THE "SUPERINTENDENT OF INSURANCE."

S 2999-P. ESTABLISHMENT OF ACO DEMONSTRATION PROGRAM. 1. AN ACCOUNTABLE CARE ORGANIZATION: (A) IS AN ORGANIZATION OF CLINICALLY INTEGRATED HEALTH CARE PROVIDERS THAT WORK TOGETHER TO PROVIDE, MANAGE, AND COORDINATE HEALTH CARE (INCLUDING PRIMARY CARE) FOR A DEFINED POPULATION; WITH A MECHANISM FOR SHARED GOVERNANCE; THE ABILITY TO NEGOTIATE, RECEIVE, AND DISTRIBUTE PAYMENTS; AND ACCOUNTABILITY FOR THE QUALITY, COST, AND DELIVERY OF HEALTH CARE TO THE ACO'S PATIENTS; IN ACCORDANCE WITH THIS ARTICLE; AND (B) HAS BEEN ISSUED A CERTIFICATE OF AUTHORITY BY THE COMMISSIONER UNDER THIS ARTICLE.

2. THE COMMISSIONER SHALL ESTABLISH A DEMONSTRATION PROGRAM WITHIN THE DEPARTMENT TO TEST THE ABILITY OF ACOS TO DELIVER AN ARRAY OF HEALTH CARE SERVICES FOR THE PURPOSE OF IMPROVING THE QUALITY, COORDINATION AND ACCOUNTABILITY OF SERVICES PROVIDED TO PATIENTS IN NEW YORK.

3. THE COMMISSIONER MAY ISSUE A CERTIFICATE OF AUTHORITY TO AN ENTITY THAT MEETS CONDITIONS FOR ACO CERTIFICATION AS SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER PURSUANT TO SECTION TWENTY-NINE HUNDRED NINETY-NINE-Q OF THIS ARTICLE. THE COMMISSIONER SHALL NOT ISSUE MORE THAN SEVEN CERTIFICATES UNDER THIS ARTICLE, AND SHALL NOT ISSUE ANY NEW CERTIFICATE UNDER THIS ARTICLE AFTER DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN.

4. THE COMMISSIONER MAY LIMIT, SUSPEND, OR TERMINATE A CERTIFICATE OF AUTHORITY IF AN ACO IS NOT OPERATING IN ACCORDANCE WITH THIS ARTICLE.

5. THE COMMISSIONER IS AUTHORIZED TO SEEK FEDERAL APPROVALS AND WAIVERS TO IMPLEMENT THIS ARTICLE, INCLUDING BUT NOT LIMITED TO THOSE APPROVALS OR WAIVERS NECESSARY TO OBTAIN FEDERAL FINANCIAL PARTICIPATION.

S 2999-Q. ACCOUNTABLE CARE ORGANIZATIONS; REQUIREMENTS. 1. THE COMMISSIONER SHALL PROMULGATE REGULATIONS ESTABLISHING CRITERIA FOR CERTIFICATES OF AUTHORITY, QUALITY STANDARDS FOR ACOS, REPORTING REQUIREMENTS AND OTHER MATTERS DEEMED TO BE APPROPRIATE AND NECESSARY IN THE OPERATION AND EVALUATION OF THE DEMONSTRATION PROGRAM. IN PROMULGATING SUCH REGULATIONS, THE COMMISSIONER SHALL CONSULT WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, HEALTH CARE PROVIDERS, THIRD-PARTY HEALTH CARE PAYERS, ADVOCATES REPRESENTING PATIENTS, AND OTHER APPROPRIATE PARTIES.

2. SUCH REGULATIONS MAY, AND SHALL AS NECESSARY FOR PURPOSES OF THIS ARTICLE, ADDRESS MATTERS INCLUDING BUT NOT LIMITED TO:

(A) THE GOVERNANCE, LEADERSHIP AND MANAGEMENT STRUCTURE OF THE ACO, INCLUDING THE MANNER IN WHICH CLINICAL AND ADMINISTRATIVE SYSTEMS AND CLINICAL PARTICIPATION WILL BE MANAGED;

(B) DEFINITION OF THE POPULATION PROPOSED TO BE SERVED BY THE ACO, WHICH MAY INCLUDE REFERENCE TO A GEOGRAPHICAL AREA AND PATIENT CHARACTERISTICS;

(C) THE CHARACTER, COMPETENCE AND FISCAL RESPONSIBILITY AND SOUNDNESS OF AN ACO AND ITS PRINCIPALS, IF AND TO THE EXTENT DEEMED APPROPRIATE BY THE COMMISSIONER;

(D) THE ADEQUACY OF AN ACO'S NETWORK OF PARTICIPATING HEALTH CARE PROVIDERS, INCLUDING PRIMARY CARE HEALTH CARE PROVIDERS;

(E) MECHANISMS BY WHICH AN ACO WILL PROVIDE, MANAGE, AND COORDINATE QUALITY HEALTH CARE FOR ITS PATIENTS AND PROVIDE ACCESS TO HEALTH CARE PROVIDERS THAT ARE NOT PARTICIPANTS IN THE ACO;

(F) MECHANISMS BY WHICH THE ACO SHALL RECEIVE AND DISTRIBUTE PAYMENTS TO ITS PARTICIPATING HEALTH CARE PROVIDERS, WHICH MAY INCLUDE INCENTIVE PAYMENTS OR MECHANISMS FOR POOLING PAYMENTS RECEIVED BY PARTICIPATING HEALTH CARE PROVIDERS FROM THIRD-PARTY PAYERS AND PATIENTS;

(G) MECHANISMS AND CRITERIA FOR ACCEPTING HEALTH CARE PROVIDERS TO PARTICIPATE IN THE ACO THAT ARE RELATED TO THE NEEDS OF THE PATIENT POPULATION TO BE SERVED AND NEEDS AND PURPOSES OF THE ACO, AND PREVENTING UNREASONABLE DISCRIMINATION;

(H) MECHANISMS FOR QUALITY ASSURANCE AND GRIEVANCE PROCEDURES FOR PATIENTS OR HEALTH CARE PROVIDERS WHERE APPROPRIATE;

(I) MECHANISMS THAT PROMOTE EVIDENCE-BASED HEALTH CARE, PATIENT ENGAGEMENT, COORDINATION OF CARE, ELECTRONIC HEALTH RECORDS, INCLUDING PARTICIPATION IN HEALTH INFORMATION EXCHANGES, AND OTHER ENABLING TECHNOLOGIES;

(J) PERFORMANCE STANDARDS FOR, AND MEASURES TO ASSESS, THE QUALITY AND UTILIZATION OF CARE PROVIDED BY AN ACO;

(K) APPROPRIATE REQUIREMENTS FOR ACOS TO PROMOTE COMPLIANCE WITH THE PURPOSES OF THIS ARTICLE;

(L) POSTING ON THE DEPARTMENT'S WEBSITE INFORMATION ABOUT ACOS THAT WOULD BE USEFUL TO HEALTH CARE PROVIDERS AND PATIENTS;

(M) REQUIREMENTS FOR THE SUBMISSION OF INFORMATION AND DATA BY ACOS AND THEIR PARTICIPATING AND AFFILIATED HEALTH CARE PROVIDERS AS NECESSARY FOR THE EVALUATION OF THE SUCCESS OF THE DEMONSTRATION PROGRAM;

(N) PROTECTION OF PATIENT RIGHTS AS APPROPRIATE;

(O) THE IMPACT OF THE ESTABLISHMENT AND OPERATION OF AN ACO ON ACCESS TO ANY HEALTH CARE SERVICE IN THE AREA SERVED; AND

(P) ESTABLISHMENT OF STANDARDS, AS APPROPRIATE, TO PROMOTE THE ABILITY OF AN ACO TO PARTICIPATE IN APPLICABLE FEDERAL PROGRAMS FOR ACOS.

3. (A) SUBJECT TO REGULATIONS OF THE COMMISSIONER: (I) AN ACO MAY ENTER INTO ARRANGEMENTS WITH ONE OR MORE THIRD-PARTY HEALTH CARE PAYERS TO ESTABLISH PAYMENT METHODOLOGIES FOR HEALTH CARE SERVICES FOR THE THIRD-PARTY HEALTH CARE PAYER'S ENROLLEES PROVIDED BY THE ACO OR FOR WHICH THE ACO IS RESPONSIBLE, SUCH AS FULL OR PARTIAL CAPITATION OR OTHER ARRANGEMENTS; (II) SUCH ARRANGEMENTS MAY INCLUDE PROVISION FOR THE ACO TO RECEIVE AND DISTRIBUTE PAYMENTS TO THE ACO'S PARTICIPATING HEALTH CARE PROVIDERS, INCLUDING INCENTIVE PAYMENTS AND PAYMENTS FOR HEALTH CARE SERVICES FROM THIRD-PARTY HEALTH CARE PAYERS AND PATIENTS; AND (III) AN ACO MAY INCLUDE MECHANISMS FOR POOLING PAYMENTS RECEIVED BY PARTICIPATING HEALTH CARE PROVIDERS FROM THIRD-PARTY PAYERS AND PATIENTS.

(B) SUBJECT TO REGULATIONS OF THE COMMISSIONER, THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, MAY AUTHORIZE A THIRD-PARTY HEALTH CARE PAYER TO PARTICIPATE IN PAYMENT METHODOLOGIES WITH AN ACO UNDER THIS SUBDIVISION, NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS CHAPTER, THE INSURANCE LAW, THE SOCIAL SERVICES LAW, OR THE ELDER LAW, ON FINDING THAT THE PAYMENT METHODOLOGY IS CONSISTENT WITH THE PURPOSES OF THIS ARTICLE.

4. THE PROVISION OF HEALTH CARE SERVICES DIRECTLY OR INDIRECTLY BY AN ACO THROUGH HEALTH CARE PROVIDERS SHALL NOT BE CONSIDERED THE PRACTICE OF A PROFESSION UNDER TITLE EIGHT OF THE EDUCATION LAW BY THE ACO.

S 2999-R. OTHER LAWS. 1. (A) IT IS THE POLICY OF THE STATE TO PERMIT AND ENCOURAGE COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS AMONG THIRD-PARTY HEALTH CARE PAYERS AND HEALTH CARE PROVIDERS WHO MIGHT OTHERWISE BE COMPETITORS UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. TO THE EXTENT THAT IT IS NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS ARTICLE, COMPETITION MAY BE SUPPLANTED AND THE STATE MAY PROVIDE STATE ACTION IMMUNITY UNDER STATE AND FEDERAL ANTITRUST LAWS TO PAYORS AND HEALTH CARE PROVIDERS.

(B) THE COMMISSIONER MAY ENGAGE IN STATE SUPERVISION TO PROMOTE STATE ACTION IMMUNITY UNDER STATE AND FEDERAL ANTITRUST LAWS AND MAY INSPECT, REQUIRE, OR REQUEST ADDITIONAL DOCUMENTATION AND TAKE OTHER ACTIONS UNDER THIS ARTICLE TO VERIFY AND MAKE SURE THAT THIS ARTICLE IS IMPLEMENTED IN ACCORDANCE WITH ITS INTENT AND PURPOSE.

2. WITH RESPECT TO THE PLANNING, IMPLEMENTATION, AND OPERATION OF ACOS, THE COMMISSIONER, BY REGULATION, MAY SPECIFICALLY DELINEATE SAFE HARBORS THAT EXEMPT ACOS FROM THE APPLICATION OF THE FOLLOWING STATUTES:

(A) ARTICLE TWENTY-TWO OF THE GENERAL BUSINESS LAW RELATING TO ARRANGEMENTS AND AGREEMENTS IN RESTRAINT OF TRADE;

(B) ARTICLE ONE HUNDRED THIRTY-ONE-A OF THE EDUCATION LAW RELATING TO FEE-SPLITTING ARRANGEMENTS; AND

(C) TITLE TWO-D OF ARTICLE TWO OF THIS CHAPTER RELATING TO HEALTH CARE PRACTITIONER REFERRALS.

3. FOR THE PURPOSES OF THIS ARTICLE, AN ACO SHALL BE DEEMED TO BE A HOSPITAL FOR PURPOSES OF SECTIONS TWENTY-EIGHT HUNDRED FIVE-J, TWENTY-EIGHT HUNDRED FIVE-K, TWENTY-EIGHT HUNDRED FIVE-L AND TWENTY-EIGHT HUNDRED FIVE-M OF THIS CHAPTER AND SUBDIVISIONS THREE AND FIVE OF SECTION SIXTY-FIVE HUNDRED TWENTY-SEVEN OF THE EDUCATION LAW.

S 67. Section 18 of part B of chapter 58 of the laws of 2010, amending chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities and other laws relating to Medicaid payments, is amended to read as follows:

S 18. Notwithstanding any contrary provision of law, surcharges and assessments due and owing pursuant to sections 2807-j, 2807-s and 2807-t of the public health law for any period prior to January 1, [2010] 2011, which are paid and accompanied by all required reports and which are received on or before December 31, [2010] 2011 shall not be subject to interest or penalties as otherwise provided in such sections, provided, however, that such reports may be based on estimates by payors and designated providers of services of the amounts owed, subject to subsequent audit by the commissioner of health or the commissioner's designee, and provided further, however, with regard to all principal, interest and penalty amounts collected by the commissioner of health prior to the effective date of this act, the penalty provisions of sections 2807-j, 2807-s and 2807-t of the public health law shall remain in full force and effect and such amounts collected shall not be subject to further adjustment pursuant to this section, and provided further, however, that payments of principal amounts of surcharges and assessments which were paid late and received prior to the effective date of this provision, and in regard to which interest and penalty amounts have not been collected, shall not be subject to such interest and penalties, and provided, further, however, that the provisions of this section shall not apply to delinquent amounts which have been referred by the commissioner of health for recoupment or collection proceeding.

Furthermore, the provisions of this section shall not apply to any surcharge or assessment payments made in response to a final audit finding issued by the commissioner of health or the commissioner's designee.

S 68. Intentionally omitted.

S 69. Subparagraph (iii) of paragraph (b) of subdivision 25 of section 2808 of the public health law, as added by section 31 of part B of chapter 109 of the laws of 2010, is amended and a new subparagraph (iv) is added to read as follows:

(iii) payment to a facility for reserved bed days provided on behalf of such person for non-hospitalization leaves of absence may not exceed ten days in any twelve month period[.]; AND

(IV) PAYMENTS FOR RESERVED BED DAYS FOR TEMPORARY HOSPITALIZATIONS SHALL ONLY BE MADE TO A RESIDENTIAL HEALTH CARE FACILITY IF AT LEAST FIFTY PERCENT OF THE FACILITY'S RESIDENTS ELIGIBLE TO PARTICIPATE IN A MEDICARE MANAGED CARE PLAN ARE ENROLLED IN SUCH A PLAN.

S 70. Intentionally omitted.

S 71. Intentionally omitted.

S 72. Intentionally omitted.

S 73. Intentionally omitted.

S 74. Section 366 of the social services law is amended by adding a new subdivision 14 to read as follows:

14. THE COMMISSIONER OF HEALTH MAY MAKE ANY AVAILABLE AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THIS TITLE, OR, IF AN AMENDMENT IS NOT POSSIBLE, DEVELOP AND SUBMIT AN APPLICATION FOR ANY WAIVER OR APPROVAL UNDER THE FEDERAL SOCIAL SECURITY ACT THAT MAY BE NECESSARY TO DISREGARD OR EXEMPT AN AMOUNT OF INCOME, FOR THE PURPOSE OF ASSISTING WITH HOUSING COSTS, FOR INDIVIDUALS RECEIVING COVERAGE OF NURSING FACILITY SERVICES UNDER THIS TITLE WHO ARE: (I) DISCHARGED FROM THE NURSING FACILITY TO THE COMMUNITY; (II) ENROLLED IN A PLAN CERTIFIED PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW; AND (III) WHILE SO ENROLLED, NOT CONSIDERED AN "INSTITUTIONALIZED SPOUSE" FOR PURPOSES OF SECTION THREE HUNDRED SIXTY-SIX-C OF THIS TITLE.

S 75. Intentionally Omitted.

S 76. Subdivision 6 of section 364-i of the social services law is amended by adding a new paragraph (a-2) to read as follows:

(A-2) AT THE TIME OF APPLICATION FOR PRESUMPTIVE ELIGIBILITY PURSUANT TO THIS SUBDIVISION, A PREGNANT WOMAN WHO RESIDES IN A SOCIAL SERVICES DISTRICT THAT HAS IMPLEMENTED THE STATE'S MANAGED CARE PROGRAM PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE MUST CHOOSE A MANAGED CARE PROVIDER. IF A MANAGED CARE PROVIDER IS NOT CHOSEN AT THE TIME OF APPLICATION, THE PREGNANT WOMAN WILL BE ASSIGNED TO A MANAGED CARE PROVIDER IN ACCORDANCE WITH SUBPARAGRAPHS (II), (III), (IV) AND (V) OF PARAGRAPH (F) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE.

S 77. Paragraphs (b), (c), (d) and (f) of subdivision 3 of section 364-j of the social services law are REPEALED, paragraph (e) is relettered paragraph (d), and two new paragraphs (b) and (c) are added to read as follows:

(B) THE FOLLOWING MEDICAL ASSISTANCE RECIPIENTS SHALL NOT BE REQUIRED TO PARTICIPATE IN A MANAGED CARE PROGRAM ESTABLISHED PURSUANT TO THIS SECTION:

(I) INDIVIDUALS WITH A CHRONIC MEDICAL CONDITION WHO ARE BEING TREATED BY A SPECIALIST PHYSICIAN THAT IS NOT ASSOCIATED WITH A MANAGED CARE PROVIDER IN THE INDIVIDUAL'S SOCIAL SERVICES DISTRICT MAY DEFER PARTIC-

IPATION IN THE MANAGED CARE PROGRAM FOR SIX MONTHS OR UNTIL THE COURSE OF TREATMENT IS COMPLETE, WHICHEVER OCCURS FIRST; AND

(II) NATIVE AMERICANS.

(C) THE FOLLOWING MEDICAL ASSISTANCE RECIPIENTS SHALL NOT BE ELIGIBLE TO PARTICIPATE IN A MANAGED CARE PROGRAM ESTABLISHED PURSUANT TO THIS SECTION:

(I) A PERSON ELIGIBLE FOR MEDICARE PARTICIPATING IN A CAPITATED DEMONSTRATION PROGRAM FOR LONG TERM CARE;

(II) AN INFANT LIVING WITH AN INCARCERATED MOTHER IN A STATE OR LOCAL CORRECTIONAL FACILITY AS DEFINED IN SECTION TWO OF THE CORRECTION LAW;

(III) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR LESS THAN SIX MONTHS;

(IV) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(V) INDIVIDUALS RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;

(VI) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAILABLE FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY PAYMENT, OR PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN PAYMENT OF SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE, AS DETERMINED BY THE LOCAL SOCIAL SERVICES DISTRICT;

(VII) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARAGRAPH ELEVEN OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(VIII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO PARAGRAPH (V) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE; AND

(IX) A PERSON WHO IS MEDICARE/MEDICAID DUALLY ELIGIBLE AND WHO IS NOT ENROLLED IN A MEDICARE MANAGED CARE PLAN.

S 77-a. Paragraph (g) of subdivision 3 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, and subparagraph (i) as amended by section 30 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

[(g)] (E) The following categories of individuals [will not] MAY be required to enroll with a managed care program [until] WHEN program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the [commissioner] COMMISSIONERS OF THE DEPARTMENT OF mental health, THE OFFICE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, THE OFFICE OF CHILDREN AND FAMILY SERVICES, AND THE OFFICE OF ALCOHOL AND SUBSTANCE ABUSE SERVICES:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program and enrolled in a Medicare managed care plan offered by an entity that is also a managed care provider; provided that (notwithstanding paragraph (g) of subdivision four of this section):

(a) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and enrolls in another Medicare managed care plan that is also a managed care provider, the individual shall be (if required by the commissioner under this paragraph) enrolled in that managed care provider;

(b) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, but enrolls in another Medicare managed care plan that is not also a managed care provider, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(c) if the individual disenrolls from his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and does not enroll in another Medicare managed care plan, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(d) nothing herein shall require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals; [and]

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law[.];

(V) A PERSON RECEIVING SERVICES PROVIDED BY A RESIDENTIAL ALCOHOL OR SUBSTANCE ABUSE PROGRAM OR FACILITY FOR THE MENTALLY RETARDED;

(VI) A PERSON RECEIVING SERVICES PROVIDED BY AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED OR WHO HAS CHARACTERISTICS AND NEEDS SIMILAR TO SUCH PERSONS;

(VII) A PERSON WITH A DEVELOPMENTAL OR PHYSICAL DISABILITY WHO RECEIVES HOME AND COMMUNITY-BASED SERVICES OR CARE-AT-HOME SERVICES THROUGH EXISTING WAIVERS UNDER SECTION NINETEEN HUNDRED FIFTEEN (C) OF THE FEDERAL SOCIAL SECURITY ACT OR WHO HAS CHARACTERISTICS AND NEEDS SIMILAR TO SUCH PERSONS;

(VIII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH TWELVE OR SUBPARAGRAPH THIRTEEN OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(IX) A PERSON RECEIVING SERVICES PROVIDED BY A LONG TERM HOME HEALTH CARE PROGRAM, OR A PERSON RECEIVING INPATIENT SERVICES IN A STATE-OPERATED PSYCHIATRIC FACILITY OR A RESIDENTIAL TREATMENT FACILITY FOR CHILDREN AND YOUTH;

(X) CERTIFIED BLIND OR DISABLED CHILDREN LIVING OR EXPECTED TO BE LIVING SEPARATE AND APART FROM THE PARENT FOR THIRTY DAYS OR MORE;

(XI) RESIDENTS OF NURSING FACILITIES;

(XII) A FOSTER CHILD IN THE PLACEMENT OF A VOLUNTARY AGENCY OR IN THE DIRECT CARE OF THE LOCAL SOCIAL SERVICES DISTRICT;

(XIII) A PERSON OR FAMILY THAT IS HOMELESS; AND

(XIV) INDIVIDUALS FOR WHOM A MANAGED CARE PROVIDER IS NOT GEOGRAPHICALLY ACCESSIBLE SO AS TO REASONABLY PROVIDE SERVICES TO THE PERSON. A MANAGED CARE PROVIDER IS NOT GEOGRAPHICALLY ACCESSIBLE IF THE PERSON CANNOT ACCESS THE PROVIDER'S SERVICES IN A TIMELY FASHION DUE TO DISTANCE OR TRAVEL TIME.

S 78. Subparagraph (v) of paragraph (e) of subdivision 4 of section 364-j of the social services law, as amended by section 14 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(v) Upon delivery of the pre-enrollment information, the local district or the enrollment organization shall certify the participant's receipt of such information. Upon verification that the participant has received the pre-enrollment education information, a managed care provider, a local district or the enrollment organization may enroll a participant into a managed care provider. Managed care providers must submit enrollment forms to the local department of social services. Upon enrollment, participants will sign an attestation that they have been informed that: participants have a choice of managed care providers; participants have a choice of primary care practitioners; and, except as otherwise provided in this section, including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdi-

vision, participants must exclusively use their primary care practitioners and plan providers. The commissioner of health [or with respect to a managed care plan serving participants in a city with a population of over two million, the local department of social services in such city,] may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

S 79. Subparagraph (i) of paragraph (f) of subdivision 4 of section 364-j of the social services law, as amended by section 14 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(i) Participants SHALL CHOOSE A MANAGED CARE PROVIDER AT THE TIME OF APPLICATION FOR MEDICAL ASSISTANCE; IF THE PARTICIPANT DOES NOT CHOOSE SUCH A PROVIDER THE COMMISSIONER SHALL ASSIGN SUCH PARTICIPANT TO A MANAGED CARE PROVIDER IN ACCORDANCE WITH SUBPARAGRAPHS (II), (III), (IV) AND (V) OF THIS PARAGRAPH. PARTICIPANTS ALREADY IN RECEIPT OF MEDICAL ASSISTANCE shall have no less than [sixty] THIRTY days from the date selected by the district to enroll in the managed care program to select a managed care provider, and as appropriate, a mental health special needs plan, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider or mental health special needs plan, the commissioner of health shall assign such participant to a managed care provider, and as appropriate, to a mental health special needs plan, taking into account capacity and geographic accessibility. The commissioner may after the period of time established in subparagraph (ii) of this paragraph assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants.

S 80. Paragraphs (d), (e), and (f) of subdivision 5 of section 364-j of the social services law, as added by section 15 of part C of chapter 58 of the laws of 2004, are amended to read as follows:

(d) Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health [or the local department of social services in a city with a population of over two million] may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health [or the local department of social services in a city with a population of over two million], to qualified managed care providers pursuant to this section.

(f) The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health [or the local department of social services in a city with a population of over two million], and meet applicable federal law and regulations.

S 81. Paragraph (k) of subdivision 2 of section 365-a of the social services law, as amended by chapter 659 of the laws of 1997, is amended to read as follows:

(k) care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public

health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations [provided, that no such agreement shall allow for medical assistance payments on a capitated basis for nursing facility, home care or other long term care services of a duration and scope defined in regulations of the department of health promulgated pursuant to section forty-four hundred three-f of the public health law, unless such entity has received a certificate of authority as a managed long term care plan or is an operating demonstration or is an approved managed long term care demonstration, pursuant to such section].

S 82. Paragraph (a) of subdivision 1 of section 367-f of the social services law, as amended by section 37 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(a) "Medicaid extended coverage" shall mean eligibility for medical assistance (i) without regard to the resource requirements of section three hundred sixty-six of this title, or in the case of an individual covered under an insurance policy or certificate described in subdivision two of this section that provided a residential health care facility benefit less than [three] TWO years in duration, without consideration of an amount of resources equivalent to the value of benefits received by the individual under such policy or certificate, as determined under the rules of the partnership for long-term care program; (ii) without regard to the recovery of medical assistance from the estates of individuals and the imposition of liens on the homes of persons pursuant to section three hundred sixty-nine of this title, with respect to resources exempt from consideration pursuant to subparagraph (i) of this paragraph; provided, however, that nothing in this section shall prevent the imposition of a lien or recovery against property of an individual on account of medical assistance incorrectly paid; and (iii) based on an income eligibility standard for married couples equal to the amount of the minimum monthly maintenance needs allowance defined in paragraph (h) of subdivision two of section three hundred sixty-six-c of this title, and for single individuals equal to one-half of such amount; provided, however, that the commissioner of health shall not be required to implement the provisions of this subparagraph if the use of such income eligibility standards will result in a loss of federal financial participation in the costs of Medicaid extended coverage furnished in accordance with subparagraphs (i) and (ii) of this paragraph.

S 83. Intentionally omitted.

S 84. Intentionally omitted.

S 85. Intentionally omitted.

S 86. Intentionally omitted.

S 87. Intentionally omitted.

S 88. Subparagraph 11 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 1-h of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(11) for purposes of receiving family planning services eligible for reimbursement by the federal government at a rate of ninety percent, is not otherwise eligible for medical assistance and whose income is two hundred percent or less of the comparable federal income official poverty line (as defined and annually revised by the United States department

of health and human services); provided, however, that such ninety percent limitation shall not apply to those services identified by the commissioner of health as services, including treatment for sexually transmitted diseases, generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement; PROVIDED FURTHER THAT THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ESTABLISH CRITERIA FOR PRESUMPTIVE ELIGIBILITY FOR SERVICES PROVIDED PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH ALL APPLICABLE REQUIREMENTS OF FEDERAL LAW OR REGULATION PERTAINING TO SUCH ELIGIBILITY. The commissioner of health shall submit whatever waiver applications as may be necessary to receive federal financial participation for services provided under this subparagraph and the provisions of this subparagraph shall be effective if and so long as such federal financial participation shall be available; or

S 89. Paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(e) (I) personal care services, including personal emergency response services, shared aide and an individual aide, SUBJECT TO THE PROVISIONS OF SUBPARAGRAPHS (II), (III), AND (IV) OF THIS PARAGRAPH, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate [in accordance with section three hundred sixty-seven-k and section three hundred sixty-seven-o of this title], and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(II) THE COMMISSIONER IS AUTHORIZED TO ADOPT STANDARDS, PURSUANT TO EMERGENCY REGULATION, FOR THE PROVISION AND MANAGEMENT OF SERVICES AVAILABLE UNDER THIS PARAGRAPH FOR INDIVIDUALS WHOSE NEED FOR SUCH SERVICES EXCEEDS A SPECIFIED LEVEL TO BE DETERMINED BY THE COMMISSIONER;

(III) THE COMMISSIONER IS AUTHORIZED TO PROVIDE ASSISTANCE TO PERSONS RECEIVING SERVICES UNDER THIS PARAGRAPH WHO ARE TRANSITIONING TO RECEIVING CARE FROM A MANAGED LONG TERM CARE PLAN CERTIFIED PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW;

(IV) PERSONAL CARE SERVICES AVAILABLE PURSUANT TO THIS PARAGRAPH SHALL NOT EXCEED EIGHT HOURS PER WEEK FOR INDIVIDUALS WHOSE NEEDS ARE LIMITED TO NUTRITIONAL AND ENVIRONMENTAL SUPPORT FUNCTIONS;

S 90. (a) Notwithstanding any other provision of law to the contrary, for the state fiscal years beginning April 1, 2011 and ending on March 31, 2013, all Medicaid payments made for services provided on and after April 1, 2011, shall, except as hereinafter provided, be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry including but not limited to, a uniform reduction in Medicaid rates of payments or other reductions provided that any method selected achieves up to $345,000,000 in Medicaid state share savings in state fiscal year 2011-12 and up to $357,000,000 in state fiscal year 2012-13, except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, 2013. Any alternative methods to achieve the reduction must be

provided in writing and shall be filed with the senate finance committee and the assembly ways and means committee not less than thirty days before the date on which implementation is expected to begin. Nothing in this section shall be deemed to prevent all or part of such alternative reduction plan from taking effect retroactively, to the extent permitted by the federal centers for medicare and medicaid services.

(b) The following types of appropriations shall be exempt from reductions pursuant to this section:

(i) any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal Medicare program;

(ii) any reductions related to payments pursuant to article 32, article 31 and article 16 of the mental hygiene law;

(iii) payments the state is obligated to make pursuant to court orders or judgments;

(iv) payments for which the non-federal share does not reflect any state funding; and

(v) at the discretion of the commissioner of health and the director of the budget, payments with regard to which it is determined by the commissioner of health and the director of the budget that application of reductions pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

(c) Reductions to Medicaid payments or Medicaid rates of payments made pursuant to this section shall be subject to the receipt of all necessary federal approvals.

(d) Not less than 30 days prior to the conclusion of each state fiscal year in which the provisions of this section apply, the department of health shall prepare and transmit a report to the legislature that details the actions taken to implement the Medicaid state share reductions established pursuant to this section. Such report shall be provided to the chairman of the senate finance committee and the assembly ways and means committee.

S 91. Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds Medicaid spending shall not exceed the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years.

S 92. 1. For state fiscal years 2011-12 and 2012-13, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the

federal social security act, changes in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund.

2. Such medicaid savings allocation plan shall be designed, to reduce the disbursements authorized by the appropriations herein in compliance with the following guidelines: (1) reductions shall be made in compliance with applicable federal law, including the provisions of the Patient Protection and Affordable Care Act, Public Law No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (collectively "Affordable Care Act") and any subsequent amendments thereto or regulations promulgated thereunder; (2) reductions shall be made in a manner that complies with the state Medicaid plan approved by the federal centers for medicare and medicaid services, provided, however, that the commissioner of health is authorized to submit any state plan amendment or seek other federal approval, including waiver authority, to implement the provisions of the medicaid savings allocation plan that meets the other criteria set forth herein; (3) reductions shall be made in a manner that maximizes federal financial participation, to the extent practicable, including any federal financial participation that is available or is reasonably expected to become available, in the discretion of the commissioner of health, under the Affordable Care Act; (4) reductions shall be made uniformly among categories of services and geographic regions of the state, to the extent practicable, and shall be made uniformly within a category of service, to the extent practicable, except where the commissioner of health determines that there are sufficient grounds for non-uniformity, including but not limited to: the extent to which specific categories of services contributed to department of health medicaid state funds spending in excess of the limits specified herein; the need to maintain safety net services in underserved communities; or the potential benefits of pursuing innovative payment models contemplated by the Affordable Care Act, in which case such grounds shall be set forth in the medicaid savings allocation plan; and (5) reductions shall be made in a manner that does not unnecessarily create administrative burdens to Medicaid applicants and recipients or providers.

3. (a) The commissioner of health shall seek the input of the legislature, as well as organizations representing health care providers, consumers, businesses, workers, health insurers, and others with relevant expertise, in developing such medicaid savings allocation plan, to the extent that all or part of such plan, in the discretion of the commissioner, is likely to have a material impact on the overall medicaid program, particular categories of service or particular geographic regions of the states.

(b)(i) The commissioner of health shall post the medicaid savings allocation plan on the department of health's website and shall provide written copies of such plan to the chairs of the senate finance and the assembly ways and means committees at least 30 days before the date on which implementation is expected to begin.

(ii) The commissioner of health may revise the medicaid savings allocation plan subsequent to the provision of notice and prior to implementation but need provide a new notice pursuant to subparagraph (i) of this paragraph only if the commissioner determines, in his or her discretion, that such revisions materially alter the plan.

(c) Notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, the commissioner of health need not seek the input described in paragraph (a) of this subdivision or provide notice pursu-

ant to paragraph (b) of this paragraph if, in the discretion of the commissioner, expedited development and implementation of a medicaid savings allocation plan is necessary due to a public health emergency.

For purposes of this section, a public health emergency is defined as: (i) a disaster, natural or otherwise, that significantly increases the immediate need for health care personnel in an area of the state; (ii) an event or condition that creates a widespread risk of exposure to a serious communicable disease, or the potential for such widespread risk of exposure; or (iii) any other event or condition determined by the commissioner to constitute an imminent threat to public health.

(d) Nothing in this paragraph shall be deemed to prevent all or part of such medical savings allocation plan from taking effect retroactively to the extent permitted by the federal centers for medicare and medicaid services.

4. In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid disbursements by the amount of the projected overspending through, actions including, but not limited to modifying or suspending reimbursement methods, including but not limited to all fees, premium levels and rates of payment, notwithstanding any provision of law that sets a specific amount or methodology for any such payments or rates of payment; modifying Medicaid program benefits; seeking all necessary Federal approvals, including, but not limited to waivers, waiver amendments; and suspending time frames for notice, approval or certification of rate requirements, notwithstanding any provision of law, rule or regulation to the contrary, including but not limited to sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h).

5. The department of health shall prepare a monthly report that sets forth: (a) known and projected department of health medicaid expenditures as described in subdivision one of this section; and (b) the actions taken to implement any medicaid savings allocation plan implemented pursuant to subdivision four of this section, including information concerning the impact of such actions on each category of service and each geographic region of the state. Each such monthly report shall be provided to the chairs of the senate finance and the assembly ways and means committees and shall be posted on the department of health's website in a timely manner.

S 93. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments for professional services provided by physicians, nurse practitioners and physician assistants who are employed by a public benefit corporation or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a facility of such public benefit corporation as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation, in accordance with title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, in amounts that will increase fees for such professional services to an amount equal to either the Medicare rate or the average commercial rate that would otherwise be received for such services rendered by such physi-

cians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule or made as aggregate lump sum payments to entities authorized to receive professional fees.

2. The supplemental Medicaid payments for professional services authorized by subdivision one of this section may be made only at the election of the public benefit corporation or the local social services district in which the non-state operated public general hospital is located. The electing public benefit corporation or local social services district shall, notwithstanding the social services district Medicaid cap provisions of Part C of chapter 58 of the laws of 2005, be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments, in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services. Social services district or public benefit corporation funding of the non-federal share of any such payments shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009, provided, however, that in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such act, the provisions of this section shall be null and void.

S 94. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 1 of part D of chapter 58 of the laws of 2010, is amended to read as follows:

(i) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine [through June thirtieth, two thousand eleven] the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which do not receive a per diem add-on adjustment pursuant to subparagraph (ii) of paragraph (a) of this subdivision, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which did not receive a per diem adjustment in accordance with subparagraph (ii) of paragraph (a) of this subdivision shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this para-

graph, utilizing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

S 95. Subdivision 2-c of section 2808 of the public health law is REPEALED and a new subdivision 2-c is added to read as follows:

2-C. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE NON-CAPITAL COMPONENT OF RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR INPATIENT SERVICES PROVIDED BY RESIDENTIAL HEALTH CARE FACILITIES ON OR AFTER OCTOBER FIRST, TWO THOUSAND ELEVEN, BUT NO LATER THAN JANUARY FIRST, TWO THOUSAND TWELVE, SHALL REFLECT A DIRECT STATEWIDE PRICE COMPONENT, AND INDIRECT STATEWIDE PRICE COMPONENT, AND A FACILITY SPECIFIC NON-COMPARABLE COMPONENT, UTILIZING ALLOWABLE OPERATING COSTS FOR A BASE YEAR AS DETERMINED BY THE COMMISSIONER BY REGULATION. SUCH RATE COMPONENTS SHALL BE PERIODICALLY UPDATED TO REFLECT CHANGES IN OPERATING COSTS.

(B) THE DIRECT AND INDIRECT STATEWIDE PRICE COMPONENTS SHALL BE ADJUSTED BY A WAGE EQUALIZATION FACTOR AND SUCH OTHER FACTORS AS DETERMINED TO BE APPROPRIATE TO RECOGNIZE LEGITIMATE COST DIFFERENTIALS AND THE DIRECT STATEWIDE PRICE COMPONENT SHALL BE SUBJECT TO A CASE MIX ADJUSTMENT UTILIZING THE PATIENTS THAT ARE ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. SUCH WAGE EQUALIZATION FACTOR SHALL BE PERIODICALLY UPDATED TO REFLECT CURRENT LABOR MARKET CONDITIONS.

(C) THE NON-CAPITAL COMPONENT OF THE RATES FOR: (I) AIDS FACILITIES OR DISCRETE AIDS UNITS WITHIN FACILITIES; (II) DISCRETE UNITS FOR RESIDENTS RECEIVING CARE IN A LONG-TERM INPATIENT REHABILITATION PROGRAM FOR TRAUMATIC BRAIN INJURED PERSONS; (III) DISCRETE UNITS PROVIDING SPECIALIZED PROGRAMS FOR RESIDENTS REQUIRING BEHAVIORAL INTERVENTIONS; (IV) DISCRETE UNITS FOR LONG-TERM VENTILATOR DEPENDENT RESIDENTS; AND (V) FACILITIES OR DISCRETE UNITS WITHIN FACILITIES THAT PROVIDE EXTENSIVE NURSING, MEDICAL, PSYCHOLOGICAL AND COUNSELING SUPPORT SERVICES SOLELY TO CHILDREN SHALL REFLECT THE RATES IN EFFECT FOR SUCH FACILITIES ON JANUARY FIRST, TWO THOUSAND NINE, AS ADJUSTED FOR INFLATION AND RATE APPEALS IN ACCORDANCE WITH APPLICABLE STATUTES, PROVIDED, HOWEVER, THAT SUCH RATES FOR FACILITIES DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH SHALL REFLECT THE APPLICATION OF THE PROVISIONS OF SECTION TWELVE OF PART D OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE, AND PROVIDED FURTHER, HOWEVER, THAT INSOFAR AS SUCH RATES REFLECT TREND ADJUSTMENTS FOR TREND FACTORS ATTRIBUTABLE TO THE TWO THOUSAND EIGHT AND TWO THOUSAND NINE CALENDAR YEARS THE AGGREGATE AMOUNT OF SUCH TREND FACTOR ADJUSTMENTS SHALL BE SUBJECT TO THE PROVISIONS OF SECTION TWO OF PART D OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE, AS AMENDED.

(D) THE COMMISSIONER SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION. SUCH REGULATIONS SHALL BE DEVELOPED IN CONSULTATION WITH THE NURSING HOME INDUSTRY AND ADVOCATES FOR RESIDENTIAL HEALTH CARE FACILITY RESIDENTS AND, FURTHER, THE COMMISSIONER SHALL PROVIDE NOTIFICATION CONCERNING SUCH REGULATIONS TO THE CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES, THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE. SUCH REGULATIONS SHALL INCLUDE PROVISIONS FOR RATE ADJUSTMENTS OR PAYMENT ENHANCEMENTS TO FACILITATE A MINIMUM FOUR-YEAR TRANSITION OF FACILITIES TO THE RATE-SETTING METHODOLOGY ESTABLISHED BY THIS SUBDIVISION AND MAY ALSO INCLUDE, BUT NOT BE LIMITED TO, PROVISIONS FOR FACILITATING QUALITY IMPROVEMENTS IN RESIDENTIAL HEALTH CARE FACILITIES.

S 96. Section 2 of part D of chapter 58 of the laws of 2009 amending the public health law and other laws relating to Medicaid reimbursements to residential health care facilities, as amended by section 3 of part D of chapter 58 of the laws of 2010, is amended to read as follows:

S 2. Notwithstanding paragraph (b) of subdivision 2-b of section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to medicaid rates of payment for inpatient services provided by residential health care facilities for the period April 1, 2009 through March 31, 2010, made pursuant to paragraph (b) of subdivision 2-b of section 2808 of the public health law, the commissioner of health and the director of the budget shall, upon a determination that such adjustments, including the application of adjustments authorized by the provisions of paragraph (g) of subdivision 2-b of section 2808 of the public health law, shall result in an aggregate increase in total Medicaid rates of payment for such services for such period that is less than or more than two hundred ten million dollars ($210,000,000), make such proportional adjustments to such rates as are necessary to result in an increase of such aggregate expenditures of two hundred ten million dollars ($210,000,000), and provided further, however, that notwithstanding section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to inpatient rates of payment made pursuant to section 2808 of the public health law for inpatient services provided by residential health care facilities for the period April 1, 2010 through [June 30, 2011] MARCH 31, 2012, the commissioner of health and the director of the budget shall, upon a determination by such commissioner and such director that such rate adjustments shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in total Medicaid rates of payment for such services, including payments made pursuant to subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, make such proportional adjustments to such rates as are necessary to reduce such total aggregate rate adjustments such that the aggregate total reflects no such increase or decrease, and provided further, however, the case mix adjustments as otherwise authorized by subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law and as scheduled for January AND JULY of 2011 shall not be made. Adjustments made pursuant to this section shall not be subject to subsequent correction or reconciliation.

S 97. Section 2808 of the public health law is amended by adding a new subdivision 2-d to read as follows:

2-D. RESIDENTIAL HEALTH CARE FACILITY SUPPLEMENTAL PAYMENTS. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, RULE OR REGULATION AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PERIOD MAY FIRST, TWO THOUSAND ELEVEN THROUGH MAY THIRTY-FIRST, TWO THOUSAND ELEVEN, THE COMMISSIONER SHALL ADJUST INPATIENT MEDICAID RATES OF PAYMENT ESTABLISHED PURSUANT TO THIS ARTICLE FOR ELIGIBLE RESIDENTIAL HEALTH CARE FACILITIES IN ACCORDANCE WITH THE FOLLOWING:

(A) RATE ADJUSTMENTS MADE PURSUANT TO THIS SUBDIVISION SHALL BE IN THE FORM OF RATE ADD-ONS AND SHALL NOT EXCEED AN AGGREGATE AMOUNT OF TWO HUNDRED TWENTY-ONE MILLION THREE HUNDRED THOUSAND DOLLARS.

(B) ELIGIBLE FACILITIES ARE THOSE FACILITIES WHICH THE COMMISSIONER DETERMINES HAVE EXPERIENCED A NET REDUCTION IN THEIR INPATIENT MEDICAID REIMBURSEMENT FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN AS A RESULT OF THE FOLLOWING:

(I) INPATIENT RATE ADJUSTMENTS MADE PURSUANT TO PARAGRAPH (B) OF SUBDIVISION TWO-B OF THIS SECTION;

(II) USE OF THE CASE MIX METHODOLOGY DESCRIBED IN PARAGRAPH (G) OF SUBDIVISION TWO-B OF THIS SECTION;

(III) INPATIENT RATE ADJUSTMENTS MADE PURSUANT TO SECTION TWO OF PART D OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE, AS AMENDED.

(C) THE FOLLOWING ELIGIBLE FACILITIES SHALL RECEIVE RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION EQUAL TO ONE HUNDRED PERCENT OF THEIR NET REIMBURSEMENT REDUCTION AS COMPUTED BY THE COMMISSIONER IN ACCORDANCE WITH PARAGRAPH (B) OF THIS SUBDIVISION:

(I) FACILITIES THAT HAVE BEEN DETERMINED BY THE COMMISSIONER AS BEING ELIGIBLE FOR DISTRIBUTIONS OF AMOUNTS AVAILABLE FOR THE TWO THOUSAND NINE PERIOD AS PROVIDED IN SUBDIVISION TWENTY-ONE OF THIS SECTION;

(II) NON-PUBLIC FACILITIES WHOSE TOTAL OPERATING LOSSES EQUAL OR EXCEED FIVE PERCENT OF TOTAL OPERATING REVENUE AND WHOSE MEDICAID UTILIZATION EQUALS OR EXCEEDS SEVENTY PERCENT, BASED ON EITHER THEIR TWO THOUSAND NINE COST REPORT OR BASED ON THE OTHERWISE MOST RECENTLY AVAILABLE COST REPORT, AS DETERMINED BY THE COMMISSIONER;

(III) FACILITIES OR DISTINCT UNITS OF FACILITIES PROVIDING INPATIENT SERVICES PRIMARILY TO CHILDREN UNDER THE AGE OF TWENTY-ONE.

(D) ELIGIBLE FACILITIES, OTHER THAN ELIGIBLE FACILITIES DESCRIBED IN PARAGRAPH (C) OF THIS SUBDIVISION, SHALL RECEIVE RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION EQUAL TO FIFTY PERCENT OF THEIR NET REIMBURSEMENT REDUCTION AS COMPUTED BY THE COMMISSIONER IN ACCORDANCE WITH PARAGRAPH (B) OF THIS SUBDIVISION.

(E) ELIGIBLE FACILITIES AS DESCRIBED IN PARAGRAPH (D) OF THIS SUBDIVISION WHICH, AS DETERMINED BY THE COMMISSIONER, AFTER APPLICATION OF THE RATE ADJUSTMENTS AUTHORIZED BY PARAGRAPH (D) OF THIS SUBDIVISION, REMAIN SUBJECT TO A NET REDUCTION IN THEIR INPATIENT MEDICAID REVENUE THAT IS IN EXCESS OF TWO PERCENT, AS MEASURED WITH REGARD TO THE NON-CAPITAL COMPONENTS OF FACILITY INPATIENT RATES IN EFFECT ON MARCH THIRTY-FIRST, TWO THOUSAND NINE AS COMPUTED PRIOR TO THE APPLICATION OF TREND FACTOR ADJUSTMENTS ATTRIBUTABLE TO THE TWO THOUSAND EIGHT AND TWO THOUSAND NINE CALENDAR YEARS, SHALL HAVE THEIR RATES FURTHER ADJUSTED SUCH THAT SUCH NET REDUCTION DOES NOT EXCEED SUCH TWO PERCENT.

(F) ELIGIBLE FACILITIES AS DESCRIBED IN PARAGRAPH (D) OF THIS SUBDIVISION WHICH, AS DETERMINED BY THE COMMISSIONER, HAVE EXPERIENCED A NET REDUCTION IN THEIR INPATIENT RATES OF MORE THAN SIX MILLION DOLLARS AS A RESULT OF THE APPLICATION OF THE FACTOR DESCRIBED IN SUBPARAGRAPH (III) OF PARAGRAPH (B) OF THIS SUBDIVISION SHALL AFTER APPLICATION OF THE PROVISIONS OF PARAGRAPH (E) OF THIS SUBDIVISION, HAVE THEIR RATES FURTHER ADJUSTED SUCH THAT ANY SUCH NET REDUCTION REMAINING AFTER THE APPLICATION OF THE OTHER PROVISIONS OF THIS SUBDIVISION IS REDUCED TO ZERO.

(G) IN COMPUTING NET REDUCTIONS OF MEDICAID REIMBURSEMENT PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION THE COMMISSIONER SHALL:

(I) DISREGARD THE IMPACT OF CASE MIX ADJUSTMENTS AS OTHERWISE SCHEDULED FOR JULY FIRST, TWO THOUSAND TEN; AND,

(II) DISREGARD THE IMPACT OF ANY RATE ADJUSTMENTS ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND ELEVEN, INCLUDING ADJUSTMENTS TO RATE PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND ELEVEN.

(H) PAYMENTS MADE PURSUANT TO THIS SUBDIVISION SHALL NOT BE SUBJECT TO SUBSEQUENT ADJUSTMENT OR RECONCILIATION AND, FURTHER, THE COMPUTATION AND APPLICATION OF LIMITATIONS ON MEDICAID RATES OF PAYMENT AS DESCRIBED IN SECTION TWO OF PART D OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE, AS AMENDED, AND AS APPLICABLE TO THE RATE PERIODS DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION, SHALL DISREGARD PAYMENTS MADE PURSUANT TO THIS SUBDIVISION.

(I) ADDITIONAL RATE ADJUSTMENTS SHALL BE MADE PURSUANT TO THIS SUBDIVISION TO ELIGIBLE FACILITIES IN THE FORM OF RATE ADD-ONS FOR THE PERIOD MAY FIRST, TWO THOUSAND ELEVEN THROUGH MAY THIRTY-FIRST, TWO THOUSAND ELEVEN WHICH SHALL IN AGGREGATE BE EQUAL TO TWENTY-FIVE PERCENT OF THE AGGREGATE AMOUNT DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION AND WHICH SHALL BE DISTRIBUTED TO EACH ELIGIBLE FACILITY IN THE SAME PROPORTION AS THE TOTAL DISTRIBUTIONS OTHERWISE RECEIVED BY EACH FACILITY PURSUANT TO THIS SUBDIVISION.

(J) THE COMMISSIONER MAY, WITH THE APPROVAL OF THE DIRECTOR OF THE BUDGET, AND SUBJECT TO THE IDENTIFICATION OF SUFFICIENT NURSING HOME RELATED MEDICAID SAVINGS TO OFFSET THE EXPENDITURES AUTHORIZED BY THIS PARAGRAPH, MAKE ADDITIONAL RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION TO ELIGIBLE FACILITIES IN THE FORM OF RATE ADD-ONS FOR THE PERIOD DECEMBER FIRST, TWO THOUSAND ELEVEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND ELEVEN WHICH SHALL IN AGGREGATE BE EQUAL TO TWELVE AND FIVE-TENTHS PERCENT OF THE AGGREGATE AMOUNT DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION AND WHICH SHALL BE DISTRIBUTED TO EACH ELIGIBLE FACILITY IN THE SAME PROPORTION AS THE TOTAL DISTRIBUTIONS OTHERWISE RECEIVED BY EACH FACILITY PURSUANT TO THIS SUBDIVISION.

S 98. Paragraph (b) of subdivision 17 of section 2808 of the public health law, as added by section 30 of part B of chapter 109 of the laws of 2010, is amended and a new paragraph (c) is added to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal year beginning April first, two thousand ten and ending March thirty-first, two thousand [eleven] FIFTEEN, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [eleven] FIFTEEN, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for EACH such state fiscal year PROVIDED, HOWEVER, THAT FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE SUCH AGGREGATE ANNUAL AMOUNT SHALL BE FIFTY MILLION DOLLARS. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; PROVIDED, HOWEVER, THAT THE COMMISSIONER'S AUTHORITY TO NEGOTIATE SUCH AGREEMENTS RESOLVING MULTIPLE PENDING RATE APPEALS AS HEREINBEFORE DESCRIBED SHALL CONTINUE ON AND AFTER APRIL FIRST, TWO THOUSAND FIFTEEN. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

(C) NOTWITHSTANDING ANY OTHER CONTRARY PROVISION OF LAW, RULE OR REGULATION, FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN THE COMMISSIONER SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING PRIORITIES AND TIME FRAMES FOR PROCESSING RATE

APPEALS, INCLUDING RATE APPEALS FILED PRIOR TO APRIL FIRST, TWO THOUSAND ELEVEN, WITHIN AVAILABLE ADMINISTRATIVE RESOURCES; PROVIDED, HOWEVER, THAT SUCH REGULATIONS SHALL NOT BE INCONSISTENT WITH THE PROVISIONS OF PARAGRAPH (B) OF THIS SUBDIVISION.

S 99. Subdivision 2-b of section 2808 of the public health law is amended by adding a new paragraph (h) to read as follows:

(H) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH JUNE THIRTIETH, TWO THOUSAND ELEVEN, THE NON-CAPITAL COMPONENTS OF RATES SHALL BE SUBJECT TO A UNIFORM PERCENTAGE REDUCTION SUFFICIENT TO REDUCE SUCH RATES BY AN AGGREGATE AMOUNT OF TWENTY-SEVEN MILLION ONE HUNDRED THOUSAND DOLLARS, AND PROVIDED FURTHER, HOWEVER, THAT SUCH REDUCTIONS SHALL BE DISREGARDED IN COMPUTATIONS MADE PURSUANT TO SECTION TWO OF PART D OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE, AS AMENDED.

S 100. Paragraph (a) of subdivision 21 of section 2808 of the public health law, as amended by section 8 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five THROUGH APRIL THIRTIETH, TWO THOUSAND ELEVEN AND ON AND AFTER MAY FIRST, TWO THOUSAND TWELVE, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, provided, however, that public residential health care facilities shall not be eligible for rate adjustments pursuant to this subdivision for rate periods on and after April first, two thousand nine[.], PROVIDED FURTHER, HOWEVER, THAT NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, EACH FACILITY THAT RECEIVES A RATE ADJUSTMENT PURSUANT TO THIS SUBDIVISION FOR THE PERIOD MAY FIRST, TWO THOUSAND TEN THROUGH APRIL THIRTIETH, TWO THOUSAND ELEVEN SHALL HAVE ITS MEDICAID RATES REDUCED FOR THE RATE PERIOD DECEMBER FIRST, TWO THOUSAND ELEVEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND ELEVEN BY AN AMOUNT EQUAL IN AGGREGATE TO THE AGGREGATE AMOUNT OF THE FUNDS SUCH FACILITY RECEIVED PURSUANT TO THIS SUBDIVISION FOR THE PERIOD MAY FIRST, TWO THOUSAND TEN THROUGH APRIL THIRTIETH, TWO THOUSAND ELEVEN.

S 101. The public health law is amended by adding a new section 2807-dd to read as follows:

S 2807-DD. TEMPORARY NURSING HOME STABILITY CONTRIBUTIONS. 1. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE RECEIPT OF ALL NECESSARY FEDERAL APPROVALS OR WAIVERS, FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN, A TEMPORARY NURSING HOME STABILITY CONTRIBUTION SHALL BE IMPOSED ON THE GROSS RECEIPTS OF EACH RESIDENTIAL HEALTH CARE FACILITY EQUAL TO FOUR TENTHS OF ONE PERCENT OF SUCH RECEIPTS AND PROVIDED FURTHER, HOWEVER, THAT ON AND AFTER APRIL FIRST, TWO THOUSAND TWELVE THROUGH OCTOBER THIRTY-FIRST, TWO THOUSAND TWELVE SUCH CONTRIBUTIONS SHALL BE REDUCED TO TWO TENTHS OF ONE PERCENT, AND PROVIDED FURTHER, HOWEVER, THAT ON AND AFTER NOVEMBER FIRST, TWO THOUSAND TWELVE, SUCH CONTRIBUTIONS SHALL BE REDUCED TO ZERO.

2. THE GROSS RECEIPTS SUBJECT TO THIS SECTION SHALL BE AS DEFINED IN PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE AND SHALL INCLUDE INCOME FROM ALL PATIENT CARE

SERVICES AND OTHER OPERATING INCOME ON A CASH BASIS, BUT EXCLUDING REVENUE RECEIVED PURSUANT TO THE FEDERAL MEDICARE PROGRAM. THE CONTRIBUTIONS DESCRIBED IN THIS SECTION SHALL BE ADMINISTERED IN ACCORDANCE WITH AND SUBJECT TO THE PROVISIONS OF SUBDIVISIONS FOUR, FIVE, SIX, SEVEN, EIGHT, NINE AND TWELVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE, PROVIDED, HOWEVER, THAT SUCH CONTRIBUTIONS SHALL NOT BE AN ALLOWABLE COST IN THE DETERMINATION OF REIMBURSEMENT RATES OF PAYMENT COMPUTED PURSUANT TO THIS ARTICLE.

S 102. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 37 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, AND FURTHER PROVIDED THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN SUCH ASSESSMENT SHALL BE SIX PERCENT.

S 103. Paragraph (c) of subdivision 10 of section 2807-d of the public health law, as amended by section 2 of part H of chapter 686 of the laws of 2003, is amended to read as follows:

(c) provided, however, that for the purposes of determining rates of payment pursuant to this article for residential health care facilities, the assessment imposed pursuant to subparagraph (vi) of paragraph (b) of subdivision two of this section shall be a reimbursable cost to be reflected as timely as practicable, and subsequently reconciled to actual cost, in rates of payment applicable within the assessment period, PROVIDED FURTHER, HOWEVER, THAT INSOFAR AS SUCH ASSESSMENT IS IN EXCESS OF SIX PERCENT IT SHALL NOT BE DEEMED A REIMBURSABLE COST AND SHALL NOT BE REFLECTED IN SUCH RATES OF PAYMENT.

S 104. Subdivision 17-a of section 2808 of the public health law, as amended by section 4 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

17-a. Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January first, nineteen hundred ninety-eight, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either nineteen hundred eighty-three, nineteen hundred eighty-seven or nineteen hundred ninety-three calendar year financial and statistical data and for periods beginning April first, two thousand four through March thirty-first, two thousand nine based on

either nineteen hundred eighty-three, nineteen hundred eighty-seven, nineteen hundred ninety-three or two thousand one calendar year financial and statistical data; provided, however, the state share amount for the utilization of two thousand one calendar year data shall be no more than twenty-two million dollars on a pro rata basis per calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of any of the other three years' data. Such methodology shall utilize the nineteen hundred eighty-three and nineteen hundred eighty-seven regional direct and indirect input price adjustment factor corridor percentages in existence on January first, nineteen hundred ninety-seven as well as nineteen hundred ninety-three regional direct and indirect input price adjustment factor corridor percentage in existence on January first, two thousand four as well as a two thousand one regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the nineteen hundred ninety-three direct and indirect input price adjustment factor corridor percentages in existence on January first, two thousand four; provided, however, for rate periods on and after April first, two thousand nine, the regional input price adjustment factors shall be based on the case mix predicted staffing for registered nurses, licensed practical nurses, nurses' aides, licensed therapists and therapist aides. For the rate period beginning April first, two thousand nine through [March thirty-first, two thousand ten,] THE DAY IMMEDIATELY PRIOR TO THE DAY THE PROVISIONS OF SUBDIVISION TWO-C OF THIS SECTION TAKE EFFECT, the regional direct and indirect input price adjustment factors to be applied to a facility's rate calculation shall be based upon the utilization of two thousand two calendar year financial and statistical data. Such methodology shall utilize two thousand two regional direct and indirect input price adjustment factor corridor percentages calculated in the same manner as the two thousand one regional direct and indirect input price adjustment factor corridor percentages in existence on December thirty-first, two thousand six except that every region shall receive a corridor to reflect the region's actual variation subject to a maximum statewide average variable corridor percentage of ten percent.

S 105. Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, or section 142 of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract without a competitive bid or request for proposal process for the purposes set forth in the Early Innovator federal grant awarded to the department of health by the federal centers for medicare and medicaid services pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), provided, however, that:

(i) the department of health shall post on its website, for a period of no less than thirty days:

(1) a description of the proposed services to be provided pursuant to the contract or contracts;

(2) the criteria for selection of a contractor or contractors which shall include but not be limited to the ability of the contractor to meet the federal grant requirements;

(3) the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(4) the manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(ii) all reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health;

(iii) the commissioner of health shall select such contractor or contractors that, in his or her discretion, are best suited to carry out the purposes set forth in the Early Innovator federal grant awarded to the department of health; and

(iv) prior to the execution of any resulting contract, the commissioner of health shall submit a copy to the office of the state comptroller for review and approval.

S 106. Section 2 of chapter 385 of the laws of 2008 amending the insurance law relating to an exemption to certain provisions of law relating to risk-based capital for property/casualty insurance companies is amended to read as follows:

S 2. This act shall take effect immediately, and shall expire and be deemed repealed [December 31, 2011] JUNE 30, 2014.

S 106-a. Subsection (c) of section 2343 of the insurance law, as amended by section 27 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(c) Notwithstanding any other provision of this chapter, no application for an order of rehabilitation or liquidation of a domestic insurer whose primary liability arises from the business of medical malpractice insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter, shall be made on the grounds specified in subsection (a) or (c) of section seven thousand four hundred two of this chapter at any time prior to June thirtieth, two thousand [eleven] FOURTEEN.

S 107. Section 4 of 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, as amended by section 68 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 4. This act shall take effect 120 days after it shall have become a law and shall expire and be deemed repealed March 31, [2012] 2014.

S 108. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 109. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 110. 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.

S 111. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011; provided however, that:

(a) regulations retroactive to April 1, 2011 may be promulgated for the regulations authorized pursuant to sections three, ninety-eight, twenty-six, thirty-six, thirty-five-a, and fifty of this act;

(b) the amendments to section 272 of the public health law, made by sections nine and seventeen of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith;

(c) the amendments to subdivision 9 of section 367-a of the social services law, made by sections ten, ten-a, and ten-b of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(d) the amendments to section 271 of the public health law, made by sections thirteen, fourteen and fifteen of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith;

(e) the amendments to subparagraph (i) of paragraph (b-1) of subdivision 1 of section 2807-c of the public health law, made by section thirty-two of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(f) the amendments to section 4403-f of the public health law, made by sections forty-one, forty-one-a and forty-one-b of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(g) sections fifty and fifty-one of this act shall take effect on the ninetieth day after it shall have become a law;

(h) sections five, twenty, twenty-one, twenty-seven, thirty-nine, forty-one, forty-one-a, forty-one-b, forty-eight, fifty-four and fifty-eight of this act shall take effect on the one hundred eightieth day after it shall have become a law;

(i) the amendments to paragraph (b) and subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section forty-one-b of this act shall expire and be repealed April 1, 2015;

(j) the amendments to section 364-j of the social services law made by sections nineteen, forty-two-b, forty-two-c, seventy-seven, seventy-seven-a, seventy-eight, seventy-nine and eighty of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(k) the amendments to paragraph (k) of subdivision 2 of section 365-a of the social services law made by section eighty-one of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(l) sections thirteen, fourteen, fifteen and seventeen of this act shall take effect May 1, 2011;

(m) section forty of this act shall take effect September 1, 2011;

(n) sections sixty-nine and eighty-two of this act shall take effect on January 1, 2012 and, further, section eighty-two of this act shall apply to taxable years beginning on or after January 1, 2012;

(o) sections thirty-eight and thirty-eight-a of this act shall expire and be deemed repealed March 31, 2015;

(p) section ninety-one of this act shall take effect April 1, 2012;

(q) the operation of the fund established by section fifty-two of this act shall commence on October 1, 2011; provided, however, that the provisions of section fifty-two of this act shall apply to birth-related neurological injury lawsuits as to which no judgment has been entered and no settlement agreement has been entered into by the parties before the date of enactment; provided, however, that notwithstanding any inconsistent provision of law, nothing in this act shall be construed to prevent a qualified plaintiff from obtaining medical care and assistance through the medicaid program or services provided in private physician practices on the basis of one hundred percent of the usual and customary rates as defined by the commissioner of health in regulation during the period of time subsequent to the date of enactment of this act and prior to the date upon which the operation of such fund commences and, if such costs are qualifying health costs as defined in this act, having such costs paid from the fund; and provided, further, that the commissioner of health shall be authorized to promulgate any regulations as necessary to implement such sections prior to such effective date, including on an emergency basis;

(r) sections fifty-two-a through fifty-two-h of this act shall take effect on the ninetieth day after it shall have become law;

(s) the amendments to subdivision 7 of section 2807-s of the public health law made by section thirty of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(t) any rules or regulations necessary to implement the provisions of this act may be promulgated and any procedures, forms, or instructions necessary for such implementation may be adopted and issued on or after the date this act shall have become a law, provided that the (i) commissioner of health (ii) the superintendent of financial services or, prior to October 3, 2011, the superintendent of insurance, or (iii) any appropriate council may promulgate regulations including on an emergency basis, necessary to implement this act, prior to its effective date and may take any steps necessary to implement this act prior to its effective date;

(u) this act shall not be construed to alter, change, affect, impair or defeat any rights, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act; and

(v) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health, the superintendent of financial services or, prior to October 3, 2011, the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act.

S 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.

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