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

2606--C

I N S E N A T E

January 22, 2013

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

AN ACT to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to the cap on local Medicaid expenditures; to amend the social services law, in relation to the medical assistance information and payment system; to amend the state finance law, in relation to liability for certain acts under the false claims act; to amend the state finance law, in relation to civil actions pursuant to the false claims act; to amend the public health law, in relation to the preferred drug program; to amend the public health law, in relation to antipsychotic therapeutic drugs; to amend the social services law, in relation to reducing pharmacy reimbursement for name brand drugs; to amend the social services law, in relation to managed care coverage of certain drugs; to amend the public health law, in relation to eliminating the summary posting requirement for the pharmacy and therapeutic committee; to amend the social services law, in relation to early refill of prescriptions; to amend the social services law, in relation to authorizing the commissioner of health to implement an incontinence supply utilization management program; to amend part C of chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, in relation to the effectiveness thereof; to amend the public health law, in relation to general hospital inpatient reimbursement; to amend the social services law, in relation to managed care programs; to amend section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to the effectiveness thereof; to amend the public health law, in relation to

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

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rates of payment for residential health care facilities; to amend the public health law, in relation to hospital inpatient base years; to amend the public health law, in relation to the Medicaid managed care inpatient psychiatric care default rate; to amend the public health law, in relation to the Medicaid managed care default rate; to amend the public health law, in relation to moving rate setting for child health plus to the department of health; to amend the social services law and the public health law, in relation to requiring the use of an enrollment broker for counties that are mandated Medicaid managed care and managed long term care; to amend the state finance law, in relation to the federal-state health reform partnership program account; to amend the public health law, in relation to repealing the twentieth day of the month enrollment cut-off for managed long term care enrollees; to amend the public health law, in relation to the nursing home financially disadvantaged program; to amend the public health law, in relation to eliminating the recruitment and retention attestation requirement for certain certified home health agencies; to amend the public health law, in relation to extending the office of the Medicaid inspector general's power to audit rebasing rates; to amend the public health law, in relation to rebasing transition payments; to amend the public health law, in relation to capital cost reimbursement for nursing homes; to amend the public health law, in relation to eliminating the bed hold requirement; to amend the public health law, in relation to authorizing upper payment limits for certain nursing homes; to amend the public health law, in relation to rates for specialty nursing homes; to amend the social services law, in relation to eliminating spousal refusal of medical care; to amend the social services law, in relation to treatment of income and resources of institutionalized persons; to amend the public health law, in relation to certain payments for certain home care agencies and services; to amend the social services law, in relation to Medicaid eligibility; to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital inpatient reimbursement, in relation to the effectiveness thereof; to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state funds Medicaid expenditures, in relation to the effectiveness thereof; in relation to eliminating the 2013-2014 trend factor and thereafter; to repeal certain provisions of the social services law and the public health law relating to managed care programs; and to repeal certain provisions of the public health law and the social services law relating to the pharmacy and therapeutics committee; providing for the repeal of certain provisions upon expiration thereof (Part A); to amend the public health law, in relation to payments to hospital assessments; to amend part C of chapter 58 of the laws of 2009 amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness of eligibility for medical assistance and the family health plus program; 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 the long term care integration and finance act of 1997, in relation to extending the expiration of operating demonstrations

operating a managed long term care plan; 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 and the effectiveness of certain provisions of such chapter; to amend the social services law, in relation to reports on chronic illness demonstration projects and reports by the commissioner of health on health homes; 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 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings and chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to extending a demonstration program for physicians suffering from alcoholism, drug abuse or mental illness; to amend part X2 of chapter 62 of the laws of 2003 amending the public health law relating to allowing 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 of certain provisions thereof (Part B); to amend the public health law, in relation to indigent care (Part C); to amend the social services law, in relation to eligibility conditions, permitting online and telephone Medicaid applications, allowing administrative renewals and self-attestation of residency, ending applications for family health plus and modified adjusted gross income and Medicaid eligibility groups; to amend the public health law, in relation to establishing methodology for modified adjusted gross income, centralizing child health plus eligibility determinations, requiring audit standards for eligibility, residency and income attestation and verification for child health plus, eliminating temporary enrollment in child health plus, expanding the child health plus social security number requirement to lawfully residing children, modified adjusted gross income under child health plus and personal interviews under child health plus; to amend the insurance law and the public health law, in relation to clarifying the identity of persons to whom insurance licensing requirements apply, insurance brokers and agents, coverage limitations requirements and student accident and health insurance and standardization of individual enrollee direct payment contracts; to repeal sections 369-ee and 369-ff of the social services law, relating to the family health plus program; to repeal certain other provisions of the social services law relating thereto; to repeal certain provisions of the insurance law relating thereto; and providing for the repeal of certain provisions upon expiration thereof (Part D); to amend the public health law, in relation to the general public health work program; to amend chapter 577 of the laws of 2008 amending the public health law, relating to expedited partner therapy for persons infected with chlamydia trachomatis, in

relation to the effectiveness of such chapter; to amend the public health law and the mental hygiene law, in relation to consolidating the excess medical malpractice liability coverage pool; to amend the education law, in relation to medical malpractice reform; to amend part S of chapter 56 of the laws of 2012 relating to the excess medical malpractice liability coverage pool, in relation to the application of coverage for physicians and dentists; and to repeal certain provisions of the public health law relating to state aid for certain public health programs and provisions relating to sexually transmitted diseases; to amend the public health law, in relation to medical assistance recoupment and reductions; to amend the public health law, in relation to enacting the "home care stabilization act"; to amend the insurance law, the public health law and the financial services law, in relation to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, adequacy of and access to out-of-network care and prohibition of excessive emergency charges; to amend the social services law, in relation to coverage of mail order prescriptions by managed care providers; to provide for the rates of payment to general hospitals for total hip or knee joint replacement cases; to amend the public health law, in relation to directing the commissioner of health to report to the legislature on the progress and preparedness of the health benefit exchange; to amend the public health law, in relation to directing the commissioner of health to report to the legislature on the department of health's annual activities, mission and goals; to amend chapter 56 of the laws of 2012, amending the public health law relating to evaluations or services under the early intervention program for infants and toddlers with disabilities and their families, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to establishing the broadscale systems integration demonstration program; to amend the public health law, in relation to requiring adrenoleukodystrophy screening of newborns; to amend the public health law, in relation to payments to rural hospitals designated as critical access hospitals; to amend the state finance law, in relation to the monies of the spinal cord injury research trust fund; and to amend the social services law, in relation to a health technology assessment committee; to amend the social services law, in relation to creating incentives for counties to investigate and prosecute medicaid fraud; to amend the public health law, in relation to establishing the Medicaid identification and anti-fraud biometric technology program; and to amend the social services law, in relation to conforming medical assistance identification with the Medicaid identification and anti-fraud biometric technology program; to amend the state finance law, in relation to establishing the health care efficiency and affordability law of New Yorkers (HEAL NY) account; to repeal section 365-d of the social services law relating to early and periodic screening diagnosis and treatment outreach demonstration projects; to repeal section 2818 of the public health law, relating to the health care efficiency and affordability law of New Yorkers (HEAL NY) capital grant program; and providing for the repeal of certain provisions upon expiration thereof (Part E); to amend the mental hygiene law, in relation to the addition to the methadone registry of dosage and such other information as is necessary to facilitate disaster management (Part F); to amend the mental hygiene law, in relation to state aid funding authorization of services funded by the office of alcoholism and substance abuse

services; to repeal article 26 of such law relating thereto (Part G); to amend the mental hygiene law, in relation to inpatient facilities; to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part H); to amend the mental hygiene law, in relation to the recovery of exempt income by the office of mental health for community residential programs and providing for the repeal of such provisions upon expiration thereof (Part I); intentionally omitted (Part J); to amend the mental hygiene law, in relation to an annual examination and notice of rights provided to respondent sex offenders who are confined in a secure treatment facility (Part K); to amend the mental hygiene law and the education law, in relation to creating mental health incident review panels (Part L); to amend the mental hygiene law, in relation to statewide comprehensive plans of service for persons with mental disabilities; and to repeal certain provisions of the mental hygiene law and certain provisions of chapter 723 of the laws of 1989, amending the mental hygiene law and other laws relating to the establishment of comprehensive psychiatric emergency programs, relating to eliminating the annual reports on the comprehensive psychiatric emergency program; family care; and the confinement, care and treatment of persons with developmental disabilities (Part M); 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 2013-2014 state fiscal year (Part N); to authorize the actions necessary to manage the loss of federal revenue and create the Mental Hygiene Stabilization fund (Part O); and in relation to adult homes (Part P)

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 2013-2014 state fiscal year. Each component is wholly contained within a Part identified as Parts A through P. 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. Subdivision (a) of section 90 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, is amended to read as follows:

(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] FEBRUARY 15, 2014 AND FOR THE RATE PERIOD APRIL 1, 2013 THROUGH DECEMBER 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, AND UP TO $311,000,000 FOR THE PERIOD APRIL 1, 2013 THROUGH DECEMBER 31, 2013 except as hereinafter provided, for services provided on and after April 1, 2011 through [March] DECEMBER 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.

S 2. Subdivision 1 of section 91 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 5 of part F of chapter 56 of the laws of 2012, is amended to read as follows:

1. 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[.]; PROVIDED, HOWEVER, THAT FOR STATE FISCAL YEAR 2013-14 AND FOR EACH FISCAL YEAR THEREAFTER, THE MAXIMUM ALLOWABLE ANNUAL INCREASE IN THE AMOUNT OF DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING SHALL BE CALCULATED BY MULTIPLYING THE DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING FOR THE PREVIOUS YEAR, MINUS THE AMOUNT OF ANY DEPARTMENT OF HEALTH STATE OPERATIONS SPENDING INCLUDED THEREIN, BY SUCH TEN YEAR ROLLING AVERAGE.

S 3. Section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state funds Medicaid expenditures, subdivision 1 as amended by section 57 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

S 92. 1. For state fiscal years 2011-12 through [2013-14] 2014-2015, 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 depart-

ment of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund; AND PROVIDED FURTHER, HOWEVER, THAT SUCH PROJECTIONS SHALL BE ADJUSTED BY THE DIRECTOR OF THE BUDGET TO ACCOUNT FOR INCREASED OR EXPEDITED DEPARTMENT OF HEALTH STATE FUNDS MEDICAID EXPENDITURES AS A RESULT OF A NATURAL OR OTHER TYPE OF DISASTER, INCLUDING A GOVERNMENTAL DECLARATION OF EMERGENCY; AND PROVIDED FURTHER, HOWEVER, THAT BEGINNING APRIL 1, 2013 SUCH PROJECTIONS SHALL BE ADJUSTED BY THE DIRECTOR OF THE BUDGET TO ACCOUNT FOR NEW DEPARTMENT OF HEALTH STATE FUNDS MEDICAID EXPENDITURES RELATED TO ANY MEDICAID WAIVER APPROVED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

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 rele-

vant 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 MEDICAID SAVINGS ALLOCATION PLAN SHALL BE SUBMITTED TO THE LEGISLATURE FOR THEIR CONSIDERATION AND APPROVAL PRIOR TO IMPLEMENTATION OF THE PLAN.

(C) The commissioner of health shall post the APPROVED 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)] (D) Notwithstanding the provisions of paragraphs (a) and [(b)] (C) of this subdivision, the commissioner of health need not seek the input described in paragraph (a) of this subdivision or provide notice pursuant to paragraph [(b)] (C) of this [paragraph] SUBDIVISION 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. IF THE COMMISSIONER DECIDES THAT EXPEDITED DEVELOPMENT AND IMPLEMENTATION OF A MEDICAID SAVINGS ALLOCATION PLAN IS NECESSARY, THE COMMISSIONER SHALL NOTIFY THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY SEVENTY-TWO HOURS PRIOR TO TAKING ANY ACTION.

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)] (E) 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 expendi-

tures as described in subdivision one of this section, DETAILING THE SPECIFIC MEDICAID EXPENDITURES INCLUDED IN THE REPORT THAT ARE SUBJECT TO THE AGGREGATE LIMIT LEVEL SPECIFIED IN THE ENACTED BUDGET FINANCIAL PLAN AND ANY MEDICAID EXPENDITURES THAT ARE NOT SUBJECT TO THE AGGREGATE LIMIT LEVEL SPECIFIED IN THE ENACTED BUDGET FINANCIAL PLAN; 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.

6. ON OR BEFORE DECEMBER 31, 2013, THE DIRECTOR OF THE BUDGET, IN CONSULTATION WITH THE CHAIRS OF THE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS COMMITTEES SHALL PROVIDE A REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY CONTAINING RECOMMENDATIONS FOR INCLUSION IN THE 2014-2015 EXECUTIVE BUDGET ON MODIFYING, CONTINUING OR DISCONTINUING SECTION NINETY-ONE OF THIS PART AND THIS SECTION. IN PREPARING SUCH RECOMMENDATIONS, THE FOLLOWING SHALL BE ANALYZED: (A) THE ADEQUACY OF THE YEAR TO YEAR RATE OF GROWTH IN DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING PROVIDED FOR IN SECTION NINETY-ONE OF THIS PART, (B) THE TYPES OF EXPENDITURES TO BE INCLUDED, AND THE FACTORS THAT MUST BE ACCOUNTED FOR, IN DETERMINING THE DEPARTMENT OF HEALTH STATE FUNDS MEDICAID AGGREGATE LIMIT LEVEL SPECIFIED IN THE ENACTED BUDGET FINANCIAL PLAN, THE PROCESS FOR ASSESSING MONTHLY EXPENDITURE LEVELS AND ESTABLISHING THE MEDICAID SAVINGS ALLOCATION PLAN, AND THE ADEQUACY OF THE MONTHLY REPORT ON KNOWN AND PROJECTED DEPARTMENT OF HEALTH STATE FUNDS MEDICAID EXPENDITURES, AND (C) OTHER RELEVANT ISSUES AS AGREED TO BY THE DIRECTOR OF THE BUDGET AND THE CHAIRS OF THE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS COMMITTEES. IN PREPARING SUCH REPORT, THE DIRECTOR OF THE BUDGET AND THE CHAIRS OF THE SENATE FINANCE AND ASSEMBLY WAYS AND MEANS COMMITTEES SHALL SEEK THE INPUT OF ORGANIZATIONS REPRESENTING HEALTH CARE PROVIDERS, CONSUMERS, BUSINESSES, WORKERS, HEALTH INSURERS, AND OTHERS WITH RELEVANT EXPERIENCE.

S 4. Section 2 of part H of chapter 59 of the laws of 2011; amending the public health law and other laws relating to general hospital reimbursement for annual rates, is amended to read as follows:

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] 2014, 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] 2014 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] 2014 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] 2014, trend factors attributable to the [2013] 2014 calendar year shall be established at no greater than zero percent.

S 5. Paragraph (a) of subdivision 8 of section 367-b of the social services law, as amended by chapter 109 of the laws of 2007, is amended to read as follows:

(a) For the purpose of orderly and timely implementation of the medical assistance information and payment system, the department is hereby authorized to enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payments, subject to audits being conducted by the state in accordance with the terms of such agreements, for medical assistance claims under the system described by this section in any social services district. Such agreements shall specifically provide that the state shall have complete oversight responsibility for the fiscal intermediaries' or fiscal agents' performance and shall be solely responsible for establishing eligibility requirements for recipients, provider qualifications, rates of payment, investigation of suspected fraud and abuse, issuance of identification cards, establishing and maintaining recipient eligibility files, provider profiles, and conducting state audits of the fiscal intermediaries' or agents' at least once annually. The system described in this subdivision shall be operated by [a] ONE OR MORE fiscal [intermediary] INTERMEDIARIES or fiscal [agent] AGENTS in accordance with this subdivision unless the department is otherwise authorized by a law enacted subsequent to the effective date of this subdivision to operate the system in another manner. In no event shall such intermediary or agent be a political subdivision of the state or any other governmental agency or entity. NOTWITHSTANDING THE FOREGOING, THE DEPARTMENT MAY MAKE PAYMENTS TO A PROVIDER UPON THE COMMISSIONER'S DETERMINATION THAT THE PROVIDER IS TEMPORARILY UNABLE TO COMPLY WITH BILLING REQUIREMENTS. The department shall consult with the office of Medicaid inspector general regarding any activities undertaken by the fiscal intermediaries or fiscal agents regarding investigation of suspected fraud and abuse.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. Paragraph (g) of subdivision 1 of section 189 of the state finance law, as amended by chapter 379 of the laws of 2010, is amended to read as follows:

(g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a local government, OR KNOWINGLY CONCEALS OR KNOWINGLY AND IMPROPERLY AVOIDS OR DECREASES AN OBLIGATION TO PAY OR TRANSMIT MONEY OR PROPERTY TO THE STATE OR A LOCAL GOVERNMENT, shall be liable to the state or a local government, as applicable, for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of all damages, including

consequential damages, which the state or local government sustains because of the act of that person.

S 9. Subparagraphs (d) and (e) of subdivision 2 of section 190 of the state finance law, paragraph (d) as amended by chapter 379 of the laws of 2010, paragraph (e) as added by section 39 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

(d) If the state notifies the court that it intends to file a complaint against the defendant and thereby be substituted as the plaintiff in the action, or to permit a local government to do so, such complaint, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, must be filed within thirty days after the notification to the court. For statute of limitations purposes, any such complaint filed by the state or a local government shall relate back to the filing date of the complaint of the qui tam plaintiff, to the extent that the cause of action of the state or local government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the [prior] complaint of the qui tam plaintiff.

(e) If the state notifies the court that it intends to intervene in the action, or to permit a local government to do so, then such motion [for intervention] TO INTERVENE, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, shall be filed within thirty days after the notification to the court. FOR STATUTE OF LIMITATIONS PURPOSES, ANY COMPLAINT FILED BY THE STATE OR A LOCAL GOVERNMENT, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, SHALL RELATE BACK TO THE FILING DATE OF THE COMPLAINT OF THE QUI TAM PLAINTIFF, TO THE EXTENT THAT THE CAUSE OF ACTION OF THE STATE OR LOCAL GOVERNMENT ARISES OUT OF THE CONDUCT, TRANSACTIONS, OR OCCURRENCES SET FORTH, OR ATTEMPTED TO BE SET FORTH, IN THE COMPLAINT OF THE QUI TAM PLAINTIFF.

S 9-a. Subdivision 4 of section 190 of the state finance law, as added by section 39 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

4. Related actions. When a person brings a qui tam action under this section, no person other than the attorney general, or a local government attorney acting pursuant to subdivision one of this section or paragraph (b) of subdivision two of this section, may intervene or bring a related civil action based upon the facts underlying the pending action[, unless such other person has first obtained the permission of the attorney general to intervene or to bring such related action]; provided, however, that nothing in this subdivision shall be deemed to deny persons the right, upon leave of court, to file briefs amicus curiae.

S 9-b. Subdivisions 6 and 7 of section 190 of the state finance law, as added by section 39 of part C of chapter 58 of the laws of 2007, are amended and a new subdivision 11 is added to read as follows:

6. Awards to qui tam plaintiff. (a) If the attorney general elects to convert the qui tam civil action into an attorney general enforcement action, or to permit a local government to convert the action into a civil enforcement action by such local government, or if the attorney general or a local government elects to intervene in the qui tam civil action, then the person or persons who initiated the qui tam civil action collectively shall be entitled to receive between fifteen and twenty-five percent of the proceeds recovered in the action or in settlement of the action. The court shall determine the percentage of the proceeds to which a person commencing a qui tam civil action is entitled, by considering the extent to which the plaintiff substantially

contributed to the prosecution of the action. Where the court finds that the action was based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil or administrative hearing, in a legislative or administrative report, hearing, audit or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the person or persons bringing the action in advancing the case to litigation. ANY SUCH PERSON SHALL ALSO RECEIVE AN AMOUNT FOR REASONABLE EXPENSES THAT THE COURT FINDS TO HAVE BEEN NECESSARILY INCURRED, REASONABLE ATTORNEYS' FEES, AND COSTS PURSUANT TO ARTICLE EIGHTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. ALL SUCH EXPENSES, FEES, AND COSTS SHALL BE AWARDED AGAINST THE DEFENDANT.

(b) If the attorney general or a local government does not elect to intervene or convert the action, and the action is successful, then the person or persons who initiated the qui tam action which obtains proceeds shall be entitled to receive between twenty-five and thirty percent of the proceeds recovered in the action or settlement of the action. The court shall determine the percentage of the proceeds to which a person commencing a qui tam civil action is entitled, by considering the extent to which the plaintiff substantially contributed to the prosecution of the action. SUCH PERSON SHALL ALSO RECEIVE AN AMOUNT FOR REASONABLE EXPENSES WHICH THE COURT FINDS TO HAVE BEEN NECESSARILY INCURRED, REASONABLE ATTORNEYS' FEES, AND COSTS PURSUANT TO ARTICLE EIGHTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. ALL SUCH EXPENSES, FEES, AND COSTS SHALL BE AWARDED AGAINST THE DEFENDANT.

(c) With the exception of a court award of costs, expenses or attorneys' fees, any payment to a person pursuant to this paragraph shall be made from the proceeds.

(D) IF THE ATTORNEY GENERAL OR A LOCAL GOVERNMENT DOES NOT PROCEED WITH THE ACTION AND THE PERSON BRINGING THE ACTION CONDUCTS THE ACTION, THE COURT MAY AWARD TO THE DEFENDANT ITS REASONABLE ATTORNEYS' FEES AND EXPENSES IF THE DEFENDANT PREVAILS IN THE ACTION AND THE COURT FINDS THAT THE CLAIM OF THE PERSON BRINGING THE ACTION WAS CLEARLY FRIVOLOUS, CLEARLY VEXATIOUS, OR BROUGHT PRIMARILY FOR PURPOSES OF HARASSMENT.

7. Costs, expenses, disbursements and attorneys' fees. In any action brought pursuant to this article, the court may award [the attorney general, on behalf of the people of the state of New York, and] any local government that participates as a party in the action[, and any person who is a qui tam plaintiff,] an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees, plus costs pursuant to article eighty-one of the civil practice law and rules. All such expenses, fees and costs shall be awarded directly against the defendant and shall not be charged from the proceeds, but shall only be awarded if [the state or] a local government [or the qui tam civil action plaintiff] prevails in the action.

11. FEES AND EXPENSES TO PREVAILING DEFENDANT. IF, IN A CIVIL ACTION BROUGHT BY THE ATTORNEY GENERAL, THE DEMAND BY THE ATTORNEY GENERAL IS SUBSTANTIALLY IN EXCESS OF THE JUDGMENT FINALLY OBTAINED BY THE ATTORNEY GENERAL AND IS UNREASONABLE WHEN COMPARED WITH SUCH JUDGMENT, UNDER THE FACTS AND CIRCUMSTANCES OF THE CASE, THE COURT SHALL AWARD TO THE PARTY THE FEES AND OTHER EXPENSES RELATED TO DEFENDING AGAINST THE EXCESSIVE DEMAND, UNLESS THE PARTY HAS COMMITTED A WILLFUL VIOLATION OF LAW OR OTHERWISE ACTED IN BAD FAITH, OR SPECIAL CIRCUMSTANCES MAKE AN AWARD UNJUST.

S 10. Intentionally omitted.

S 11. Intentionally omitted.

S 11-a. Section 364-j of the social services law is amended by adding a new subdivision 27 to read as follows:

27. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, MANAGED CARE PROVIDERS, INCLUDING A SPECIAL NEEDS MANAGED CARE PLAN OR COMPREHENSIVE HIV SPECIAL NEEDS PLAN, SHALL COVER MEDICALLY NECESSARY PRESCRIPTION DRUGS, INCLUDING NON-FORMULARY DRUGS, UPON DEMONSTRATION BY THE PRESCRIBER, AFTER CONSULTING WITH THE MANAGED CARE PROVIDER, THAT SUCH DRUGS, IN THE PRESCRIBER'S REASONABLE PROFESSIONAL JUDGMENT, ARE MEDICALLY NECESSARY AND WARRANTED.

S 12. Paragraph (g-1) of subdivision 2 of section 365-a of the social services law, as amended by section 23 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(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] MORE THAN A SIX DAY SUPPLY OF THE PREVIOUSLY DISPENSED AMOUNT SHOULD REMAIN 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 13. Intentionally omitted.

S 14. Section 271 of the public health law is REPEALED.

S 15. Subdivision 3 of section 270 of the public health law is REPEALED, subdivision 2 is renumbered subdivision 3 and a new subdivision 2 is added to read as follows:

2. "BOARD" SHALL MEAN THE DRUG UTILIZATION REVIEW BOARD CREATED BY SECTION THREE HUNDRED SIXTY-NINE-BB OF THE SOCIAL SERVICES LAW.

S 15-a. Subdivision 12 of section 270 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:

12. "Supplemental rebate" means a supplemental rebate under subdivision [ten] ELEVEN of section two hundred seventy-two of this article.

S 16. Section 272 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, subdivision 4 as amended by section 30 of part A of chapter 58 of the laws of 2008, subdivision 8 as amended by section 5 of part B of chapter 109 of the laws of 2010, paragraph (d) of subdivision 10 as added by section 17 of part H of chapter 59 of the laws of 2011, subdivision 11 as amended by section 36 of part C of chapter 58 of the laws of 2009, paragraph (b) of subdivision 11 as amended by section 9 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 272. Preferred drug program. 1. There is hereby established a preferred drug program to promote access to the most effective prescription drugs while reducing the cost of prescription drugs for persons in state public health plans.

2. When a prescriber prescribes a non-preferred drug, state public health plan reimbursement shall be denied unless prior authorization is obtained, unless no prior authorization is required under this article.

3. The commissioner shall establish performance standards for the program that, at a minimum, ensure that the preferred drug program and the clinical drug review program provide sufficient technical support and timely responses to consumers, prescribers and pharmacists.

4. Notwithstanding any other provision of law to the contrary, no preferred drug program or prior authorization requirement for prescription drugs, except as created by this article, paragraph (a-1) or (a-2) of subdivision four of section three hundred sixty-five-a of the social services law, paragraph (g) of subdivision two of section three hundred sixty-five-a of the social services law, subdivision one of section two hundred forty-one of the elder law and shall apply to the state public health plans.

5. The [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD shall consider and make recommendations to the commissioner for the adoption of a preferred drug program. (a) In developing the preferred drug program, the [committee] BOARD shall, without limitation: (i) identify therapeutic classes or drugs to be included in the preferred drug program; (ii) identify preferred drugs in each of the chosen therapeutic classes; (iii) evaluate the clinical effectiveness and safety of drugs considering the latest peer-reviewed research and may consider studies submitted to the federal food and drug administration in connection with its drug approval system; (iv) consider the potential impact on patient care and the potential fiscal impact that may result from making such a therapeutic class subject to prior authorization; [and] (v) consider the potential impact of the preferred drug program on public health and safety by the use of drug-specific delivery system to reduce illegal or unauthorized use or diversion of opioids; and (vi) consider the potential impact of the preferred drug program on the health of special populations such as children, the elderly, the chronically ill, persons with HIV/AIDS and persons with mental health conditions.

(b) In developing the preferred drug program, the [committee] BOARD may consider preferred drug programs or evidence based research operated or conducted by or for other state governments, the federal government, or multi-state coalitions. Notwithstanding any inconsistent provision of section one hundred twelve or article eleven of the state finance law or section one hundred forty-two of the economic development law or any other law, the department may enter into contractual agreements with the Oregon Health and Science University Drug Effectiveness Review Project to provide technical and clinical support to the [committee] BOARD and

the department in researching and recommending drugs to be placed on the preferred drug list.

(c) The [committee] BOARD shall from time to time review all therapeutic classes included in the preferred drug program, and may recommend that the commissioner add or delete drugs or classes of drugs to or from the preferred drug program, subject to this subdivision.

(d) The [committee] BOARD shall establish procedures to promptly review prescription drugs newly approved by the federal food and drug administration.

6. The [committee] BOARD shall recommend a procedure and criteria for the approval of non-preferred drugs as part of the prior authorization process. In developing these criteria, the [committee] BOARD shall include consideration of the following:

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

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

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

(d) other clinical indications for the use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, the elderly, the chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS.

7. The commissioner shall provide thirty days public notice on the department's website prior to any meeting of the [committee] BOARD to develop recommendations concerning the preferred drug program. Such notice regarding meetings of the [committee] BOARD shall include a description of the proposed therapeutic class to be reviewed, a listing of drug products in the therapeutic class, and the proposals to be considered by the [committee] BOARD. The [committee] BOARD shall allow interested parties a reasonable opportunity to make an oral presentation to the [committee] BOARD related to the prior authorization of the therapeutic class to be reviewed. The [committee] BOARD shall consider any information provided by any interested party, including, but not limited to, prescribers, dispensers, patients, consumers and manufacturers of the drug in developing their recommendations.

8. The commissioner shall provide notice of any recommendations developed by the [committee] BOARD regarding the preferred drug program, at least five days before any final determination by the commissioner, by making such information available on the department's website. Such public notice shall include: a summary of the deliberations of the [committee] BOARD; a summary of the positions of those making public comments at meetings of the [committee] BOARD; the response of the [committee] BOARD to those comments, if any; and the findings and recommendations of the [committee] BOARD. THE COMMISSIONER SHALL ALSO PROVIDE SUCH NOTICE OF THE BOARD'S RECOMMENDATIONS BY MAKING A VIDEO OR AUDIO OF THE BOARD'S MEETINGS AVAILABLE ON THE DEPARTMENT'S WEBSITE AT LEAST FIVE DAYS BEFORE ANY FINAL DETERMINATION BY THE COMMISSIONER.

9. Within ten days of a final determination regarding the preferred drug program, the commissioner shall provide public notice on the department's website of such determinations, including: the nature of the determination; and analysis of the impact of the commissioner's determination on state public health plan populations and providers; and the projected fiscal impact to the state public health plan programs of the commissioner's determination.

10. The commissioner shall adopt a preferred drug program and amendments after considering the recommendations from the [committee] BOARD and any comments received from prescribers, dispensers, patients, consumers and manufacturers of the drug.

(a) The preferred drug list in any therapeutic class included in the preferred drug program shall be developed based initially on an evaluation of the clinical effectiveness, safety and patient outcomes, followed by consideration of the cost-effectiveness of the drugs.

(b) In each therapeutic class included in the preferred drug program, the [committee] BOARD shall determine whether there is one drug which is significantly more clinically effective and safe, and that drug shall be included on the preferred drug list without consideration of cost. If, among two or more drugs in a therapeutic class, the difference in clinical effectiveness and safety is not clinically significant, then cost effectiveness (including price and supplemental rebates) may also be considered in determining which drug or drugs shall be included on the preferred drug list.

(c) In addition to drugs selected under paragraph (b) of this subdivision, any prescription drug in the therapeutic class, whose cost to the state public health plans (including net price and supplemental rebates) is equal to or less than the cost of another drug in the therapeutic class that is on the preferred drug list under paragraph (b) of this subdivision, may be selected to be on the preferred drug list, based on clinical effectiveness, safety and cost-effectiveness.

(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] BOARD pursuant to this section.

11. (a) The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public health plans for drugs within a therapeutic class; such supplemental rebates shall be taken into consideration by the [committee] BOARD and the commissioner in determining the cost-effectiveness of drugs within a therapeutic class under the state public health plans.

(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 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.

(c) Supplemental rebates under this subdivision shall be in addition to those required by applicable federal law and subdivision seven of section three hundred sixty-seven-a of the social services law. In order to be considered in connection with the preferred drug program, such

supplemental rebates shall apply to the drug products dispensed under the Medicaid program and the EPIC program. The commissioner is prohibited from approving alternative rebate demonstrations, value added programs or guaranteed savings from other program benefits as a substitution for supplemental rebates.

13. The commissioner may implement all or a portion of the preferred drug program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

14. For a period of eighteen months, commencing with the date of enactment of this article, and without regard to the preferred drug program or the clinical drug review program requirements of this article, the commissioner is authorized to implement, or continue, a prior authorization requirement for a drug which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, for which there is a non-prescription version within the same drug class, or for which there is a comparable non-prescription version of the same drug. Any such prior authorization requirement shall be implemented in a manner that is consistent with the process employed by the commissioner for such authorizations as of one day prior to the date of enactment of this article. At the conclusion of the eighteen month period, any such drug or drug class shall be subject to the preferred drug program requirements of this article; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions five through eleven of this section.

S 17. Subdivisions 4, 5 and 6 of section 274 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended to read as follows:

4. The commissioner shall obtain an evaluation of the factors set forth in subdivision three of this section and a recommendation as to the establishment of a prior authorization requirement for a drug under the clinical drug review program from the [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD. For this purpose, the commissioner and the [committee] BOARD, as applicable, shall comply with the following meeting and notice processes established by this article:

(a) the open meetings law and freedom of information law provisions of subdivision six of section two hundred seventy-one of this article; and

(b) the public notice and interested party provisions of subdivisions seven, eight and nine of section two hundred seventy-two of this article.

5. The [committee] BOARD shall recommend a procedure and criteria for the approval of drugs subject to prior authorization under the clinical drug review program. Such criteria shall include the specific approved clinical indications for use of the drug.

6. The commissioner shall identify a drug for which prior authorization is required, as well as the procedures and criteria for approval of use of the drug, under the clinical drug review program after considering the recommendations from the [committee] BOARD and any comments received from prescribers, dispensers, consumers and manufacturers of the drug. In no event shall the prior authorization criteria for approval pursuant to this subdivision result in denial of the prior authorization request based on the relative cost of the drug subject to prior authorization.

S 18. Section 277 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:

S 277. Review and reports. 1. The commissioner, in consultation with the [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD, shall undertake periodic reviews, at least annually, of the preferred drug program which shall include consideration of:

(a) the volume of prior authorizations being handled, including data on the number and characteristics of prior authorization requests for particular prescription drugs;

(b) the quality of the program's responsiveness, including the quality of the administrator's responsiveness;

(c) complaints received from patients and providers;

(d) the savings attributable to the state, and to each county and the city of New York, due to the provisions of this article;

(e) the aggregate amount of supplemental rebates received in the previous fiscal year and in the current fiscal year, to date; and such amounts are to be broken out by fiscal year and by month;

(f) the education and outreach program established by section two hundred seventy-six of this article.

2. The commissioner and the [panel] BOARD shall, beginning March thirty-first, two thousand six and annually thereafter, submit a report to the governor and the legislature concerning each of the items subject to periodic review under subdivision one of this section.

3. The commissioner and the [panel] BOARD shall, [beginning with the commencement of the preferred drug program and monthly thereafter,] submit a MONTHLY report to the governor and the legislature concerning the amount of supplemental rebates AND REBATES UNDER FEDERAL LAW received.

S 19. Subdivision 5 of section 369-bb of the social services law is REPEALED and a new subdivision 5 is added to read as follows:

5. (A) THE FUNCTIONS, POWERS AND DUTIES OF THE FORMER PHARMACY AND THERAPEUTICS COMMITTEE AS ESTABLISHED IN ARTICLE TWO-A OF THE PUBLIC HEALTH LAW SHALL NOW BE CONSIDERED A FUNCTION OF THE DRUG UTILIZATION REVIEW BOARD, INCLUDING BUT NOT LIMITED TO:

(I) CONDUCTING AN EXECUTIVE SESSION FOR THE PURPOSE OF RECEIVING AND EVALUATING DRUG PRICING INFORMATION RELATED TO SUPPLEMENTAL REBATES, OR RECEIVING AND EVALUATING TRADE SECRETS, OR OTHER INFORMATION WHICH, IF DISCLOSED, WOULD CAUSE SUBSTANTIAL INJURY TO THE COMPETITIVE POSITION OF THE MANUFACTURER; AND

(II) EVALUATING AND PROVIDING RECOMMENDATIONS TO THE COMMISSIONER OF HEALTH ON OTHER ISSUES RELATING TO PHARMACY SERVICES UNDER MEDICAID OR EPIC, INCLUDING, BUT NOT LIMITED TO: THERAPEUTIC COMPARISONS; ENHANCED USE OF GENERIC DRUG PRODUCTS; ENHANCED TARGETING OF PHYSICIAN PRESCRIBING PATTERNS; AND

(III) COLLABORATING WITH MANAGED CARE ORGANIZATIONS TO ADDRESS DRUG UTILIZATION CONCERNS AND TO IMPLEMENT CONSISTENT MANAGEMENT STRATEGIES ACROSS THE FEE-FOR-SERVICE AND MANAGED CARE PHARMACY BENEFITS.

(B) ANY BUSINESS OR OTHER MATTER UNDERTAKEN OR COMMENCED BY THE PHARMACY AND THERAPEUTICS COMMITTEE PERTAINING TO OR CONNECTED WITH THE FUNCTIONS, POWERS, OBLIGATIONS AND DUTIES ARE HEREBY TRANSFERRED AND ASSIGNED TO THE DRUG UTILIZATION REVIEW BOARD AND PENDING ON THE EFFECTIVE DATE OF THIS SUBDIVISION, MAY BE CONDUCTED AND COMPLETED BY THE DRUG UTILIZATION REVIEW BOARD IN THE SAME MANNER AND UNDER THE SAME TERMS AND CONDITIONS AND WITH THE SAME EFFECT AS IF CONDUCTED AND COMPLETED BY THE PHARMACY AND THERAPEUTICS COMMITTEE. ALL BOOKS, PAPERS, AND PROPERTY OF THE PHARMACY AND THERAPEUTICS COMMITTEE SHALL CONTINUE TO BE MAINTAINED BY THE DRUG UTILIZATION REVIEW BOARD.

(C) ALL RULES, REGULATIONS, ACTS, ORDERS, DETERMINATIONS, AND DECISIONS OF THE PHARMACY AND THERAPEUTICS COMMITTEE PERTAINING TO THE FUNCTIONS AND POWERS HEREIN TRANSFERRED AND ASSIGNED, IN FORCE AT THE TIME OF SUCH TRANSFER AND ASSUMPTION, SHALL CONTINUE IN FULL FORCE AND EFFECT AS RULES, REGULATIONS, ACTS, ORDERS, DETERMINATIONS AND DECISIONS OF THE DRUG UTILIZATION REVIEW BOARD UNTIL DULY MODIFIED OR ABROGATED BY THE COMMISSIONER OF HEALTH.

S 20. Subdivisions 1 and 2 of section 369-bb of the social services law, as added by chapter 632 of the laws of 1992, paragraph (a) of subdivision 2 as amended by chapter 843 of the laws of 1992, is amended to read as follows:

1. [A thirteen-member] AN EIGHTEEN MEMBER drug utilization review board is hereby created in the department. [The] IN ADDITION TO THE RESPONSIBILITIES UNDER SECTION TWO HUNDRED SEVENTY-TWO OF THE PUBLIC HEALTH LAW, THE board is responsible for the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.

2. The members of the DUR board shall be appointed by the commissioner and shall serve a three-year term. Members may be reappointed upon the completion of other terms. The membership shall be comprised of the following:

(a) [Five] SIX persons licensed and actively engaged in the practice of medicine in the state, [at least one of whom shall have expertise in the area of mental health, who shall be selected from a list of nominees provided by the medical society of the state of New York and other medical associations] WITH EXPERTISE IN THE AREAS OF MENTAL HEALTH, HIV/AIDS, GERIATRICS, PEDIATRICS OR INTERNAL MEDICINE AND WHO MAY BE SELECTED BASED ON INPUT FROM PROFESSIONAL ASSOCIATIONS AND/OR ADVOCACY GROUPS IN NEW YORK STATE.

(b) [Five] SIX persons licensed and actively practicing in [community] pharmacy in the state who [shall] MAY be selected [from a list of nominees provided by pharmaceutical societies/associations of] BASED ON INPUT FROM PROFESSIONAL ASSOCIATIONS AND/OR ADVOCACY GROUPS IN New York state.

(c) Two persons with expertise in drug utilization review who are [either] health care professionals licensed under Title VIII of the education law [or who are pharmacologists] AT LEAST ONE OF WHOM IS A PHARMACOLOGIST.

(d) [One person from the department of social services (commissioner or designee).] TWO PERSONS THAT ARE CONSUMERS OR CONSUMER 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.

(E) ONE PERSON LICENSED AND ACTIVELY PRACTICING AS A NURSE PRACTITIONER OR MIDWIFE.

(F) THE COMMISSIONER SHALL DESIGNATE A PERSON FROM THE DEPARTMENT TO SERVE AS CHAIRPERSON OF THE BOARD.

S 21. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 7 of part D of chapter 56 of the laws of 2012, 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-pre-

ferred 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, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (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; AND (V) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO IMPLEMENT AN INCONTINENCE SUPPLY UTILIZATION MANAGEMENT PROGRAM TO REDUCE COSTS WITHOUT LIMITING ACCESS THROUGH THE EXISTING PROVIDER NETWORK, INCLUDING BUT NOT LIMITED TO SINGLE OR MULTIPLE SOURCE CONTRACTS OR, A PREFERRED INCONTINENCE SUPPLY PROGRAM WHEREIN THE DEPARTMENT OF HEALTH WILL RECEIVE ENHANCED REBATES FROM PREFERRED MANUFACTURERS OF INCONTINENCE SUPPLIES, AND MAY SUBJECT NON-PREFERRED MANUFACTURERS' INCONTINENCE SUPPLIES TO PRIOR APPROVAL PURSUANT TO REGULATIONS OF THE DEPARTMENT, PROVIDED ANY NECESSARY APPROVALS UNDER FEDERAL LAW HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF INCONTINENCE SUPPLIES PROVIDED PURSUANT TO THIS SUBPARAGRAPH;

S 22. Intentionally omitted.

S 23. Intentionally omitted.

S 24. Intentionally omitted.

S 25. Intentionally omitted.

S 26. Paragraph (c) 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 to read as follows:

(c) The base period reported costs and statistics used for rate-setting for operating cost components, including the weights assigned to diagnostic related groups, shall be updated no less frequently than every four years and the new base period shall be no more than four years prior to the first applicable rate period that utilizes such new base period PROVIDED, HOWEVER, THAT THE FIRST UPDATED BASE PERIOD SHALL BEGIN ON JANUARY FIRST, TWO THOUSAND FOURTEEN.

S 27. Intentionally omitted.

S 28. Intentionally omitted.

S 29. Intentionally omitted.

S 30. Intentionally omitted.

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 33. Intentionally omitted.

S 33-a. Subparagraphs (ii) and (x) 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, are amended to read as follows:

(ii) Only those two thousand five base year costs which relate to the cost of services provided to Medicaid inpatients, as determined by the applicable ratio of costs to charges methodology, shall be utilized for rate-setting purposes, PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY UTILIZE UPDATED MEDICAID INPATIENT RELATED BASE YEAR COSTS AND STATISTICS AS NECESSARY TO ADJUST INPATIENT RATES IN ACCORDANCE WITH CLAUSE (C) OF SUBPARAGRAPH (X) OF THIS PARAGRAPH;

(x) Such regulations shall provide for administrative rate appeals, but only with regard to: (A) the correction of computational errors or omissions of data, including with regard to the hospital specific computations pertaining to graduate medical education, wage equalization factor adjustments, [and] (B) capital cost reimbursement, AND, (C) CHANGES TO THE BASE YEAR STATISTICS AND COSTS USED TO DETERMINE THE DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION COMPONENTS OF THE RATES AS A RESULT OF NEW TEACHING PROGRAMS AT NEW TEACHING HOSPITALS AND/OR AS A RESULT OF RESIDENTS DISPLACED AND TRANSFERRED AS A RESULT OF TEACHING HOSPITAL CLOSURES;

S 34. Section 364-i of the social services law is amended by adding a new subdivision 7 to read as follows:

7. NOTWITHSTANDING THE PROVISIONS OF SECTION ONE HUNDRED THIRTY-THREE OF THIS CHAPTER OR ANY LAW TO THE CONTRARY, NO MEDICAL ASSISTANCE, AS DEFINED IN SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE, SHALL BE AUTHORIZED OR REQUIRED TO BE FURNISHED TO AN INDIVIDUAL PRIOR TO THE DATE THE INDIVIDUAL IS DETERMINED ELIGIBLE FOR ASSISTANCE UNDER THIS TITLE, EXCEPT AS PROVIDED FOR IN THIS SECTION OR PURSUANT TO THE REGULATIONS OF THE DEPARTMENT.

S 35. Intentionally Omitted

S 35-a. Subparagraph (i) of paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 433 of the laws of 1997, is amended to read as follows:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis, INCLUDING A SPECIAL NEEDS MANAGED CARE PLAN OR COMPREHENSIVE HIV SPECIAL NEEDS PLAN; or

S 36. Paragraphs (c), (m) and (p) of subdivision 1 of section 364-j of the social services law, paragraph (c) as amended by section 12 of part C of chapter 58 of the laws of 2004, paragraph (m) as amended by section 42-b of part H of chapter 59 of the laws of 2011, and paragraph (p) as amended by chapter 649 of the laws of 1996, are amended and a new paragraph (z) is added to read as follows:

(c) "Managed care program". A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly and indirectly (including by referral) from a managed care provider, [and] INCLUDING as applicable, a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN or a comprehensive HIV special needs plan, under this section.

(m) "Special needs managed care plan" [and "specialized managed care plan"] shall have the same meaning as in section forty-four hundred one of the public health law.

(p) "Grievance". Any complaint presented by a participant or a participant's representative for resolution through the grievance process of a managed care provider[, comprehensive HIV special needs plan or a mental health special needs plan].

(Z) "CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELOR (CASAC)". AN INDIVIDUAL CREDENTIALED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN ACCORDANCE WITH APPLICABLE REGULATIONS OF THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

S 37. Paragraph (c) of subdivision 2 of section 364-j of the social services law, as added by section 42-c of part H of chapter 59 of the laws of 2011, is amended 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. WITH REGARD TO SUCH SPECIAL NEEDS MANAGED CARE PLANS, SUCH COMMISSIONERS SHALL JOINTLY ESTABLISH STANDARDS AND REQUIREMENTS TO:

(I) ENSURE THAT ANY SPECIAL NEEDS MANAGED CARE PLAN SHALL HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SPECIAL NEEDS MANAGED CARE PLAN, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE.

(II) ENSURE THAT ANY SPECIAL NEEDS MANAGED CARE PLAN SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES.

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF SPECIAL NEEDS MANAGED CARE PLANS.

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

S 37-a. Paragraphs (b) and (c) of subdivision 3 of section 364-j of the social services law are REPEALED.

S 38. Paragraphs (a), (d) and (e) of subdivision 3 of section 364-j of the social services law, paragraph (a) as amended by section 13 of part C of chapter 58 of the laws of 2004, paragraph (d) as amended by chapter 648 of the laws of 1999 and as relettered by section 77 and paragraph (e) as amended by section 77-a of part H of chapter 59 of the laws of 2011, are amended to read as follows:

(a) Every person eligible for or receiving medical assistance under this article, who resides in a social services district providing medical assistance, which has implemented the state's managed care program shall participate in the program authorized by this section. Provided, however, that participation in a comprehensive HIV special needs plan also shall be in accordance with article forty-four of the public health law and participation in a [mental health special needs] SPECIAL NEEDS MANAGED CARE plan shall also be in accordance with article forty-four of the public health law and article thirty-one of the mental hygiene law.

(d) [The] UNTIL SUCH TIME AS PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, THE OFFICE OF CHILDREN AND FAMILY SERVICES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AS APPROPRIATE, THE following services shall not be provided to medical assistance recipients through managed care programs established pursuant to this

section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies:

(i) day treatment services provided to individuals with developmental disabilities;

(ii) comprehensive medicaid case management services provided to individuals with developmental disabilities;

(iii) services provided pursuant to title two-A of article twenty-five of the public health law;

(iv) services provided pursuant to article eighty-nine of the education law;

(v) mental health services provided by a certified voluntary free-standing day treatment program where such services are provided in conjunction with educational services authorized in an individualized education program in accordance with regulations promulgated pursuant to article eighty-nine of the education law;

(vi) long term services as determined by the commissioner of mental retardation and developmental disabilities, provided to individuals with developmental disabilities at facilities licensed pursuant to article sixteen of the mental hygiene law or clinics serving individuals with developmental disabilities at facilities licensed pursuant to article twenty-eight of the public health law;

(vii) TB directly observed therapy;

(viii) AIDS adult day health care;

(ix) HIV COBRA case management; and

(x) other services as determined by the commissioner of health.

(e) The following categories of individuals may be required to enroll with a managed care program when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioners of the [department] OFFICE of mental health, the office for [persons] PEOPLE with developmental disabilities, the office of children and family services, and the office of [alcohol] ALCOHOLISM 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):]; PROVIDED, HOWEVER, 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;

[(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;

(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] DEVELOPMENTALLY DISABLED;

(vi) a person receiving services provided by an intermediate care facility for the [mentally retarded] DEVELOPMENTALLY DISABLED 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[.];

(XV) A PERSON ELIGIBLE FOR MEDICARE PARTICIPATING IN A CAPITATED DEMONSTRATION PROGRAM FOR LONG TERM CARE;

(XVI) AN INFANT LIVING WITH AN INCARCERATED MOTHER IN A STATE OR LOCAL CORRECTIONAL FACILITY AS DEFINED IN SECTION TWO OF THE CORRECTION LAW;

(XVII) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR LESS THAN SIX MONTHS;

(XVIII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(XIX) INDIVIDUALS RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;

(XX) 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;

(XXI) 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;

(XXII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO PARAGRAPH (V) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(XXIII) A PERSON WHO IS MEDICARE/MEDICAID DUALLY ELIGIBLE AND WHO IS NOT ENROLLED IN A MEDICARE MANAGED CARE PLAN;

(XXIV) 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; AND

(XXV) NATIVE AMERICANS.

S 39. Subparagraphs (ii), (iv) and (vii) of paragraph (e), subparagraphs (i) and (v) of paragraph (f) and paragraphs (g), (h), (i), (o), (p), (q) and (r) of subdivision 4 of section 364-j of the social services law, subparagraphs (ii), (iv) and (vii) of paragraph (e), subparagraph (v) of paragraph (f) and paragraph (g) as amended by section 14 of part C of chapter 58 of the laws of 2004, subparagraph (i) of paragraph (f) as amended by section 79 of part H of chapter 59 of the laws of 2011, paragraph (h) as amended by chapter 433 of the laws of 1997, and paragraphs (i), (o), (p), (q) and (r) as amended by chapter 649 of the laws of 1996, are amended and a new paragraph (v) is added to read as follows:

(ii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the requirements of this subparagraph shall apply to the extent consistent with federal law and regulations. The department of health, may contract with one or more independent organizations to provide enrollment counseling and enrollment services, for participants required to enroll in managed care programs, for each social services district requesting the services of an enrollment broker. To select such organizations, the department of health shall issue a request for proposals (RFP), shall evaluate proposals submitted in response to such RFP and, pursuant to such RFP, shall award a contract to one or more qualified and responsive organizations. Such organizations shall not be owned, operated, or controlled by any governmental agency, managed care provider, [comprehensive HIV special needs plan, mental health special needs plan,] or medical services provider.

(iv) Local social services districts or enrollment organizations through their enrollment counselors shall provide participants with the opportunity for face to face counseling including individual counseling upon request of the participant. Local social services districts or enrollment organizations through their enrollment counselors shall also provide participants with information in a culturally and linguistically appropriate and understandable manner, in light of the participant's needs, circumstances and language proficiency, sufficient to enable the participant to make an informed selection of a managed care provider. Such information shall include, but shall not be limited to: how to access care within the program; a description of the medical assistance services that can be obtained other than through a managed care provider[, mental health special needs plan or comprehensive HIV special needs plan]; the available managed care providers[, mental health special needs plans and comprehensive HIV special needs plans] and the scope of services covered by each; a listing of the medical services providers associated with each managed care provider; the participants' rights within the managed care program; and how to exercise such rights. Enrollment counselors shall inquire into each participant's existing relationships with medical services providers and explain whether and how such relationships may be maintained within the managed care

program. For enrollments made during face to face counseling, if the participant has a preference for particular medical services providers, enrollment counselors shall verify with the medical services providers that such medical services providers whom the participant prefers participate in the managed care provider's network and are available to serve the participant.

(vii) Any marketing materials developed by a managed care provider[, comprehensive HIV special needs plan or mental health special needs plan] shall be approved by the department of health or the local social services district, and the commissioner of mental health AND THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, where appropriate, within sixty days prior to distribution to recipients of medical assistance. All marketing materials shall be reviewed within sixty days of submission.

(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 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] WHICH, IF as appropriate, [to] MAY BE a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE 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.

(v) The commissioner shall assign all participants not otherwise assigned to a managed care plan pursuant to subparagraphs (ii), (iii) and (iv) of this paragraph equally among each of the managed care providers that meet the criteria established in subparagraph (i) of this paragraph; PROVIDED, HOWEVER, THAT THE COMMISSIONER SHALL ASSIGN INDIVIDUALS MEETING THE CRITERIA FOR ENROLLMENT IN A SPECIAL NEEDS MANAGED CARE PLAN TO SUCH PLAN OR PLANS WHERE AVAILABLE.

(g) If another managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] is available, participants may change such provider or plan without cause within thirty days of notification of enrollment or the effective date of enrollment, whichever is later with a managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] by making a request of the local social services district except that such period shall be forty-five days for participants who have been assigned to a provider by the commissioner of health. However, after such thirty or forty-five day period, whichever is applicable, a participant may be prohibited from changing managed care providers more frequently than once every twelve months, as permitted by federal law except for good cause as determined by the commissioner of health through regulations.

(h) If another medical services provider is available, a participant may change his or her provider of medical services (including primary care practitioners) without cause within thirty days of the partic-

ipant's first appointment with a medical services provider by making a request of the managed care provider[, mental health special needs plan or comprehensive HIV special needs plan]. However, after that thirty day period, no participant shall be permitted to change his or her provider of medical services other than once every six months except for good cause as determined by the commissioner through regulations.

(i) A managed care provider[, mental health special needs plan, and comprehensive HIV special needs plan] requesting a disenrollment shall not disenroll a participant without the prior approval of the local social services district in which the participant resides, provided that disenrollment from a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN must comply with the standards of the commissioner of health, THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, and the commissioner of mental health. A managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] shall not request disenrollment of a participant based on any diagnosis, condition, or perceived diagnosis or condition, or a participant's efforts to exercise his or her rights under a grievance process, provided however, that a managed care provider may, where medically appropriate, request permission to refer participants to a [mental health special needs plan] MANAGED CARE PROVIDER THAT IS A SPECIAL NEEDS MANAGED CARE PLAN or a comprehensive HIV special needs plan after consulting with such participant and upon obtaining his/her consent to such referral, and[,] provided further that a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN may, where clinically appropriate, disenroll individuals who no longer require the level of services provided by a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN.

(o) A managed care provider shall provide or arrange, directly or indirectly, (including by referral) for the full range of covered services to all participants, notwithstanding that such participants may be eligible to be enrolled in a comprehensive HIV special needs plan or [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN.

(p) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall implement procedures to communicate appropriately with participants who have difficulty communicating in English and to communicate appropriately with visually-impaired and hearing-impaired participants.

(q) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall comply with applicable state and federal law provisions prohibiting discrimination on the basis of disability.

(r) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act.

(V) A MANAGED CARE PROVIDER MUST ALLOW ENROLLEES TO ACCESS CHEMICAL DEPENDENCE TREATMENT SERVICES FROM FACILITIES CERTIFIED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, EVEN IF SUCH SERVICES ARE RENDERED BY A PRACTITIONER WHO WOULD NOT OTHERWISE BE SEPARATELY REIMBURSED, INCLUDING BUT NOT LIMITED TO A CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELOR (CASAC).

S 40. Paragraph (a) of subdivision 5 of section 364-j of the social services law, as amended by section 15 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(a) The managed care program shall provide for the selection of qualified managed care providers by the commissioner of health [and, as appropriate, mental health special needs plans and comprehensive HIV special needs plans] to participate in the program, INCLUDING COMPREHENSIVE HIV SPECIAL NEEDS PLANS AND SPECIAL NEEDS MANAGED CARE PLANS IN ACCORDANCE WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FIVE-M OF THIS TITLE; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans consistent with standards set forth in this section, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks.

S 41. The opening paragraph of subdivision 6 of section 364-j of the social services law, as added by chapter 649 of the laws of 1996, is amended to read as follows:

6. A managed care provider[, mental health special needs plan or comprehensive HIV special needs plan provider] shall not engage in the following practices:

S 42. Subdivision 17 of section 364-j of the social services law, as amended by section 94 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

17. (A) The provisions of this section regarding participation of persons receiving family assistance and supplemental security income in managed care programs shall be effective if, and as long as, federal financial participation is available for expenditures for services provided pursuant to this section.

(B) THE PROVISIONS OF THIS SECTION REGARDING THE FURNISHING OF HEALTH AND BEHAVIORAL HEALTH SERVICES THROUGH A SPECIAL NEEDS MANAGED CARE PLAN SHALL BE EFFECTIVE IF, AND AS LONG AS, FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR EXPENDITURES FOR SERVICES PROVIDED BY SUCH PLANS PURSUANT TO THIS SECTION.

S 43. Subdivision 20 of section 364-j of the social services law, as added by chapter 649 of the laws of 1996, is amended to read as follows:

20. Upon a determination that a participant appears to be suitable for admission to a comprehensive HIV special needs plan or a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN, a managed care provider shall inform the participant of the availability of such plans, where available and appropriate.

S 44. Paragraph (a) of subdivision 23 of section 364-j of the social services law, as added by section 65 of part A of chapter 57 of the laws of 2006, is amended to read as follows:

(a) As a means of protecting the health, safety and welfare of recipients, in addition to any other sanctions that may be imposed, the commissioner, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, WHERE APPROPRIATE, shall appoint temporary management of a managed care provider upon determining that the managed care provider has repeatedly failed to meet the substantive requirements of sections 1903(m) and 1932 of the federal Social Security Act and regulations. A hearing shall not be required prior to the appointment of temporary management.

S 45. The opening paragraph of subdivision 4 of section 365-m of the social services law, as added by section 42-d of part H of chapter 59 of the laws of 2011, is amended to read as follows:

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] NEEDS 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] FOURTEEN, 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[,] OR 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:

S 45-a. Paragraph c of subdivision 3 of section 365-m of the social services law, as added by section 42-d of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(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. IN SELECTING SUCH CONTRACTOR OR CONTRACTORS, THE COMMISSIONERS SHALL:

(I) ENSURE THAT ANY SUCH CONTRACTOR OR CONTRACTORS HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SUCH CONTRACT OR CONTRACTS, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE.

(II) ENSURE THAT SUCH CONTRACTOR OR CONTRACTORS SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNATED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES.

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF ANY SUCH CONTRACTOR OR CONTRACTORS.

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

S 45-b. Paragraph (c) of subdivision 4 of section 365-m of the social services, as added by section 42-d of part H of chapters 59 of the laws of 2011, is amended to read as follows:

(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. IN SELECTING SUCH PLANS OR SYSTEMS, THE COMMISSIONERS SHALL:

(I) ENSURE THAT ANY SUCH PLANS OR SYSTEMS HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SUCH PLANS OR SYSTEMS, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE.

(II) ENSURE THAT SUCH PLANS OR SYSTEMS SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES.

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF ANY SUCH PLANS OR SYSTEMS.

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

S 45-c. Section 365-m of the social services law is amended by adding a new subdivision 5 to read as follows:

5. ON OR BEFORE JUNE THIRTIETH, TWO THOUSAND SIXTEEN, 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 PREPARE A REPORT ON THE EXTENT TO WHICH ENTITIES COVERED UNDER THIS SECTION MEET THE REQUIREMENTS SET FORTH IN SUBPARAGRAPHS (I), (II), (III), AND (IV) OF PARAGRAPH (C) OF SUBDIVISION THREE AND SUBPARAGRAPHS (I), (II), (III), AND (IV) OF PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION AND ENTITIES COVERED UNDER PARAGRAPH (C) OF SUBDIVISION 2 OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE MEET THE REQUIREMENTS OF SUBPARAGRAPHS (I), (II), (III), AND (IV) OF SUCH PARAGRAPH. THE REPORT SHALL BE DELIVERED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE MINORITY LEADER OF THE SENATE, AND THE MINORITY LEADER OF THE ASSEMBLY ON OR BEFORE JUNE THIRTIETH, TWO THOUSAND SIXTEEN.

S 46. Subdivision 8 of section 4401 of the public health law, as added by section 42 of part H of chapter 59 of the laws of 2011, is amended 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 47. Section 4403-d of the public health law, as added by section 42-a of part H of chapter 59 of the laws of 2011, is amended 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 47-a. Subparagraphs (iii) and (iv) of paragraph (b) of subdivision 7 of section 4403-f of the public health law are REPEALED.

S 48. Subparagraph (v) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(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[.];

(6) 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;

(7) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(8) A PERSON RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;

(9) 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;

(10) 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;

(11) 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; AND

(12) NATIVE AMERICANS.

S 48-a. Notwithstanding any contrary provision of law, the commissioner of alcoholism and substance abuse services is authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing hospital-based and free-standing chemical dependence outpatient and opioid treatment clinics licensed pursuant to article 28 of the public health law or article 32 of the mental hygiene law for chemical dependency services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of alcoholism and substance abuse services for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services, promulgate regulations, including emergency regulations, as are necessary to implement the provisions of this section.

S 49. Section 2 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, AND SHALL EXPIRE ON MARCH 31, 2017.

S 50. Paragraph (e) of subdivision 8 of section 2511 of the public health law, as added by section 21-a of part B of chapter 109 of the laws of 2010, is amended to read as follows:

(e) The commissioner shall adjust subsidy payments to approved organizations made on and after April first, two thousand ten THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, so that the amount of each such payment, as otherwise calculated pursuant to this subdivision, is reduced by twenty-eight percent of the amount by which such calculated payment exceeds the statewide average subsidy payment for all approved organizations in effect on April first, two thousand ten. Such statewide

average subsidy payment shall be calculated by the commissioner and shall not reflect adjustments made pursuant to this paragraph.

S 51. Intentionally Omitted.

S 52. Intentionally Omitted.

S 53. Intentionally Omitted.

S 53-a. Subdivision (c-1) of section 1 of part C of chapter 58 of the laws of 2005, relating to as added by section 1 of part F of chapter 56 of the laws of 2012, authorizing reimbursement for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, is amended to read as follows:

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

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

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

S 54. Subparagraph (iii) of paragraph (g) of subdivision 7 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the 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 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 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 or a contractor selected pursuant to paragraph (d) of this subdivision.

S 55. Paragraph (a) of subdivision 8 of section 3614 of the public health law, as added by section 54 of part J of chapter 82 of the laws of 2002, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term home health care programs and AIDS home care programs in accordance with this paragraph and paragraph (b) of this subdivision for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following

amounts for services provided on and after December first, two thousand two.

(i) rates of payment by governmental agencies for certified home health agency services FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT (including services provided through contracts with licensed home care services agencies) shall be increased by three percent;

(ii) rates of payment by governmental agencies for long term home health care program services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent; and

(iii) rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

S 56. The opening paragraph of subdivision 9 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:

Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment for certified home health agencies FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term home health care programs, AIDS home care programs established pursuant to this article, hospice programs established under article forty of this chapter and for 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. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

S 57. Paragraph (a) of subdivision 10 of section 3614 of the public health law, as amended by section 24 of part C of chapter 59 of the laws of 2011, 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] AGENCY, 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 recently available cost report as submitted to the department 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; PROVIDED THAT SUCH ADJUSTMENTS TO RATES OF PAYMENTS TO CERTIFIED HOME HEALTH AGENCIES SHALL ONLY BE FOR THAT PORTION OF SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT.

S 58. Intentionally omitted.

S 59. Paragraph (d) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(d) Cost reports submitted by residential health care facilities for the two thousand two calendar year or any part thereof shall, notwithstanding any contrary provision of law, be subject to audit through December thirty-first, two thousand [fourteen] EIGHTEEN and facilities shall retain for the purpose of such audits all fiscal and statistical records relevant to such cost reports, provided, however, that any such audit commenced on or before December thirty-first, two thousand [fourteen] EIGHTEEN, may be completed and used for the purpose of adjusting any Medicaid rates which utilize such costs.

S 60. Subparagraph (ii) of paragraph (a) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(ii) Rates for the periods two thousand seven and two thousand eight shall be further adjusted by a per diem add-on amount, as determined by the commissioner, reflecting the proportional amount of each facility's projected Medicaid benefit to the total projected Medicaid benefit for all facilities of the imputed use of the rate-setting methodology set forth in paragraph (b) of this subdivision, provided, however, that for those facilities that do not receive a per diem add-on adjustment pursuant to this subparagraph, 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, provided, further, however, that the aggregate total of the rate adjustments made pursuant to this subparagraph shall not exceed one hundred thirty-seven million five hundred thousand dollars for the two thousand seven rate period and one hundred sixty-seven million five hundred thousand dollars for the two thousand eight rate period AND PROVIDED FURTHER, HOWEVER, THAT SUCH RATE ADJUSTMENTS AS MADE PURSUANT TO THIS SUBPARAGRAPH PRIOR TO TWO THOUSAND TWELVE SHALL NOT BE SUBJECT TO SUBSEQUENT ADJUSTMENT OR RECONCILIATION.

S 61. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 94 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) (A) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine 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] ARE DETERMINED BY THE COMMISSIONER TO BE QUALIFYING FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B) OF THIS SUBPARAGRAPH, 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] ARE DETERMINED BY THE COMMISSIONER TO BE QUALIFYING FACILI-

TIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B) OF THIS SUBPARAGRAPH 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 paragraph, 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.

(B) FOR THE PURPOSES OF THIS SUBPARAGRAPH QUALIFYING FACILITIES ARE THOSE FACILITIES FOR WHICH THE COMMISSIONER DETERMINES THAT THEIR REPORTED TWO THOUSAND TWO BASE YEAR OPERATING COST COMPONENT, AS DEFINED IN ACCORDANCE WITH THE REGULATIONS OF THE DEPARTMENT AS SET FORTH IN 10 NYCRR 86-2.10(A)(7); IS LESS THAN THE OPERATING COMPONENT SUCH FACILITIES RECEIVED IN THE TWO THOUSAND EIGHT RATE PERIOD, AS ADJUSTED BY APPLICABLE TREND FACTORS.

S 62. Intentionally omitted.

S 63. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 1 of part D of chapter 59 of the laws of 2011, 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, additional 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, AND PROVIDED FURTHER, HOWEVER, THAT, IN CONSULTATION WITH IMPACTED PROVIDERS, OF THE FUNDS ALLOCATED FOR DISTRIBUTION IN THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND THIRTEEN, UP TO THIRTY-TWO MILLION DOLLARS MAY BE ALLOCATED IN ACCORDANCE WITH PARAGRAPH (F-1) OF THIS SUBDIVISION.

S 64. Subdivision 12 of section 2808 of the public health law is amended by adding a new paragraph (f-1) to read as follows:

(F-1) FUNDS ALLOCATED BY THE PROVISIONS OF PARAGRAPH (E-1) OF THIS SUBDIVISION FOR DISTRIBUTION PURSUANT TO THIS PARAGRAPH, SHALL BE ALLO-

CATED PROPORTIONALLY TO THOSE PUBLIC RESIDENTIAL HEALTH CARE FACILITIES WHICH WERE SUBJECT TO RETROACTIVE REDUCTIONS IN PAYMENTS MADE PURSUANT TO THIS SUBDIVISION FOR STATE FISCAL YEAR PERIODS BEGINNING APRIL FIRST, TWO THOUSAND SIX.

S 65. Intentionally omitted.

S 66. Paragraph (c) of subdivision 2-c of section 2808 of the public health law, as added by section 95 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(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; AND PROVIDED FURTHER, HOWEVER, THAT NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SUBDIVISION AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR ALL RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, RATES CONSISTENT WITH PARAGRAPHS (A) AND (B) OF THIS SUBDIVISION FOR FACILITIES DESCRIBED IN THIS PARAGRAPH, INCLUDING A PATIENT ACUITY ADJUSTMENT FOR FACILITIES DESCRIBED IN SUBPARAGRAPH (V) OF THIS PARAGRAPH, SHALL BE ESTABLISHED BY THE COMMISSIONER BY REGULATION AS AUTHORIZED BY PARAGRAPH (D) OF THIS SUBDIVISION AND IN CONSULTATION WITH AFFECTED PROVIDERS.

S 67. Intentionally omitted.

S 68. Paragraph (a) of subdivision 2 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989, is amended to read as follows:

(a) For purposes of this section an "institutionalized spouse" is a person (I) WHO IS in a medical institution or nursing facility [(i) who is] AND expected to remain in such facility or institution for at least thirty consecutive days[,]; or (II) WHO is receiving care, services and supplies pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act OR IS RECEIVING CARE, SERVICES AND SUPPLIES IN A MANAGED LONG-TERM CARE PLAN PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE SOCIAL SECURITY ACT; and [(ii)] (III) who is married to a person who is not in a medical institution or nursing facility or is not receiving WAIVER services [pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act] DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH; PROVIDED, HOWEVER, THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS PARAGRAPH ONLY IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE THEREFOR. THE COMMISSIONER OF HEALTH SHALL MAKE ANY AMENDMENTS TO THE

STATE PLAN FOR MEDICAL ASSISTANCE, OR APPLY FOR ANY WAIVER OR APPROVAL UNDER THE FEDERAL SOCIAL SECURITY ACT THAT ARE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS PARAGRAPH.

S 69. Paragraph (b) of subdivision 6 of section 3614 of the public health law, as added by chapter 645 of the laws of 2003, is amended to read as follows:

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: THE FACILITY HOUSES EXCLUSIVELY ASSISTED LIVING PROGRAM BEDS AUTHORIZED PURSUANT TO PARAGRAPH (J) OF SUBDIVISION THREE OF SECTION FOUR HUNDRED SIXTY-ONE-L OF THE SOCIAL SERVICES LAW OR (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved beds are provided to residents who are subject to the assisted living program; and (iii) the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, PROVIDED THAT THE COMMISSIONER MAY ADOPT RULES AND REGULATIONS WHICH ESTABLISH A CAP ON REAL PROPERTY CAPITAL CONSTRUCTION COSTS FOR THOSE FACILITIES THAT HOUSE EXCLUSIVELY ASSISTED LIVING PROGRAM BEDS AUTHORIZED PURSUANT TO PARAGRAPH (J) OF SUBDIVISION THREE OF SECTION FOUR HUNDRED SIXTY-ONE-L OF THE SOCIAL SERVICES LAW.

S 70. Subdivision 3 of section 461-l of the social services law is amended by adding a new paragraph (j) to read as follows:

(J) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ADD UP TO FOUR THOUSAND FIVE HUNDRED ASSISTED LIVING PROGRAM BEDS TO THE GROSS NUMBER OF ASSISTED LIVING PROGRAM BEDS HAVING BEEN DETERMINED TO BE AVAILABLE AS OF APRIL FIRST, TWO THOUSAND TWELVE. APPLICANTS ELIGIBLE TO SUBMIT AN APPLICATION UNDER THIS PARAGRAPH SHALL BE LIMITED TO ADULT HOMES ESTABLISHED PURSUANT TO SECTION FOUR HUNDRED SIXTY-ONE-B OF THIS ARTICLE WITH, AS OF SEPTEMBER FIRST, TWO THOUSAND TWELVE, A CERTIFIED CAPACITY OF EIGHTY BEDS OR MORE IN WHICH TWENTY-FIVE PERCENT OR MORE OF THE RESIDENT POPULATION ARE PERSONS WITH SERIOUS MENTAL ILLNESS AS DEFINED IN REGULATIONS PROMULGATED BY THE COMMISSIONER OF HEALTH. THE COMMISSIONER OF HEALTH SHALL NOT BE REQUIRED TO REVIEW ON A COMPARATIVE BASIS APPLICATIONS SUBMITTED FOR ASSISTED LIVING PROGRAM BEDS MADE AVAILABLE UNDER THIS PARAGRAPH.

S 71. Subdivision 14 of section 366 of the social services law, as added by section 74 of part H of chapter 59 of the laws of 2011, is amended 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, OTHER THAN SHORT-TERM REHABILITATION SERVICES, AND FOR INDIVIDUALS IN RECEIPT OF MEDICAL ASSISTANCE WHILE IN AN ADULT HOME, AS DEFINED IN SUBDIVISION TWENTY-FIVE OF SECTION TWO OF THIS CHAPTER, who [are]: ARE (i) discharged [from the nursing facility] to the community; AND (ii) IF ELIGIBLE, enrolled in a plan certified pursuant to section forty-four hundred three-f of the public health law; and (iii) [while so

enrolled, not] DO NOT MEET THE CRITERIA TO BE considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

S 71-a. Section 97-eeee of the state finance law, as amended by section 10 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

S 97-eeee. Federal-state health reform partnership program account. 1. There is hereby established in the joint custody of the state comptroller and the commissioner of taxation and finance a miscellaneous special revenue account to be known as the "federal-state health reform partnership program account".

2. The account shall consist of [those] ALL monies received from the federal government for additional medical assistance revenues [or], savings achieved under the federal-state health reform partnership program [or], monies earned by the state and received from the federal government to support expenditures under the federal-state health reform partnership program and/or successor program pursuant to section 1115 of the federal social security act.

3. Notwithstanding any provision of law to the contrary, where and to the extent that federal revenues or savings under subdivision two of this section made available to the state under any such New York State section 1115 waiver or amendment thereto, such revenues or savings shall be deposited in the account.

4. [All] NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, ALL monies shall remain in such account unless otherwise disbursed pursuant to appropriation by the legislature.

S 72. Section 364-j of the social services law is amended by adding a new subdivision 27 to read as follows:

27. (A) THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HAS ESTABLISHED AN INITIATIVE TO ALIGN INCENTIVES BETWEEN MEDICARE AND MEDICAID. THE GOAL OF THE INITIATIVE IS TO INCREASE ACCESS TO SEAMLESS, QUALITY PROGRAMS THAT INTEGRATE SERVICES FOR THE DUALLY ELIGIBLE BENEFICIARY AS WELL AS TO ACHIEVE BOTH STATE AND FEDERAL HEALTH CARE SAVINGS BY IMPROVING HEALTH CARE DELIVERY AND ENCOURAGING HIGH-QUALITY, EFFICIENT CARE. IN FURTHERANCE OF THIS GOAL, THE LEGISLATURE AUTHORIZES THE COMMISSIONER OF HEALTH TO ESTABLISH A FULLY INTEGRATED DUALS ADVANTAGE (FIDA) PROGRAM.

(B) THE FIDA PROGRAM SHALL PROVIDE TARGETED POPULATIONS OF MEDICARE/MEDICAID DUALLY ELIGIBLE PERSONS WITH COMPREHENSIVE HEALTH SERVICES THAT INCLUDE THE FULL RANGE OF MEDICARE AND MEDICAID COVERED SERVICES, INCLUDING BUT NOT LIMITED TO PRIMARY AND ACUTE CARE, PRESCRIPTION DRUGS, BEHAVIORAL HEALTH SERVICES, CARE COORDINATION SERVICES, AND LONG-TERM SUPPORTS AND SERVICES, AS WELL AS OTHER SERVICES, THROUGH MANAGED CARE PROVIDERS, AS DEFINED IN SUBDIVISION ONE OF THIS SECTION, INCLUDING MANAGED LONG TERM CARE PLANS CERTIFIED PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW.

(C) UNDER THE FIDA PROGRAM ESTABLISHED PURSUANT TO THIS SUBDIVISION, UP TO THREE MANAGED LONG TERM CARE PLANS MAY BE AUTHORIZED TO EXCLUSIVELY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW. THE COMMISSIONER OF HEALTH MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY. THE COMMISSIONER OF DEVEL-

OPMENTAL DISABILITIES MAY WAIVE ANY OF THE OFFICE FOR PEOPLE WITH DEVEL-OPMENTAL DISABILITIES' REGULATIONS AS SUCH COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.

(D) THE PROVISIONS OF THIS SUBDIVISION SHALL NOT APPLY UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF HEALTH CARE SERVICES PROVIDED PURSUANT TO THIS SUBDIVISION.

(E) THE COMMISSIONER OF HEALTH 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 AS MAY BE NECESSARY TO OBTAIN THE FEDERAL APPROVALS NECESSARY TO IMPLEMENT THIS SUBDIVISION.

(F) THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, AS APPROPRIATE, MAY CONTRACT WITH MANAGED CARE PLANS APPROVED TO PARTICIPATE IN THE FIDA PROGRAM WITHOUT THE NEED FOR A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, AND WITHOUT REGARD TO THE PROVISIONS OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER PROVISION OF LAW.

S 73. The public health law is amended by adding a new section 4403-g to read as follows:

S 4403-G. DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATIONS. 1. DEFINITIONS. AS USED IN THIS SECTION:

(A) "DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION" OR "DISCO" MEANS AN ENTITY THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY PURSUANT TO THIS SECTION TO PROVIDE, OR ARRANGE FOR, HEALTH AND LONG TERM CARE SERVICES, AS DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, ON A CAPITATED BASIS IN ACCORDANCE WITH THIS SECTION, FOR A POPULATION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW, WHICH THE ORGANIZATION IS AUTHORIZED TO ENROLL.

(B) "ELIGIBLE APPLICANT" MEANS AN ENTITY CONTROLLED BY ONE OR MORE NON-PROFIT ORGANIZATIONS WHICH HAVE A HISTORY OF PROVIDING OR COORDINATING HEALTH AND LONG TERM CARE SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES.

(C) "HABILITATION SERVICES" MEANS SERVICES, INCLUDING BUT NOT LIMITED TO LONG TERM HOME AND COMMUNITY BASED SERVICES, DESIGNED TO ASSIST INDIVIDUALS IN ACQUIRING, RETAINING, AND IMPROVING THE SELF-HELP, SOCIALIZATION, AND ADAPTIVE SKILLS NECESSARY TO RESIDE SUCCESSFULLY IN HOME AND COMMUNITY BASED SETTINGS, INCLUDING PREVOCATIONAL, EDUCATIONAL, AND SUPPORTED EMPLOYMENT SERVICES, BUT NOT INCLUDING SPECIAL EDUCATION AND RELATED SERVICES THAT OTHERWISE ARE AVAILABLE TO THE INDIVIDUAL THROUGH A LOCAL EDUCATIONAL AGENCY, OR VOCATIONAL REHABILITATION SERVICES THAT OTHERWISE ARE AVAILABLE TO THE INDIVIDUAL THROUGH A PROGRAM FUNDED UNDER SECTION ONE HUNDRED TEN OF THE REHABILITATION ACT OF NINETEEN HUNDRED SEVENTY-THREE;

(D) "HEALTH AND LONG TERM CARE SERVICES" MEANS SERVICES INCLUDING, BUT NOT LIMITED TO, HABILITATION SERVICES, OTHER HOME AND COMMUNITY-BASED AND INSTITUTION-BASED LONG TERM CARE SERVICES, 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, AND MAY INCLUDE PRIMARY CARE AND ACUTE CARE IF THE DISCO IS AUTHORIZED TO PROVIDE OR ARRANGE FOR SUCH SERVICES. EACH PERSON

ENROLLED IN A DISCO SHALL RECEIVE THE HABILITATION AND OTHER SERVICES NECESSARY TO ACHIEVE PERSON-CENTERED GOALS, TO LIVE IN THE MOST INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT POSSIBLE, PROVIDED THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE EXTENT SUCH WISHES ARE KNOWN.

2. APPROVAL AUTHORITY. AN APPLICANT SHALL BE ISSUED A CERTIFICATE OF AUTHORITY AS A DISCO UPON A DETERMINATION BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES THAT THE APPLICANT COMPLIES WITH THE OPERATING REQUIREMENTS FOR A DISCO UNDER THIS SECTION.

3. APPLICATION FOR CERTIFICATE OF AUTHORITY; FORM. THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL JOINTLY DEVELOP APPLICATION FORMS FOR A CERTIFICATE OF AUTHORITY TO OPERATE A DISCO. AN ELIGIBLE APPLICANT SHALL SUBMIT AN APPLICATION FOR A CERTIFICATE OF AUTHORITY TO OPERATE A DISCO UPON FORMS PRESCRIBED BY SUCH COMMISSIONERS. SUCH ELIGIBLE APPLICANT SHALL SUBMIT INFORMATION AND DOCUMENTATION TO THE COMMISSIONER WHICH SHALL INCLUDE, BUT NOT BE LIMITED TO:

(A) A DESCRIPTION OF THE SERVICE AREA PROPOSED TO BE SERVED BY THE DISCO WITH PROJECTIONS OF ENROLLMENT THAT WILL RESULT IN A FISCALLY SOUND PLAN;

(B) A DESCRIPTION OF THE SERVICES TO BE COVERED BY SUCH DISCO;

(C) A DESCRIPTION OF THE PROPOSED MARKETING PLAN, AND HOW MARKETING MATERIALS WILL BE PRESENTED TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, OR THEIR AUTHORIZED SURROGATES, FOR THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE;

(D) THE NAMES OF THE PROVIDERS PROPOSED TO BE IN THE DISCO'S NETWORK;

(E) EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE APPLICANT'S PROPOSED OPERATORS;

(F) ADEQUATE DOCUMENTATION OF THE APPROPRIATE LICENSES, CERTIFICATIONS OR APPROVALS TO PROVIDE CARE AS PLANNED, INCLUDING AFFILIATE AGREEMENTS OR PROPOSED CONTRACTS WITH SUCH PROVIDERS AS MAY BE NECESSARY TO PROVIDE THE FULL COMPLEMENT OF SERVICES REQUIRED TO BE PROVIDED UNDER THIS SECTION;

(G) A DESCRIPTION OF THE PROPOSED QUALITY-ASSURANCE MECHANISMS, GRIEVANCE PROCEDURES, MECHANISMS TO PROTECT THE RIGHTS OF ENROLLEES AND CARE COORDINATION SERVICES TO ENSURE CONTINUITY, QUALITY, APPROPRIATENESS AND COORDINATION OF CARE;

(H) A DESCRIPTION OF THE PROPOSED QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT INCLUDES PERFORMANCE AND OUTCOME BASED QUALITY STANDARDS FOR ENROLLEE HEALTH STATUS AND SATISFACTION, AND DATA COLLECTION AND REPORTING FOR STANDARD PERFORMANCE MEASURES;

(I) A DESCRIPTION OF THE MANAGEMENT SYSTEMS AND SYSTEMS TO PROCESS PAYMENT FOR COVERED SERVICES;

(J) A DESCRIPTION OF HOW ACHIEVING OF PERSON-CENTERED GOALS, AS DEFINED BY THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, WILL BE ASSESSED; AS WELL AS A DESCRIPTION OF HOW HABILITATION SERVICES, INCLUDING LONG TERM CARE SERVICES, WILL MEET SUCH GOALS;

(K) A DESCRIPTION OF THE MECHANISM TO MAXIMIZE REIMBURSEMENT OF AND COORDINATE SERVICES REIMBURSED PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT 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;

(L) A DESCRIPTION OF THE SYSTEMS FOR SECURING AND INTEGRATING ANY POTENTIAL SOURCES OF FUNDING FOR SERVICES PROVIDED BY OR THROUGH THE

ORGANIZATION, INCLUDING, BUT NOT LIMITED TO, FUNDING AVAILABLE UNDER TITLES XVI, XVIII, XIX AND XX OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER AVAILABLE SOURCES OF FUNDING;

(M) A DESCRIPTION OF THE PROPOSED CONTRACTUAL ARRANGEMENTS FOR PROVIDERS OF HEALTH AND LONG TERM CARE SERVICES IN THE BENEFIT PACKAGE; AND

(N) INFORMATION RELATED TO THE FINANCIAL CONDITION OF THE APPLICANT.

4. CERTIFICATE OF AUTHORITY APPROVAL. THE COMMISSIONER SHALL NOT APPROVE AN APPLICATION FOR A CERTIFICATE OF AUTHORITY UNLESS THE APPLICANT DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES:

(A) THAT IT WILL HAVE IN PLACE ACCEPTABLE QUALITY ASSURANCE MECHANISMS, GRIEVANCE PROCEDURES AND MECHANISMS TO PROTECT THE RIGHTS OF ENROLLEES AND CARE COORDINATION SERVICES TO ENSURE CONTINUITY, QUALITY, APPROPRIATENESS AND COORDINATION OF CARE;

(B) THAT IT WILL HAVE IN PLACE A MECHANISM OR MEANS TO ASSURE THAT INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES CAN MAKE INFORMED CHOICES, EITHER INDEPENDENTLY OR THROUGH AN AUTHORIZED SURROGATE, ON ALL MATTERS PERTINENT TO A PERSON-CENTERED PLAN, AS DEFINED BY THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, AND WITH RESPECT TO RELATED GOALS, SERVICES, AND OBJECTIVES;

(C) THAT IT HAS DEVELOPED A QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT INCLUDES PERFORMANCE AND OUTCOME BASED QUALITY STANDARDS FOR ENROLLEE HEALTH STATUS AND SATISFACTION, WHICH SHALL BE REVIEWED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES. THE PROGRAM SHALL INCLUDE DATA COLLECTION AND REPORTING FOR STANDARD PERFORMANCE MEASURES AS REQUIRED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(D) THAT AN OTHERWISE ELIGIBLE ENROLLEE SHALL NOT BE INVOLUNTARILY DISENROLLED WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(E) THAT THE APPLICANT SHALL NOT USE DECEPTIVE OR COERCIVE MARKETING METHODS TO ENCOURAGE PARTICIPANTS TO ENROLL AND THAT THE APPLICANT SHALL NOT DISTRIBUTE MARKETING MATERIALS TO POTENTIAL ENROLLEES BEFORE SUCH MATERIALS HAVE BEEN APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(F) SATISFACTORY EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE APPLICANT'S PROPOSED OPERATORS;

(G) REASONABLE ASSURANCE THAT THE APPLICANT WILL PROVIDE HIGH QUALITY SERVICES TO AN ENROLLED POPULATION, THAT THE APPLICANT'S NETWORK OF PROVIDERS IS ADEQUATE AND THAT SUCH PROVIDERS HAVE DEMONSTRATED SUFFICIENT COMPETENCY TO DELIVER HIGH QUALITY SERVICES TO THE ENROLLED POPULATION AND THAT POLICIES AND PROCEDURES WILL BE IN PLACE TO ADDRESS THE CULTURAL AND LINGUISTIC NEEDS OF THE ENROLLED POPULATION;

(H) SUFFICIENT MANAGEMENT SYSTEMS CAPACITY TO MEET THE REQUIREMENTS OF THIS SECTION AND THE ABILITY TO EFFICIENTLY PROCESS PAYMENT FOR COVERED SERVICES;

(I) READINESS AND CAPABILITY TO MAXIMIZE REIMBURSEMENT OF AND COORDINATE SERVICES REIMBURSED PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT 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;

(J) READINESS AND CAPABILITY TO ARRANGE AND MANAGE COVERED SERVICES;

(K) WILLINGNESS AND CAPABILITY OF TAKING, OR COOPERATING IN, ALL STEPS NECESSARY TO SECURE AND INTEGRATE ANY POTENTIAL SOURCES OF FUNDING FOR

SERVICES PROVIDED BY OR THROUGH THE DISCO, INCLUDING, BUT NOT LIMITED TO, FUNDING AVAILABLE UNDER TITLES XVI, XVIII, XIX AND XX OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER AVAILABLE SOURCES OF FUNDING;

(L) 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 AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES; AND

(M) THAT THE APPLICANT IS FINANCIALLY RESPONSIBLE AND SHALL BE EXPECTED TO MEET ITS OBLIGATIONS TO ITS ENROLLED MEMBERS.

5. ENROLLMENT. (A) ONLY PERSONS WITH DEVELOPMENTAL DISABILITIES, AS DETERMINED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE ELIGIBLE TO ENROLL IN DISCOS.

(B) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL ENROLL AN ELIGIBLE PERSON IN THE DISCO CHOSEN BY HIM OR HER, HIS OR HER GUARDIAN OR OTHER LEGAL REPRESENTATIVE, PROVIDED THAT SUCH DISCO IS AUTHORIZED TO ENROLL SUCH PERSON.

(C) NO PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS RECEIVING OR APPLYING FOR MEDICAL ASSISTANCE AND WHO IS RECEIVING, OR ELIGIBLE TO RECEIVE, SERVICES FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE SUCH SERVICES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH DISCOS MEET THE STANDARDS OF THIS SECTION.

(D) PERSONS REQUIRED TO ENROLL IN A DISCO SHALL HAVE NO LESS THAN SIXTY DAYS TO SELECT A DISCO, AND SUCH PERSONS AND THEIR GUARDIANS OR OTHER LEGAL REPRESENTATIVES SHALL BE PROVIDED WITH INFORMATION TO MAKE AN INFORMED CHOICE. WHERE A PERSON, GUARDIAN OR OTHER LEGAL REPRESENTATIVE HAS NOT SELECTED A DISCO, THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL ENROLL SUCH PERSON IN A DISCO CHOSEN BY SUCH COMMISSIONER, TAKING INTO ACCOUNT QUALITY, CAPACITY AND GEOGRAPHIC ACCESSIBILITY. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL AUTOMATICALLY RE-ENROLL A PERSON WITH THE SAME DISCO IF THERE IS A LOSS OF MEDICAID ELIGIBILITY OF TWO MONTHS OR LESS.

(E) ENROLLED PERSONS MAY CHANGE THEIR ENROLLMENT AT ANY TIME WITHOUT CAUSE, PROVIDED, HOWEVER, THAT A PERSON REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE SERVICES FUNDED, LICENSED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY ONLY DISENROLL FROM A DISCO IF HE OR SHE ENROLLS IN ANOTHER DISCO AUTHORIZED TO ENROLL HIM OR HER. SUCH DISENROLLMENT SHALL BE EFFECTIVE NO LATER THAN THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE REQUEST.

(F) A DISCO MAY REQUEST THE INVOLUNTARY DISENROLLMENT OF AN ENROLLED PERSON IN WRITING TO THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH DISENROLLMENT SHALL NOT BE EFFECTIVE UNTIL THE REQUEST IS REVIEWED AND APPROVED BY SUCH OFFICE. THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL ADOPT RULES AND REGULATIONS GOVERNING THIS PROCESS.

6. ASSESSMENTS. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT THAT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROL-

LEE IN A DISCO AS SUCH NEEDS RELATE TO EACH INDIVIDUAL'S HEALTH, SAFETY AND ABILITY TO LIVE IN THE MOST INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED GOALS AND SHALL BE CONSISTENT WITH, AND HELP INFORM, ANY OTHER PERSON-CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES. THE ASSESSMENT SHALL BE COMPLETED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE IN CONSULTATION WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY DESIGNATE THE DISCO TO PERFORM SUCH ASSESSMENTS.

7. PROGRAM OVERSIGHT AND ADMINISTRATION. (A) THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL JOINTLY PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION, TO PROVIDE FOR OVERSIGHT OF DISCOS, INCLUDING ON SITE REVIEWS, AND TO ENSURE THE QUALITY, APPROPRIATENESS AND COST-EFFECTIVENESS OF THE SERVICES PROVIDED BY DISCOS.

(B) THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES MAY WAIVE RULES AND REGULATIONS OF THEIR RESPECTIVE DEPARTMENT OR OFFICE, 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 DISCO ENROLLEES WILL NOT BE IMPAIRED AS A RESULT OF SUCH WAIVER. THE COMMISSIONERS WILL REPORT ANNUALLY TO THE LEGISLATURE, AND TO THE JOINT ADVISORY COUNCIL ESTABLISHED PURSUANT TO PARAGRAPH F OF THIS SUBDIVISION, ON ALL RULES AND REGULATIONS WAIVED PURSUANT TO THIS PARAGRAPH, AND ON THE ESTIMATED COST SAVINGS AND QUALITY IMPROVEMENTS THAT THE WAIVER OF SUCH RULES AND REGULATIONS ARE EXPECTED TO PRODUCE. IN ORDER TO ACHIEVE DISCO SYSTEM EFFICIENCIES AND COORDINATION AND TO PROMOTE THE OBJECTIVES OF HIGH QUALITY, INTEGRATED AND COST EFFECTIVE CARE, THE COMMISSIONERS SHALL 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 COMMISSIONERS SHALL REQUIRE DISCOS TO UTILIZE QUALITY IMPROVEMENT MEASURES, BASED ON THE ACHIEVEMENT OF PERSONAL OUTCOMES AND QUALITY OF LIFE, HEALTH OUTCOMES DATA, AND ASSESSMENTS OF CONSUMERS AND FAMILY SATISFACTION, FOR INTERNAL QUALITY ASSESSMENT PROCESSES AND MAY UTILIZE SUCH MEASURES AS PART OF THE SINGLE COORDINATED SURVEILLANCE PROCESS.

(B-1) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE OF DEVELOPMENTAL DISABILITIES, IN CONSULTATION WITH THE JOINT ADVISORY COUNCIL ESTABLISHED PURSUANT TO PARAGRAPH F OF THIS SUBDIVISION, SHALL IDENTIFY A VALID AND RELIABLE QUALITY ASSURANCE INSTRUMENT THAT INCLUDES ASSESSMENTS OF CONSUMER AND FAMILY SATISFACTION, PROVISION OF SERVICES, AND PERSONAL OUTCOMES. THE INSTRUMENT SHALL INCLUDE OUTCOME-BASED MEASURES SUCH AS HEALTH, SAFETY, WELL-BEING, RELATIONSHIPS, INTERACTIONS WITH PEOPLE WHO DO NOT HAVE A DISABILITY, EMPLOYMENT, QUALITY OF LIFE, INTEGRATION, CHOICE, SERVICE AND CONSUMER SATISFACTION.

(C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THE SOCIAL SERVICES LAW TO THE CONTRARY, THE COMMISSIONER IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES 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 AUTHOR-

IZATIONS OF, AND UTILIZATION LIMITATIONS ON, HEALTH AND LONG TERM CARE SERVICES REIMBURSED PURSUANT TO TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT ARE INCONSISTENT WITH THE FLEXIBILITY NECESSARY FOR THE EFFICIENT ADMINISTRATION OF DISCOS, AND SUCH REGULATIONS SHALL PROVIDE THAT SUCH PROVISIONS SHALL NOT BE APPLICABLE TO ENROLLEES OF DISCOS, PROVIDED THAT SUCH DETERMINATIONS ARE CONSISTENT WITH APPLICABLE FEDERAL LAW AND REGULATION.

(D) THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL ENSURE, THROUGH PERIODIC REVIEWS OF DISCOS, THAT ORGANIZATION SERVICES ARE PROMPTLY AVAILABLE TO ENROLLEES WHEN APPROPRIATE. SUCH PERIODIC REVIEWS SHALL BE MADE ACCORDING TO STANDARDS AS DETERMINED BY THE COMMISSIONERS IN REGULATIONS.

(E) THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL HAVE THE AUTHORITY TO CONDUCT BOTH ON SITE AND OFF SITE REVIEWS OF DISCOS. SUCH REVIEWS MAY INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING COMPONENTS: GOVERNANCE; FISCAL AND FINANCIAL REPORTING; RECORDKEEPING; INTERNAL CONTROLS; MARKETING; NETWORK CONTRACTING AND ADEQUACY; PROGRAM INTEGRITY ASSURANCES; UTILIZATION CONTROL AND REVIEW SYSTEMS; GRIEVANCE AND APPEALS SYSTEMS; QUALITY ASSESSMENT AND ASSURANCE SYSTEMS; CARE MANAGEMENT; ENROLLMENT AND DISENROLLMENT; MANAGEMENT INFORMATION SYSTEMS, AND OTHER OPERATIONAL AND MANAGEMENT COMPONENTS.

(F) JOINT ADVISORY COUNCIL. THERE SHALL BE A JOINT ADVISORY COUNCIL CHAIRED BY THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES COMPRISED OF TWELVE MEMBERS, INCLUDING FAMILY MEMBERS OF PEOPLE WITH DEVELOPMENTAL DISABILITIES, DEVELOPMENTAL DISABILITIES PROVIDERS, AND DEVELOPMENTAL DISABILITIES ADVOCATES, INCLUDING SELF ADVOCATES. THE JOINT ADVISORY COUNCIL SHALL MEET MONTHLY TO REVIEW ALL MANAGED CARE OPTIONS PROVIDED TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES CONCERNING: THE ADEQUACY OF HABILITATION SERVICES OFFERED; THE RECORD OF COMPLIANCE WITH PERSON-CENTERED CARE PLANS; THE ADEQUACY OF RATES; THE STATUS OF PERSON-CENTERED SERVICES AND COMMUNITY INTEGRATION; THE STATUS OF THE TRANSITION OF SERVICES OVERSEEN BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES TO MANAGED CARE; AND ALL OTHER MATTERS OF IMPORTANCE TO THE QUALITY OF LIFE, HEALTH, SAFETY AND COMMUNITY INTEGRATION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES ENROLLED IN MANAGED CARE. THE JOINT ADVISORY COUNCIL SHALL SUBMIT QUARTERLY REPORTS ON ITS FINDINGS, CONCLUSIONS, RECOMMENDATIONS, AND ANY PROPOSED AMENDMENTS TO PERTINENT SECTIONS OF THE LAW TO THE GOVERNOR, SENATE MAJORITY LEADER AND SPEAKER OF THE ASSEMBLY.

8. SOLVENCY. (A) THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, SHALL BE RESPONSIBLE FOR EVALUATING, APPROVING AND REGULATING ALL MATTERS RELATING TO FISCAL SOLVENCY, INCLUDING RESERVES, SURPLUS AND PROVIDER CONTRACTS. THE COMMISSIONER SHALL PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION. THE COMMISSIONER, IN THE ADMINISTRATION OF THIS SUBDIVISION:

(I) SHALL BE GUIDED BY THE STANDARDS THAT GOVERN THE FISCAL SOLVENCY OF A HEALTH MAINTENANCE ORGANIZATION, PROVIDED, HOWEVER, THAT THE COMMISSIONER SHALL RECOGNIZE THE SPECIFIC DELIVERY COMPONENTS, OPERATIONAL CAPACITY AND FINANCIAL CAPABILITY OF THE ELIGIBLE APPLICANT FOR A CERTIFICATE OF AUTHORITY;

(II) SHALL NOT APPLY FINANCIAL SOLVENCY STANDARDS THAT EXCEED THOSE REQUIRED FOR A HEALTH MAINTENANCE ORGANIZATION; AND

(III) SHALL ESTABLISH REASONABLE CAPITALIZATION AND CONTINGENT RESERVE REQUIREMENTS.

(B) STANDARDS ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE ADEQUATE TO PROTECT THE INTERESTS OF ENROLLEES IN THE DISCO. THE COMMIS-

SIONER SHALL BE SATISFIED THAT THE ELIGIBLE APPLICANT IS FINANCIALLY SOUND, AND HAS MADE ADEQUATE PROVISIONS TO PAY FOR QUALITY SERVICES THAT ARE COST EFFECTIVE AND APPROPRIATE TO NEEDS AND THE PROTECTION OF THE HEALTH, SAFETY, WELFARE AND SATISFACTION OF THOSE SERVED.

9. ROLE OF THE SUPERINTENDENT OF FINANCIAL SERVICES. (A) THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL DETERMINE AND APPROVE PREMIUMS IN ACCORDANCE WITH THE INSURANCE LAW WHENEVER ANY POPULATION OF ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT IS TO BE COVERED. THE DETERMINATION AND APPROVAL OF THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL RELATE TO PREMIUMS CHARGED TO SUCH ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

(B) THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL EVALUATE AND APPROVE ANY ENROLLEE CONTRACTS WHENEVER SUCH ENROLLEE CONTRACTS ARE TO COVER ANY POPULATION OF ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

10. PAYMENT RATES FOR DISCO ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE. THE COMMISSIONER SHALL ESTABLISH PAYMENT RATES FOR SERVICES PROVIDED TO ENROLLEES ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT. SUCH PAYMENT RATES SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF THE DIVISION OF THE BUDGET. PAYMENT RATES SHALL BE RISK-ADJUSTED TO TAKE INTO ACCOUNT THE CHARACTERISTICS OF ENROLLEES, OR PROPOSED ENROLLEES, INCLUDING, BUT NOT LIMITED TO: FRAILTY, DISABILITY LEVEL, HEALTH AND FUNCTIONAL STATUS, AGE, GENDER, THE NATURE OF SERVICES PROVIDED TO SUCH ENROLLEES, AND OTHER FACTORS AS DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES. THE RISK ADJUSTED PREMIUMS MAY ALSO BE COMBINED WITH DISINCENTIVES OR REQUIREMENTS DESIGNED TO MITIGATE ANY INCENTIVES TO OBTAIN HIGHER PAYMENT CATEGORIES.

11. CONTINUATION OF CERTIFICATE OF AUTHORITY. CONTINUATION OF A CERTIFICATE OF AUTHORITY ISSUED UNDER THIS SECTION SHALL BE CONTINGENT UPON COMPLIANCE BY THE DISCO WITH APPLICABLE PROVISIONS OF THIS SECTION AND RULES AND REGULATIONS PROMULGATED THEREUNDER; THE CONTINUING FISCAL SOLVENCY OF THE DISCO; 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.

12. PROTECTION OF ENROLLEES. THE COMMISSIONER MAY, IN HIS OR HER DISCRETION AND WITH THE CONCURRENCE OF THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, FOR THE PURPOSE OF THE PROTECTION OF ENROLLEES, IMPOSE MEASURES INCLUDING, BUT NOT LIMITED TO BANS ON FURTHER ENROLLMENTS UNTIL ANY IDENTIFIED PROBLEMS ARE RESOLVED TO THE SATISFACTION OF THE COMMISSIONER, OR FINES UPON A FINDING THAT THE DISCO HAS FAILED TO COMPLY WITH THE PROVISIONS OF ANY APPLICABLE STATUTE, RULE OR REGULATION.

13. INFORMATION SHARING. THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL, AS NECESSARY AND CONSISTENT WITH FEDERAL REGULATIONS PROMULGATED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, SHARE WITH SUCH DISCO THE FOLLOWING DATA IF IT IS AVAILABLE:

(A) INFORMATION CONCERNING UTILIZATION OF SERVICES AND PROVIDERS BY EACH OF ITS ENROLLEES PRIOR TO AND DURING ENROLLMENT.

(B) AGGREGATE DATA CONCERNING UTILIZATION AND COSTS FOR ENROLLEES AND FOR COMPARABLE COHORTS SERVED THROUGH THE MEDICAID FEE-FOR-SERVICE PROGRAM.

14. CONTRACTS. NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SECTION AND SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, MAY CONTRACT WITH DISCOS APPROVED UNDER THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR

PROPOSAL PROCESS, TO PROVIDE COVERAGE FOR ENROLLEES PURSUANT TO THIS SECTION. NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SECTION 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 TO QUALIFIED DISCOS PURSUANT TO THIS SECTION.

15. APPLICABILITY OF OTHER LAWS. DISCOS SHALL BE SUBJECT TO THE PROVISIONS OF THE INSURANCE LAW AND REGULATIONS APPLICABLE TO HEALTH MAINTENANCE ORGANIZATIONS, THIS ARTICLE AND REGULATIONS PROMULGATED THEREUNDER. 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.

16. EFFECTIVENESS. THE PROVISIONS OF THIS SECTION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED BY THE DISCOS TO ENROLLEES WHO ARE RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, IN ORDER TO ENSURE SUCH FEDERAL FINANCIAL PARTICIPATION.

S 74. Section 4403 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, A HEALTH MAINTENANCE ORGANIZATION MAY EXPAND ITS COMPREHENSIVE HEALTH SERVICES PLAN TO INCLUDE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, INCLUDING HABILITATION SERVICES AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THIS CHAPTER, AND MAY OFFER SUCH EXPANDED PLAN TO A POPULATION OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW, SUBJECT TO THE FOLLOWING:

(A) SUCH ORGANIZATION SHALL HAVE THE ABILITY TO PROVIDE OR COORDINATE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AS DEMONSTRATED BY CRITERIA TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(B) THE PROVISION BY SUCH ORGANIZATION OF SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO THE JOINT OVERSIGHT AND REVIEW OF BOTH THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(C) SUCH ORGANIZATION SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND COMMISSIONER OF DEVELOPMENTAL DISABILITIES APPROVE PROGRAM FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE THAT SUCH ORGANIZATION MEETS THE REQUIREMENTS OF THIS PARAGRAPH;

(D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE PLAN THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL NOT BE INVOLUNTARILY DISENROLLED FROM SUCH PLAN WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETERMINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH A

PLAN AND SHALL ENROLL INDIVIDUALS IT DETERMINES ELIGIBLE IN THE PLAN CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

(F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR IF IT SO DESIGNATES, THE HEALTH MAINTENANCE ORGANIZATION OR OTHER DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES THAT RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HEALTH, SAFETY, ENVIRONMENTAL AND HABILITATIVE NEEDS OF EACH PROSPECTIVE ENROLLEE. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. THE ASSESSMENT SHALL BE COMPLETED BY SUCH OFFICE OR ITS DESIGNEE, IN CONSULTATION WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE;

(G) NO PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE REQUIRED TO ENROLL IN A COMPREHENSIVE HEALTH SERVICES PLAN AS A CONDITION OF RECEIVING MEDICAL ASSISTANCE AND SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH PLANS MEET THE STANDARDS OF THIS SECTION; AND

(H) THE PROVISIONS OF THIS SUBDIVISION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED HEREUNDER TO RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, AS MAY BE NECESSARY TO ENSURE SUCH FEDERAL FINANCIAL PARTICIPATION. TO THE EXTENT THAT THE PROVISIONS OF THIS SUBDIVISION ARE INCONSISTENT WITH OTHER PROVISIONS OF THIS ARTICLE OR WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, THE PROVISIONS OF THIS SUBDIVISION SHALL PREVAIL.

S 75. The opening paragraph of paragraph (h) of subdivision 7 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

The commissioner AND, IN THE CASE OF A PLAN ARRANGING FOR OR PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, shall, upon request by a managed long term care plan 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:

S 76. Section 4403-f of the public health law is amended by adding three new subdivisions 12, 13 and 14 to read as follows:

12. NOTWITHSTANDING ANY PROVISION TO THE CONTRARY, A MANAGED LONG TERM CARE PLAN MAY EXPAND THE SERVICES IT PROVIDES OR ARRANGES FOR TO INCLUDE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR A POPULATION OF

PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW, INCLUDING HABILITATIVE SERVICES AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THIS CHAPTER, SUBJECT TO THE FOLLOWING:

(A) SUCH PLAN SHALL HAVE THE ABILITY TO PROVIDE OR COORDINATE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AS DEMONSTRATED BY CRITERIA TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(B) THE PROVISION BY SUCH PLAN OF SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO THE JOINT OVERSIGHT AND REVIEW OF BOTH THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(C) SUCH PLAN SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND COMMISSIONER OF DEVELOPMENTAL DISABILITIES APPROVE PROGRAM FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE THAT SUCH ORGANIZATION MEETS THE REQUIREMENTS OF THIS SUBDIVISION;

(D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE PLAN THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL NOT BE INVOLUNTARILY DISENROLLED FROM SUCH PLAN WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETERMINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH A PLAN. SUCH OFFICE OR ITS DESIGNEE SHALL ENROLL ELIGIBLE INDIVIDUALS IT DETERMINES ELIGIBLE IN A PLAN CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

(F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR IF IT SO DESIGNATES, A PLAN OR OTHER DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES WHO RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROLLEE. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE; AND

(G) NO PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE REQUIRED TO ENROLL IN A MANAGED LONG TERM CARE PLAN AS A CONDITION OF RECEIVING MEDICAL ASSISTANCE AND SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH PLANS MEET THE STANDARDS OF THIS SECTION.

13. NOTWITHSTANDING ANY INCONSISTENT PROVISION TO THE CONTRARY, THE COMMISSIONER MAY ISSUE A CERTIFICATE OF AUTHORITY TO NO MORE THAN THREE ELIGIBLE APPLICANTS TO OPERATE MANAGED LONG TERM PLANS THAT ARE AUTHORIZED TO EXCLUSIVELY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW. THE

COMMISSIONER MAY ONLY ISSUE CERTIFICATES OF AUTHORITY PURSUANT TO THIS SUBDIVISION IF, AND TO THE EXTENT THAT, THE DEPARTMENT HAS RECEIVED FEDERAL APPROVAL TO OPERATE A FULLY INTEGRATED DUALS ADVANTAGE PROGRAM FOR THE INTEGRATION OF SERVICES FOR PERSONS ENROLLED IN MEDICARE AND MEDICAID. THE COMMISSIONER MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.

14. THE PROVISIONS OF SUBDIVISIONS TWELVE AND THIRTEEN OF THIS SECTION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED THEREUNDER TO RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, AS MAY BE NECESSARY TO ENSURE SUCH FEDERAL FINANCIAL PARTICIPATION. TO THE EXTENT THAT THE PROVISIONS OF SUBDIVISIONS TWELVE AND THIRTEEN OF THIS SECTION ARE INCONSISTENT WITH OTHER PROVISIONS OF THIS ARTICLE OR WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, THE PROVISIONS OF THIS SUBDIVISION SHALL PREVAIL.

S 77. Subparagraph (ii) of paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 433 of the laws of 1997, is amended and a new subparagraph (iii) is added to read as follows:

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act[.]; OR

(III) IS AUTHORIZED TO OPERATE UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

S 78. Section 364-j of the social services law is amended by adding a new subdivision 28 to read as follows:

28. TO THE EXTENT THAT ANY PROVISION OF THIS SECTION IS INCONSISTENT WITH ANY PROVISION OF SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, SUCH PROVISION OF THIS SECTION SHALL NOT APPLY TO AN ENTITY AUTHORIZED TO OPERATE PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

S 79. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (aa) to read as follows:

(AA) CARE AND SERVICES FURNISHED BY A DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION (DISCO) THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH 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 OF HEALTH WHICH MEETS THE REQUIREMENTS OF FEDERAL LAW AND REGULATIONS.

S 80. The commissioner of health 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 finan-

cial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act and to require medical assistance recipients with developmental disabilities who require home and community-based services, as specified by the commissioner, to receive such services through an available organization certified pursuant to article 44 of the public health law. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

S 81. 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 82. 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 83. 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 84. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013 provided that:

1. the amendments to subdivision 10 of section 2807-c of the public health law, made by section four of this act, shall not affect the expiration of such subdivision and shall be deemed repealed therewith;

1-a. the amendments to section 364-j of the social services law, made by section eleven-a of this act, shall not affect the expiration and repeal of such section and shall be deemed repealed therewith;

1-b. Section twelve of this act shall take effect July 1, 2013;

1-c. section thirty-three-a of this act shall take effect January 1, 2014;

2. 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;

3. 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;

4. the commissioner of health and the superintendent of financial services and any appropriate council may take any steps necessary to implement this act prior to its effective date;

5. 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 financial services

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;

6. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act;

7. the amendments to section 364-j of the social services law made by sections thirty-five-a, thirty-six, thirty-seven, thirty-eight, thirty-nine, forty, forty-one, forty-two, forty-three, forty-four, fifty-two, seventy-two, seventy-seven and seventy-eight of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

8. section forty-eight-a of this act shall expire and be deemed repealed March 31, 2017;

9. the amendments to paragraph (b) of subdivision 7 of section 4403-f of the public health law made by section forty-eight of this act shall not affect the expiration of such paragraph and repeal of such section and shall be deemed expired and repealed therewith.

10. the amendments to section 4403-f of the public health law made by sections fifty-four, seventy-five and seventy-six of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

11. the provisions of this act shall apply to any pending cause of action brought pursuant to article 13 of the state finance law, and shall further apply to claims, records, statements or obligations, as defined by section 188 of the state finance law, that were made, used, or existing prior to, on or after April 1, 2007.

12. the amendments to paragraph (c) of subdivision 2-c of section 4403-f of the public health law made by section sixty-six of this act shall expire and be deemed repealed April 1, 2016.

13. Sections thirty-seven, forty-five-a, forty-five-b and forty-five-c of this act shall take effect on April first, two thousand fourteen.

14. the amendments made by subdivision c-1 of section 1 of part C of chapter 58 of the laws of 2005, authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, shall take effect on the same date and in the same manner as section 1 of part F of chapter 56 of the laws of 2012 takes effect.

PART B

Section 1. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, is amended to read as follows:

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [2013] 2016;

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 D of chapter 59 of the laws of 2011, 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, [2013] 2016, 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 3 of part D of chapter 59 of the laws of 2011, 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, [2013] 2015, 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 4 of part D of chapter 59 of the laws of 2011, 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] 2015;

S 5. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 102 of part H of chapter 59 of the laws of 2011, 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, AND FURTHER PROVIDED THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN SUCH ASSESSMENT SHALL BE SIX PERCENT.

S 6. Section 88 of chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, as amended by chapter 446 of the laws of 2011, is amended to read as follows:

S 88. Notwithstanding any provision of law to the contrary, all operating demonstrations, as such term is defined in paragraph (c) of subdivision 1 of section 4403-f of the public health law as added by section eighty-two of this act, due to expire prior to January 1, 2001 shall be deemed to expire on December 31, [2013] 2015.

S 7. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 2 of part G of chapter 56 of the laws of 2012, is amended to read as follows:

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable 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 comparison of the actual and 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 fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand [thirteen] FOURTEEN, 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 [thirteen] FOURTEEN and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [thirteen] FOURTEEN; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [thirteen] FOURTEEN, 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 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 8. Subdivision 2 of section 93 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 fiscal year, as amended by section 10 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

2. section two of this act shall expire and be deemed repealed on March 31, [2013] 2014;

S 8-a. Subdivision 8 of section 364-l of the social services law, as added by section 2 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

8. The commissioner of health shall provide a report to the governor and the legislature no later than January first, two thousand ten. ON AND AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SUCH COMMISSIONER SHALL

PROVIDE A REPORT ANNUALLY TO THE GOVERNOR AND THE LEGISLATURE. The report shall include findings as to the demonstration projects' effectiveness in managing the care needs and improving the health of program participants, an evaluation as to the programs' cost-effectiveness as measured against traditional medicaid care models, and recommendations as to whether the programs should be extended, modified, eliminated, or made permanent.

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 9 of part D of chapter 59 of the laws of 2011, 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 AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015 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 10 of part D of chapter 59 of the laws of 2011, 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, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015 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 11 of part D of chapter 59 of the laws of 2011, 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, February 1, 2011, February 1, 2012, [and] February 1, 2013 AND FEBRUARY 1, 2014 AND FEBRUARY 1, 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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 12 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013; 2014 AND 2015 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 13 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 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 14 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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 14-a of part D of chapter 59 of the laws of 2011, 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, AND THE 2014 TARGET PERIOD SHALL MEAN JANUARY 1, 2014 THROUGH NOVEMBER 30, 2014 AND THE 2015 TARGET PERIOD SHALL MEAN JANUARY 1, 2015 THROUGH NOVEMBER 30, 2015.

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, prior to February 1, 2011, prior to February 1, 2012 [and], prior to February 1, 2013, PRIOR TO FEBRUARY 1, 2014 AND PRIOR TO FEBRUARY 1, 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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, 2011, 2012, [and] 2013, 2014 AND 2015 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 15 of part D of chapter 59 of the laws of 2011, 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, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015;

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 16 of part D of chapter 59 of the laws of 2011, 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, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015.

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 17 of part D of chapter 59 of the laws of 2011, 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, [2013] 2015;

S 18. The opening paragraph of subdivision 7-a of section 3614 of the public health law, as amended by section 18 of part D of chapter 59 of the laws of 2011, 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 AND ON AND AFTER APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, 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. Intentionally omitted.

S 20. Subdivision 6-a of section 93 of part C of chapter 58 of the laws of 2007 amending the social services law and the public health law

relating to adjustments of rates, as amended by section 40 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed on December 31, [2013] 2018; provided that the amendments made by such section to subdivision 4 of section 366-c of the social services law shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

S 21. 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 23 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

12. Sections one hundred five-b through one hundred five-f of this act shall expire March 31, [2013] 2015.

S 22. Section 5 of chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

S 5. This act shall take effect June 1, 1983 and shall remain in full force and effect until March 31, [2013] 2018.

S 23. Section 5 of chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

S 5. This act shall take effect immediately, provided however that the provisions of this act shall remain in full force and effect until March 31, [2013] 2018 at which time the provisions of this act shall be deemed to be repealed.

S 24. Subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

(ii) Participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of New York or the New York State Osteopathic Society whose purpose is to confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse or mental illness. Such demonstration period shall commence on April first, nineteen hundred eighty and terminate on May thirty-first, nineteen hundred eighty-three. An additional demonstration period shall commence on June first, nineteen hundred eighty-three and terminate on March thirty-first, nineteen hundred eighty-six. An additional demonstration period shall commence on April first, nineteen hundred eighty-six and terminate on March thirty-first, nineteen hundred eighty-nine. An additional demonstration period shall commence April first, nineteen hundred eighty-nine and terminate March thirty-first, nineteen hundred ninety-two. An additional demonstration period shall commence April first, nineteen hundred ninety-two and terminate March thirty-first, nineteen hundred ninety-five. An additional demonstration period shall commence on April first, nineteen

hundred ninety-five and terminate on March thirty-first, nineteen hundred ninety-eight. An additional demonstration period shall commence on April first, nineteen hundred ninety-eight and terminate on March thirty-first, two thousand three. An additional demonstration period shall commence on April first, two thousand three and terminate on March thirty-first, two thousand thirteen[;]. AN ADDITIONAL DEMONSTRATION PERIOD SHALL COMMENCE APRIL FIRST, TWO THOUSAND THIRTEEN AND TERMINATE ON MARCH THIRTY-FIRST, TWO THOUSAND EIGHTEEN provided, however, that the commissioner may prescribe requirements for the continuation of such demonstration program, including periodic reviews of such programs and submission of any reports and data necessary to permit such reviews. During these additional periods, the provisions of this subparagraph shall also apply to a physician committee of a county medical society.

S 25. 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 section 27 of part A of chapter 59 of the laws of 2011, 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, [2013] 2015 when upon such date the provisions of such section shall be deemed repealed.

S 26. 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 27. 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 28. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013; provided that the amendments to subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law made by section twenty-four of this act shall not affect the expiration of such subparagraph and shall expire therewith.

PART C

Section 1. Section 2807-k of the public health law is amended by adding a new subdivision 5-d to read as follows:

5-D. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN, ALL FUNDS AVAILABLE FOR DISTRIBUTION PURSUANT TO THIS SECTION, EXCEPT

FOR FUNDS DISTRIBUTED PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH (B) OF SUBDIVISION FIVE-B OF THIS SECTION, AND ALL FUNDS AVAILABLE FOR DISTRIBUTION PURSUANT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE, SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBDIVISION.

(B) THE COMMISSIONER SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING METHODOLOGIES FOR THE DISTRIBUTION OF FUNDS AS DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION AND SUCH REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(I) SUCH REGULATIONS SHALL ESTABLISH METHODOLOGIES FOR DETERMINING EACH FACILITY'S RELATIVE UNCOMPENSATED CARE NEED AMOUNT BASED ON UNINSURED INPATIENT AND OUTPATIENT UNITS OF SERVICE FROM THE COST REPORTING YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, MULTIPLIED BY THE APPLICABLE MEDICAID RATES IN EFFECT JANUARY FIRST OF THE DISTRIBUTION YEAR, AS SUMMED AND ADJUSTED BY A STATEWIDE COST ADJUSTMENT FACTOR AND REDUCED BY THE SUM OF ALL PAYMENT AMOUNTS COLLECTED FROM SUCH UNINSURED PATIENTS, AND AS FURTHER ADJUSTED BY APPLICATION OF A NOMINAL NEED COMPUTATION THAT SHALL TAKE INTO ACCOUNT EACH FACILITY'S MEDICAID INPATIENT SHARE.

(II) ANNUAL DISTRIBUTIONS PURSUANT TO SUCH REGULATIONS FOR THE TWO THOUSAND THIRTEEN THROUGH TWO THOUSAND FIFTEEN CALENDAR YEARS SHALL BE IN ACCORD WITH THE FOLLOWING:

(A) ONE HUNDRED THIRTY-NINE MILLION FOUR HUNDRED THOUSAND DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DISPROPORTIONATE SHARE HOSPITAL ("DSH") PAYMENTS TO MAJOR PUBLIC GENERAL HOSPITALS; AND

(B) NINE HUNDRED NINETY-FOUR MILLION NINE HUNDRED THOUSAND DOLLARS AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS.

(III)(A) SUCH REGULATIONS SHALL ESTABLISH TRANSITION ADJUSTMENTS TO THE DISTRIBUTIONS MADE PURSUANT TO CLAUSES (A) AND (B) OF SUBPARAGRAPH (II) OF THIS PARAGRAPH SUCH THAT NO FACILITY EXPERIENCES A REDUCTION IN INDIGENT CARE POOL PAYMENTS PURSUANT TO THIS SUBDIVISION THAT IS GREATER THAN THE PERCENTAGES, AS SPECIFIED IN CLAUSE (C) OF THIS SUBPARAGRAPH, AS COMPARED TO THE AVERAGE DISTRIBUTION THAT EACH SUCH FACILITY RECEIVED FOR THE THREE CALENDAR YEARS PRIOR TO TWO THOUSAND THIRTEEN PURSUANT TO THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE; PROVIDED, HOWEVER, THAT SUCH REGULATIONS ESTABLISH ADJUSTMENTS FOR VOLUNTARY TEACHING HOSPITALS THAT RECEIVED PAYMENTS FROM THE VOLUNTARY TEACHING HOSPITAL POOL FOR STATE FISCAL YEARS TWO THOUSAND TEN-TWO THOUSAND TWELVE, BASED ON THE DIFFERENCE BETWEEN WHAT THE HOSPITAL WOULD HAVE RECEIVED FROM SUCH POOL HAD THE REGIONAL ALLOCATION METHODOLOGY NOT INCLUDED DATA FROM PUBLIC TEACHING HOSPITALS AND WHAT THE HOSPITAL ACTUALLY RECEIVED, PROVIDED SUCH HOSPITAL APPEALED THIS ISSUE TO THE DEPARTMENT OF HEALTH BEFORE NOVEMBER EIGHTH, TWO THOUSAND TWELVE.

(B) SUCH REGULATIONS SHALL ALSO ESTABLISH ADJUSTMENTS LIMITING THE INCREASES IN INDIGENT CARE POOL PAYMENTS EXPERIENCED BY FACILITIES PURSUANT TO THIS SUBDIVISION BY AN AMOUNT THAT WILL BE, AS DETERMINED BY THE COMMISSIONER AND IN CONJUNCTION WITH SUCH OTHER FUNDING AS MAY BE AVAILABLE FOR THIS PURPOSE, SUFFICIENT TO ENSURE FULL FUNDING FOR THE TRANSITION ADJUSTMENT PAYMENTS AUTHORIZED BY CLAUSE (A) OF THIS SUBPARAGRAPH.

(C) NO FACILITY SHALL EXPERIENCE A REDUCTION IN INDIGENT CARE POOL PAYMENTS PURSUANT TO THIS SUBDIVISION THAT: FOR THE CALENDAR YEAR BEGINNING JANUARY FIRST, TWO THOUSAND THIRTEEN, IS GREATER THAN TWO AND ONE-HALF PERCENT; FOR THE CALENDAR YEAR BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, IS GREATER THAN FIVE PERCENT; AND, FOR THE CALENDAR YEAR

BEGINNING ON JANUARY FIRST, TWO THOUSAND FIFTEEN, IS GREATER THAN SEVEN AND ONE-HALF PERCENT.

(IV) SUCH REGULATIONS SHALL RESERVE ONE PERCENT OF THE FUNDS AVAILABLE FOR DISTRIBUTION IN THE TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN CALENDAR YEARS PURSUANT TO THIS SUBDIVISION, SUBDIVISION FOURTEEN-F OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE, AND SECTIONS TWO HUNDRED ELEVEN AND TWO HUNDRED TWELVE OF CHAPTER FOUR HUNDRED SEVENTY-FOUR OF THE LAWS OF NINETEEN HUNDRED NINETY-SIX, IN A "FINANCIAL ASSISTANCE COMPLIANCE POOL" AND SHALL ESTABLISH METHODOLOGIES FOR THE DISTRIBUTION OF SUCH POOL FUNDS TO FACILITIES BASED ON THEIR LEVEL OF COMPLIANCE, AS DETERMINED BY THE COMMISSIONER, WITH THE PROVISIONS OF SUBDIVISION NINE-A OF THIS SECTION.

S 2. Subdivision 14-f of section 2807-c of the public health law, as amended by chapter 1 of the laws of 1999, is amended to read as follows:

14-f. Public general hospital indigent care adjustment. Notwithstanding any inconsistent provision of this section AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, [provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted] PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN AN ANNUAL AMOUNT OF FOUR HUNDRED TWELVE MILLION DOLLARS SHALL BE ALLOCATED TO ELIGIBLE MAJOR PUBLIC HOSPITALS BASED ON EACH HOSPITAL'S PROPORTIONATE SHARE OF MEDICAID AND UNINSURED LOSSES TO TOTAL MEDICAID AND UNINSURED LOSSES FOR ALL ELIGIBLE MAJOR PUBLIC HOSPITALS, NET OF ANY DISPROPORTIONATE SHARE HOSPITAL PAYMENTS RECEIVED PURSUANT TO SECTIONS TWENTY-EIGHT HUNDRED SEVEN-K AND TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

S 3. Paragraph (i) of subdivision 2-a of section 2807 of the public health law, as amended by section 16 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, THROUGH MARCH

THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND ONE HUNDRED FIFTY-THREE MILLION DOLLARS FOR STATE FISCAL YEAR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND THIRTEEN, provided, however, that for periods on and after April first, two thousand nine, such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the two thousand seven calendar year to the applicable rate year, and provided further, however, that funds made available as a result of any such decreases may be utilized by the commissioner to increase capitation rates paid to Medicaid managed care plans and family health plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates as the commissioner determines necessary to facilitate access to quality ambulatory care services.

S 4. The opening paragraph of subparagraph (i) of paragraph (i) of subdivision 35 of section 2807-c of the public health law, as added by section 3-a of part B of chapter 109 of the laws of 2010, is amended to read as follows:

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven [and], three hundred fourteen million dollars for each state fiscal year BEGINNING APRIL FIRST, TWO THOUSAND ELEVEN, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND NO LESS THAN THREE HUNDRED THIRTY-NINE MILLION DOLLARS FOR EACH STATE FISCAL YEAR thereafter, to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

S 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013 provided that:

a. sections one, two and four of this act shall be deemed to have been in full force and effect on and after January 1, 2013; and

b. the amendments to subdivision 14-f of section 2807-c of the public health law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART D

Section 1. Subdivision 1 of section 366 of the social services law is REPEALED and a new subdivision 1 is added to read as follows:

1. (A) DEFINITIONS. FOR PURPOSES OF THIS SECTION:

(1) "BENCHMARK COVERAGE" REFERS TO MEDICAL ASSISTANCE COVERAGE DEFINED IN SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE;

(2) "CARETAKER RELATIVE" MEANS A RELATIVE OF A DEPENDENT CHILD BY BLOOD, ADOPTION, OR MARRIAGE WITH WHOM THE CHILD IS LIVING, WHO ASSUMES PRIMARY RESPONSIBILITY FOR THE CHILD'S CARE AND WHO IS ONE OF THE FOLLOWING:

(I) THE CHILD'S FATHER, MOTHER, GRANDFATHER, GRANDMOTHER, BROTHER, SISTER, STEPFATHER, STEPMOTHER, STEPBROTHER, STEPSISTER, UNCLE, AUNT, FIRST COUSIN, NEPHEW, OR NIECE; OR

(II) THE SPOUSE OF SUCH PARENT OR RELATIVE, EVEN AFTER THE MARRIAGE IS TERMINATED BY DEATH OR DIVORCE;

(3) "FAMILY SIZE" MEANS THE NUMBER OF PERSONS COUNTED AS MEMBERS OF AN INDIVIDUAL'S HOUSEHOLD;

(4) "FEDERAL POVERTY LINE" MEANS THE POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

(5) "HOUSEHOLD," FOR PURPOSES OF DETERMINING THE FINANCIAL ELIGIBILITY OF APPLICANTS AND RECIPIENTS OF BENEFITS UNDER THIS TITLE, SHALL MEAN THE NUMBER OF INDIVIDUALS IN THE HOME WHO ACT AS A SINGLE ECONOMIC UNIT;

(6) "MAGI" MEANS MODIFIED ADJUSTED GROSS INCOME;

(7) "MAGI-BASED INCOME" MEANS INCOME CALCULATED USING THE SAME METHODOLOGIES USED TO DETERMINE MAGI UNDER SECTION 36B(D)(2)(B) OF THE INTERNAL REVENUE CODE, WITH THE EXCEPTION OF LUMP SUM PAYMENTS, CERTAIN EDUCATIONAL SCHOLARSHIPS, AND CERTAIN AMERICAN INDIAN AND ALASKA NATIVE INCOME, AS SPECIFIED BY THE COMMISSIONER OF HEALTH CONSISTENT WITH FEDERAL REGULATION AT 42 CFR 435.603 OR ANY SUCCESSOR REGULATION;

(8) "MAGI HOUSEHOLD INCOME" MEANS, WITH RESPECT TO AN INDIVIDUAL WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, THE SUM OF THE MAGI-BASED INCOME OF EVERY PERSON INCLUDED IN THE INDIVIDUAL'S MAGI HOUSEHOLD, EXCEPT THAT IT SHALL NOT INCLUDE THE MAGI-BASED INCOME OF THE FOLLOWING PERSONS IF SUCH PERSONS ARE NOT EXPECTED TO BE REQUIRED TO FILE A TAX RETURN IN THE TAXABLE YEAR IN WHICH ELIGIBILITY FOR MEDICAL ASSISTANCE IS BEING DETERMINED:

(I) A BIOLOGICAL, ADOPTED, OR STEP CHILD WHO IS INCLUDED IN THE INDIVIDUAL'S MAGI HOUSEHOLD; OR

(II) A PERSON, OTHER THAN A SPOUSE OR A BIOLOGICAL, ADOPTED, OR STEP CHILD, WHO IS EXPECTED TO BE CLAIMED AS A TAX DEPENDENT BY THE INDIVIDUAL;

(9) "STANDARD COVERAGE" REFERS TO MEDICAL ASSISTANCE COVERAGE DEFINED IN SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

(B) MAGI ELIGIBILITY GROUPS. INDIVIDUALS LISTED IN THIS PARAGRAPH ARE ELIGIBLE FOR MEDICAL ASSISTANCE BASED ON MODIFIED ADJUSTED GROSS INCOME. IN DETERMINING THE ELIGIBILITY OF AN INDIVIDUAL FOR THE MAGI ELIGIBILITY GROUP WITH THE HIGHEST INCOME STANDARD UNDER WHICH THE INDIVIDUAL MAY QUALIFY, AN AMOUNT EQUIVALENT TO FIVE PERCENTAGE POINTS OF THE FEDERAL POVERTY LEVEL FOR THE APPLICABLE FAMILY SIZE WILL BE DEDUCTED FROM THE HOUSEHOLD INCOME.

(1) AN INDIVIDUAL IS ELIGIBLE FOR BENCHMARK COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE AND HE OR SHE IS:

(I) AGE NINETEEN OR OLDER AND UNDER AGE SIXTY-FIVE; AND

(II) NOT PREGNANT; AND
(III) NOT ENTITLED TO OR ENROLLED FOR BENEFITS UNDER PARTS A OR B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT; AND
(IV) NOT OTHERWISE ELIGIBLE FOR AND RECEIVING COVERAGE UNDER SUBPARAGRAPHS TWO AND THREE OF THIS PARAGRAPH; AND
(V) NOT A PARENT OR OTHER CARETAKER RELATIVE OF A DEPENDENT CHILD UNDER TWENTY-ONE YEARS OF AGE AND LIVING WITH SUCH CHILD, UNLESS SUCH CHILD IS RECEIVING BENEFITS UNDER THIS TITLE OR UNDER TITLE 1-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, OR OTHERWISE IS ENROLLED IN MINIMUM ESSENTIAL COVERAGE.

(2) A PREGNANT WOMAN OR AN INFANT YOUNGER THAN ONE YEAR OF AGE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR AN INFANT YOUNGER THAN ONE YEAR OF AGE WHO MEETS THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(3) A CHILD WHO IS AT LEAST ONE YEAR OF AGE BUT YOUNGER THAN NINETEEN YEARS OF AGE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR A CHILD WHO IS AT LEAST ONE YEAR OF AGE BUT YOUNGER THAN NINETEEN YEARS OF AGE WHO MEETS THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(4) AN INDIVIDUAL WHO IS A PREGNANT WOMAN OR IS A MEMBER OF A FAMILY THAT CONTAINS A DEPENDENT CHILD LIVING WITH A PARENT OR OTHER CARETAKER RELATIVE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF ONE HUNDRED THIRTY PERCENT OF THE HIGHEST AMOUNT THAT ORDINARILY WOULD HAVE BEEN PAID TO A PERSON WITHOUT ANY INCOME OR RESOURCES UNDER THE FAMILY ASSISTANCE PROGRAM AS IT EXISTED ON THE FIRST DAY OF NOVEMBER, NINETEEN HUNDRED NINETY-SEVEN, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; FOR PURPOSES OF THIS SUBPARAGRAPH, THE TERM DEPENDENT CHILD MEANS A PERSON WHO IS UNDER EIGHTEEN YEARS OF AGE, OR IS EIGHTEEN YEARS OF AGE AND A FULL-TIME STUDENT, WHO IS DEPRIVED OF PARENTAL SUPPORT OR CARE BY REASON OF THE DEATH, CONTINUED ABSENCE, OR PHYSICAL OR MENTAL INCAPACITY OF A PARENT, OR BY REASON OF THE UNEMPLOYMENT OF THE PARENT, AS DEFINED BY THE DEPARTMENT OF HEALTH.

(5) A CHILD WHO IS UNDER TWENTY-ONE YEARS OF AGE AND WHO WAS IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE ON HIS OR HER EIGHTEENTH BIRTHDAY IS ELIGIBLE FOR STANDARD COVERAGE; NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE PROVISIONS OF THIS SUBPARAGRAPH SHALL BE EFFECTIVE ONLY IF AND FOR SO LONG AS FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE IN THE COSTS OF MEDICAL ASSISTANCE FURNISHED HEREUNDER.

(6) AN INDIVIDUAL WHO IS NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS SECTION IS ELIGIBLE FOR COVERAGE OF FAMILY PLANNING SERVICES REIMBURSED BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT, AND FOR COVERAGE OF THOSE SERVICES IDENTIFIED BY THE COMMISSIONER OF HEALTH AS SERVICES GENERALLY PERFORMED AS PART OF OR AS A FOLLOW-UP TO A SERVICE ELIGIBLE FOR SUCH NINETY PERCENT REIMBURSEMENT, INCLUDING TREAT-

MENT FOR SEXUALLY TRANSMITTED DISEASES, IF HIS OR HER INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(7) A CHILD WHO IS NINETEEN OR TWENTY YEARS OF AGE LIVING WITH HIS OR HER PARENT WILL BE ELIGIBLE FOR STANDARD COVERAGE IF THE SUM OF THE MAGI-BASED INCOME OF EVERY PERSON INCLUDED IN THE CHILD'S MAGI HOUSEHOLD EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT, BUT DOES NOT EXCEED ONE HUNDRED FIFTY PERCENT, OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE.

(C) NON-MAGI ELIGIBILITY GROUPS. INDIVIDUALS LISTED IN THIS PARAGRAPH ARE ELIGIBLE FOR STANDARD COVERAGE. WHERE A FINANCIAL ELIGIBILITY DETERMINATION MUST BE MADE BY THE MEDICAL ASSISTANCE PROGRAM FOR INDIVIDUALS IN THESE GROUPS, SUCH FINANCIAL ELIGIBILITY WILL BE DETERMINED IN ACCORDANCE WITH SUBDIVISION TWO OF THIS SECTION.

(1) AN INDIVIDUAL RECEIVING OR ELIGIBLE TO RECEIVE FEDERAL SUPPLEMENTAL SECURITY INCOME PAYMENTS AND/OR ADDITIONAL STATE PAYMENTS PURSUANT TO TITLE SIX OF THIS ARTICLE; ANY INCONSISTENT PROVISION OF THIS CHAPTER OR OTHER LAW NOTWITHSTANDING, THE DEPARTMENT MAY DESIGNATE THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE AS ITS AGENT TO DISCHARGE ITS RESPONSIBILITY, OR SO MUCH OF ITS RESPONSIBILITY AS IS PERMITTED BY FEDERAL LAW, FOR DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE WITH RESPECT TO PERSONS WHO ARE NOT ELIGIBLE TO RECEIVE FEDERAL SUPPLEMENTAL SECURITY INCOME PAYMENTS BUT WHO ARE RECEIVING A STATE ADMINISTERED SUPPLEMENTARY PAYMENT OR MANDATORY MINIMUM SUPPLEMENT IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION ONE OF SECTION TWO HUNDRED TWELVE OF THIS ARTICLE.

(2) AN INDIVIDUAL WHO, ALTHOUGH NOT RECEIVING PUBLIC ASSISTANCE OR CARE FOR HIS OR HER MAINTENANCE UNDER OTHER PROVISIONS OF THIS CHAPTER, HAS INCOME AND RESOURCES, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE RELATIVES, THAT DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION, AND IS (I) SIXTY-FIVE YEARS OF AGE OR OLDER, OR CERTIFIED BLIND OR CERTIFIED DISABLED OR (II) FOR REASONS OTHER THAN INCOME OR RESOURCES, IS ELIGIBLE FOR FEDERAL SUPPLEMENTAL SECURITY INCOME BENEFITS AND/OR ADDITIONAL STATE PAYMENTS.

(3) A CHILD IN FOSTER CARE, OR A CHILD DESCRIBED IN SECTION FOUR HUNDRED FIFTY-FOUR OR FOUR HUNDRED FIFTY-EIGHT-D OF THIS CHAPTER.

(4) A DISABLED INDIVIDUAL 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 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.

(5) AN INDIVIDUAL AT LEAST SIXTEEN YEARS OF AGE, BUT UNDER THE AGE OF SIXTY-FIVE, WHO: IS EMPLOYED; CEASES TO BE IN RECEIPT OF MEDICAL ASSISTANCE UNDER SUBPARAGRAPH FIVE OF THIS PARAGRAPH BECAUSE THE PERSON, BY REASON OF MEDICAL IMPROVEMENT, IS DETERMINED AT THE TIME OF A REGULARLY SCHEDULED CONTINUING DISABILITY REVIEW TO NO LONGER BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME PROGRAM BENEFITS OR DISABILITY INSURANCE BENEFITS UNDER THE SOCIAL SECURITY ACT; CONTINUES TO HAVE A SEVERE MEDICALLY DETERMINABLE IMPAIRMENT, TO BE DETERMINED IN ACCORDANCE WITH APPLICABLE FEDERAL REGULATIONS; 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, A PERSON IS CONSIDERED TO BE EMPLOYED IF THE PERSON IS EARNING AT LEAST THE APPLICABLE MINIMUM WAGE UNDER SECTION SIX OF THE FEDERAL FAIR LABOR STANDARDS ACT AND WORKING AT LEAST FORTY HOURS PER MONTH; OR

(6) AN INDIVIDUAL RECEIVING TREATMENT FOR BREAST OR CERVICAL CANCER WHO MEETS THE ELIGIBILITY REQUIREMENTS OF PARAGRAPH (D) OF SUBDIVISION FOUR OF THIS SECTION OR THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(7) AN INDIVIDUAL RECEIVING TREATMENT FOR COLON OR PROSTATE CANCER WHO MEETS THE ELIGIBILITY REQUIREMENTS OF PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION OR THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(8) AN INDIVIDUAL WHO:

(I) IS UNDER TWENTY-SIX YEARS OF AGE; AND

(II) WAS IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE ON HIS OR HER EIGHTEENTH BIRTHDAY; AND

(III) WAS IN RECEIPT OF MEDICAL ASSISTANCE UNDER THIS TITLE WHILE IN FOSTER CARE; AND

(IV) IS NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE.

(9) A RESIDENT OF A HOME FOR ADULTS OPERATED BY A SOCIAL SERVICES DISTRICT, OR A RESIDENTIAL CARE CENTER FOR ADULTS OR COMMUNITY RESIDENCE OPERATED OR CERTIFIED BY THE OFFICE OF MENTAL HEALTH, AND HAS NOT, ACCORDING TO CRITERIA PROMULGATED BY THE DEPARTMENT CONSISTENT WITH THIS TITLE, SUFFICIENT INCOME, OR IN THE CASE OF A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER, CERTIFIED BLIND, OR CERTIFIED DISABLED, SUFFICIENT INCOME AND RESOURCES, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE RELATIVES, TO MEET ALL THE COSTS OF REQUIRED MEDICAL CARE AND SERVICES AVAILABLE UNDER THIS TITLE.

(D) CONDITIONS OF ELIGIBILITY. A PERSON SHALL NOT BE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE UNLESS HE OR SHE:

(1) IS A RESIDENT OF THE STATE, OR, WHILE TEMPORARILY IN THE STATE, REQUIRES IMMEDIATE MEDICAL CARE WHICH IS NOT OTHERWISE AVAILABLE, PROVIDED THAT SUCH PERSON DID NOT ENTER THE STATE FOR THE PURPOSE OF OBTAINING SUCH MEDICAL CARE; AND

(2) ASSIGNS TO THE APPROPRIATE SOCIAL SERVICES OFFICIAL OR TO THE DEPARTMENT, IN ACCORDANCE WITH DEPARTMENT REGULATIONS: (I) ANY BENEFITS WHICH ARE AVAILABLE TO HIM OR HER INDIVIDUALLY FROM ANY THIRD PARTY FOR CARE OR OTHER MEDICAL BENEFITS AVAILABLE UNDER THIS TITLE AND WHICH ARE OTHERWISE ASSIGNABLE PURSUANT TO A CONTRACT OR ANY AGREEMENT WITH SUCH THIRD PARTY; OR (II) ANY RIGHTS, OF THE INDIVIDUAL OR OF ANY OTHER PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE AND ON WHOSE BEHALF THE INDIVIDUAL HAS THE LEGAL AUTHORITY TO EXECUTE AN ASSIGNMENT OF SUCH RIGHTS, TO SUPPORT SPECIFIED AS SUPPORT FOR THE PURPOSE OF MEDICAL CARE BY A COURT OR ADMINISTRATIVE ORDER; AND

(3) COOPERATES WITH THE APPROPRIATE SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT IN ESTABLISHING PATERNITY OR IN ESTABLISHING, MODIFYING, OR ENFORCING A SUPPORT ORDER WITH RESPECT TO HIS OR HER CHILD; PROVIDED, HOWEVER, THAT NOTHING HEREIN CONTAINED SHALL BE CONSTRUED TO REQUIRE A PAYMENT UNDER THIS TITLE FOR CARE OR SERVICES, THE COST OF WHICH MAY BE MET IN WHOLE OR IN PART BY A THIRD PARTY; NOTWITHSTANDING THE FOREGOING, A SOCIAL SERVICES OFFICIAL SHALL NOT REQUIRE SUCH COOPERATION IF THE SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT DETERMINES THAT SUCH ACTIONS WOULD BE DETRIMENTAL TO THE BEST INTEREST OF THE CHILD, APPLICANT, OR RECIPIENT, OR WITH RESPECT TO PREGNANT WOMEN DURING PREGNANCY AND DURING THE SIXTY-DAY PERIOD BEGINNING ON THE LAST DAY OF PREGNANCY, IN ACCORDANCE WITH PROCEDURES AND CRITERIA ESTABLISHED BY REGULATIONS OF THE DEPARTMENT CONSISTENT WITH FEDERAL LAW; AND

(4) APPLIES FOR AND UTILIZES GROUP HEALTH INSURANCE BENEFITS AVAILABLE THROUGH A CURRENT OR FORMER EMPLOYER, INCLUDING BENEFITS FOR A SPOUSE AND DEPENDENT CHILDREN, IN ACCORDANCE WITH THE REGULATIONS OF THE DEPARTMENT.

(E) CONDITIONS OF COVERAGE. AN OTHERWISE ELIGIBLE PERSON SHALL NOT BE ENTITLED TO MEDICAL ASSISTANCE COVERAGE OF CARE, SERVICES, AND SUPPLIES UNDER THIS TITLE WHILE HE OR SHE:

(1) IS AN INMATE OR PATIENT IN AN INSTITUTION OR FACILITY WHEREIN MEDICAL ASSISTANCE MAY NOT BE PROVIDED IN ACCORDANCE WITH APPLICABLE FEDERAL OR STATE REQUIREMENTS, EXCEPT FOR PERSONS DESCRIBED IN SUBPARAGRAPH NINE OF PARAGRAPH (C) OF THIS SUBDIVISION OR SUBDIVISION ONE-A OR SUBDIVISION ONE-B OF THIS SECTION; OR

(2) IS A PATIENT IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE TREATMENT OF TUBERCULOSIS OR CARE OF THE MENTALLY DISABLED, WITH THE EXCEPTION OF: (I) A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER AND A PATIENT IN ANY SUCH INSTITUTION; (II) A PERSON UNDER TWENTY-ONE YEARS OF AGE AND RECEIVING IN-PATIENT PSYCHIATRIC SERVICES IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE CARE OF THE MENTALLY DISABLED; (III) A PATIENT IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE CARE OF THE MENTALLY RETARDED WHO IS RECEIVING MEDICAL CARE OR TREATMENT IN THAT PART OF SUCH INSTITUTION THAT HAS BEEN APPROVED PURSUANT TO LAW AS A HOSPITAL OR NURSING HOME; (IV) A PATIENT IN AN INSTITUTION OPERATED BY THE STATE DEPARTMENT OF MENTAL HYGIENE, WHILE UNDER CARE IN A HOSPITAL ON RELEASE FROM SUCH INSTITUTION FOR THE PURPOSE OF RECEIVING CARE IN SUCH HOSPITAL; OR (V) IS A PERSON RESIDING IN A COMMUNITY RESIDENCE OR A RESIDENTIAL CARE CENTER FOR ADULTS.

S 2. Subdivision 4 of section 366 of the social services law is REPEALED and a new subdivision 4 is added to read as follows:

4. SPECIAL ELIGIBILITY PROVISIONS.

(A) TRANSITIONAL MEDICAL ASSISTANCE.

(1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, EACH FAMILY WHICH WAS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION IN AT LEAST ONE OF THE SIX MONTHS IMMEDIATELY PRECEDING THE MONTH IN WHICH SUCH FAMILY BECAME INELIGIBLE FOR SUCH ASSISTANCE BECAUSE OF INCOME FROM THE EMPLOYMENT OF THE CARETAKER RELATIVE SHALL, WHILE SUCH FAMILY INCLUDES A DEPENDENT CHILD, REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE FOR TWELVE CALENDAR MONTHS IMMEDIATELY FOLLOWING THE MONTH IN WHICH SUCH FAMILY WOULD OTHERWISE BE DETERMINED TO BE INELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THE PROVISIONS OF THIS TITLE AND THE REGULATIONS OF THE DEPARTMENT GOVERNING INCOME AND RESOURCE LIMITATIONS RELATING TO ELIGIBILITY DETERMINATIONS FOR FAMILIES DESCRIBED IN SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION.

(2) (I) UPON GIVING NOTICE OF TERMINATION OF MEDICAL ASSISTANCE PROVIDED PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION, THE DEPARTMENT SHALL NOTIFY EACH SUCH FAMILY OF ITS RIGHTS TO EXTENDED BENEFITS UNDER SUBPARAGRAPH ONE OF THIS PARAGRAPH AND DESCRIBE THE CONDITIONS UNDER WHICH SUCH EXTENSION MAY BE TERMINATED.

(II) THE DEPARTMENT SHALL PROMULGATE REGULATIONS IMPLEMENTING THE REQUIREMENTS OF THIS SUBPARAGRAPH AND SUBPARAGRAPH ONE OF THIS PARAGRAPH RELATING TO THE CONDITIONS UNDER WHICH EXTENDED COVERAGE HEREUNDER MAY BE TERMINATED, THE SCOPE OF COVERAGE, AND THE CONDITIONS UNDER WHICH COVERAGE MAY BE EXTENDED PENDING A REDETERMINATION OF ELIGIBILITY. SUCH REGULATIONS SHALL, AT A MINIMUM, PROVIDE FOR: TERMINATION OF SUCH COVERAGE AT THE CLOSE OF THE FIRST MONTH IN WHICH THE FAMILY CEASES TO INCLUDE A DEPENDENT CHILD; NOTICE OF TERMINATION PRIOR TO THE EFFECTIVE DATE OF ANY TERMINATIONS; COVERAGE UNDER EMPLOYEE HEALTH PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; AND DISQUALIFICATION OF PERSONS FOR EXTENDED COVERAGE BENEFITS UNDER THIS PARAGRAPH FOR FRAUD.

(3) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, EACH FAMILY WHICH WAS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION IN AT LEAST THREE OF THE SIX MONTHS IMMEDIATELY PRECEDING THE MONTH IN WHICH SUCH FAMILY BECAME INELIGIBLE FOR SUCH ASSISTANCE AS A RESULT, WHOLLY OR PARTLY, OF THE COLLECTION OR INCREASED COLLECTION OF SPOUSAL SUPPORT PURSUANT TO PART D OF TITLE IV OF THE FEDERAL SOCIAL SECURITY ACT, SHALL, FOR PURPOSES OF MEDICAL ASSISTANCE ELIGIBILITY, BE CONSIDERED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION FOR AN ADDITIONAL FOUR CALENDAR MONTHS BEGINNING WITH THE MONTH INELIGIBILITY FOR SUCH ASSISTANCE BEGINS.

(B) PREGNANT WOMEN AND CHILDREN.

(1) A PREGNANT WOMAN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUBPARAGRAPH TWO OR FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION ON ANY DAY OF HER PREGNANCY WILL CONTINUE TO BE ELIGIBLE FOR SUCH CARE AND SERVICES THROUGH THE END OF THE MONTH IN WHICH THE SIXTIETH DAY FOLLOWING THE END OF THE PREGNANCY OCCURS, WITHOUT REGARD TO ANY CHANGE IN THE INCOME OF THE FAMILY THAT INCLUDES THE PREGNANT WOMAN, EVEN IF SUCH CHANGE OTHERWISE WOULD HAVE RENDERED HER INELIGIBLE FOR MEDICAL ASSISTANCE.

(2) A CHILD BORN TO A WOMAN ELIGIBLE FOR AND RECEIVING MEDICAL ASSISTANCE ON THE DATE OF THE CHILD'S BIRTH SHALL BE DEEMED TO HAVE APPLIED FOR MEDICAL ASSISTANCE AND TO HAVE BEEN FOUND ELIGIBLE FOR SUCH ASSISTANCE ON THE DATE OF SUCH BIRTH AND TO REMAIN ELIGIBLE FOR SUCH ASSISTANCE FOR A PERIOD OF ONE YEAR, SO LONG AS THE CHILD IS A MEMBER OF THE WOMAN'S HOUSEHOLD AND THE WOMAN REMAINS ELIGIBLE FOR SUCH ASSISTANCE OR WOULD REMAIN ELIGIBLE FOR SUCH ASSISTANCE IF SHE WERE PREGNANT.

(3) A CHILD UNDER THE AGE OF NINETEEN WHO IS DETERMINED ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THE PROVISIONS OF THIS SECTION, SHALL, CONSISTENT WITH APPLICABLE FEDERAL REQUIREMENTS, REMAIN ELIGIBLE FOR SUCH ASSISTANCE UNTIL THE EARLIER OF:

(I) THE LAST DAY OF THE MONTH WHICH IS TWELVE MONTHS FOLLOWING THE DETERMINATION OR REDETERMINATION OF ELIGIBILITY FOR SUCH ASSISTANCE; OR

(II) THE LAST DAY OF THE MONTH IN WHICH THE CHILD REACHES THE AGE OF NINETEEN.

(4) AN INFANT ELIGIBLE UNDER SUBPARAGRAPH TWO OR FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE THE CHILD ATTAINS ONE YEAR OF AGE, AND WHO, BUT FOR ATTAINING SUCH AGE, WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPH,

SHALL CONTINUE TO REMAIN ELIGIBLE UNTIL THE END OF THE STAY FOR WHICH IN-PATIENT SERVICES ARE BEING FURNISHED.

(5) A CHILD ELIGIBLE UNDER SUBPARAGRAPH THREE OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE THE CHILD ATTAINS NINETEEN YEARS OF AGE, AND WHO, BUT FOR ATTAINING SUCH AGE, WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH, SHALL CONTINUE TO REMAIN ELIGIBLE UNTIL THE END OF THE STAY FOR WHICH IN-PATIENT SERVICES ARE BEING FURNISHED.

(6) A WOMAN WHO WAS PREGNANT WHILE IN RECEIPT OF MEDICAL ASSISTANCE WHO SUBSEQUENTLY LOSES HER ELIGIBILITY FOR MEDICAL ASSISTANCE SHALL HAVE HER ELIGIBILITY FOR MEDICAL ASSISTANCE CONTINUED FOR A PERIOD OF TWENTY-FOUR MONTHS FROM THE END OF THE MONTH IN WHICH THE SIXTIETH DAY FOLLOWING THE END OF HER PREGNANCY OCCURS, BUT ONLY FOR FEDERAL TITLE X SERVICES WHICH ARE ELIGIBLE FOR REIMBURSEMENT BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT; PROVIDED, HOWEVER, THAT SUCH NINETY PERCENT LIMITATION SHALL NOT APPLY TO THOSE SERVICES IDENTIFIED BY THE COMMISSIONER 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; AND PROVIDED FURTHER, HOWEVER, THAT NOTHING IN THIS PARAGRAPH SHALL BE DEEMED TO AFFECT PAYMENT FOR SUCH TITLE X SERVICES IF FEDERAL FINANCIAL PARTICIPATION IS NOT AVAILABLE FOR SUCH CARE, SERVICES AND SUPPLIES.

(C) BREAST AND CERVICAL CANCER TREATMENT.

(1) PERSONS WHO ARE NOT ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THE TERMS OF SECTION 1902(A)(10)(A)(I) OF THE FEDERAL SOCIAL SECURITY ACT ARE ELIGIBLE FOR MEDICAL ASSISTANCE COVERAGE DURING THE TREATMENT OF BREAST OR CERVICAL CANCER, SUBJECT TO THE PROVISIONS OF THIS PARAGRAPH.

(2) (I) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO ARE UNDER SIXTY-FIVE YEARS OF AGE, HAVE BEEN SCREENED FOR BREAST AND/OR CERVICAL CANCER UNDER THE CENTERS FOR DISEASE CONTROL AND PREVENTION BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM AND NEED TREATMENT FOR BREAST OR CERVICAL CANCER, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT; PROVIDED HOWEVER THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS CLAUSE ONLY TO THE EXTENT PERMITTED UNDER FEDERAL LAW, IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE THEREFOR.

(II) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO MEET THE REQUIREMENTS OF CLAUSE (I) OF THIS SUBPARAGRAPH BUT FOR THEIR AGE AND/OR GENDER, WHO HAVE BEEN SCREENED FOR BREAST AND/OR CERVICAL CANCER UNDER THE PROGRAM DESCRIBED IN TITLE ONE-A OF ARTICLE TWENTY-FOUR OF THE PUBLIC HEALTH LAW AND NEED TREATMENT FOR BREAST OR CERVICAL CANCER, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT; PROVIDED HOWEVER THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS CLAUSE ONLY IF AND FOR SO LONG AS THE PROVISIONS OF CLAUSE (I) OF THIS SUBPARAGRAPH ARE IN EFFECT.

(3) MEDICAL ASSISTANCE PROVIDED TO A PERSON UNDER THIS PARAGRAPH SHALL BE LIMITED TO THE PERIOD IN WHICH SUCH PERSON REQUIRES TREATMENT FOR BREAST OR CERVICAL CANCER.

(4) (I) THE COMMISSIONER OF HEALTH SHALL PROMULGATE SUCH REGULATIONS AS MAY BE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS PARAGRAPH. SUCH REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO: ELIGIBILITY REQUIREMENTS; A DESCRIPTION OF THE MEDICAL SERVICES WHICH ARE COVERED; AND A PROCESS FOR PROVIDING PRESUMPTIVE ELIGIBILITY WHEN A QUALIFIED ENTITY,

AS DEFINED BY THE COMMISSIONER, DETERMINES ON THE BASIS OF PRELIMINARY INFORMATION THAT A PERSON MEETS THE REQUIREMENTS FOR ELIGIBILITY UNDER THIS PARAGRAPH.

(II) FOR PURPOSES OF DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH, RESOURCES AVAILABLE TO SUCH INDIVIDUAL SHALL NOT BE CONSIDERED NOR REQUIRED TO BE APPLIED TOWARD THE PAYMENT OR PART PAYMENT OF THE COST OF MEDICAL CARE, SERVICES AND SUPPLIES AVAILABLE UNDER THIS PARAGRAPH.

(III) AN INDIVIDUAL SHALL BE ELIGIBLE FOR PRESUMPTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH IN ACCORDANCE WITH SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(5) THE COMMISSIONER OF HEALTH SHALL, CONSISTENT WITH THIS TITLE, MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THIS TITLE, IN ORDER TO ENSURE FEDERAL FINANCIAL PARTICIPATION IN EXPENDITURES UNDER THIS PARAGRAPH. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE PROVISIONS OF CLAUSE (I) OF SUBPARAGRAPH TWO OF THIS PARAGRAPH SHALL BE EFFECTIVE ONLY IF AND FOR SO LONG AS FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE IN THE COSTS OF MEDICAL ASSISTANCE FURNISHED THEREUNDER.

(D) COLON AND PROSTATE CANCER TREATMENT.

(1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, A PERSON WHO HAS BEEN SCREENED OR REFERRED FOR SCREENING FOR COLON OR PROSTATE CANCER BY THE CANCER SERVICES SCREENING PROGRAM, AS ADMINISTERED BY THE DEPARTMENT OF HEALTH, AND HAS BEEN DIAGNOSED WITH COLON OR PROSTATE CANCER IS ELIGIBLE FOR MEDICAL ASSISTANCE FOR THE DURATION OF HIS OR HER TREATMENT FOR SUCH CANCER.

(2) PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH SHALL HAVE AN INCOME OF TWO HUNDRED FIFTY PERCENT OR LESS OF THE COMPARABLE FEDERAL INCOME OFFICIAL POVERTY LINE AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET.

(3) AN INDIVIDUAL SHALL BE ELIGIBLE FOR PRESUMPTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH IN ACCORDANCE WITH SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(4) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO ARE UNDER SIXTY-FIVE YEARS OF AGE, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT.

S 3. Paragraph (a) of subdivision 4 of section 364-i of the social services law, as added by section 29-a of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law to the contrary, a child shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determine, on the basis of preliminary information, that the [net] MAGI household income of the child does not exceed the applicable level for eligibility as provided for pursuant to SUBPARAGRAPH TWO OR THREE OF paragraph [(u)] (B) of subdivision [four] ONE of section three hundred sixty-six of this title.

S 4. Paragraph (a) of subdivision 5 of section 364-i of the social services law, as added by chapter 176 of the laws of 2006, is amended to read as follows:

(a) An individual shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determines, on the basis of preliminary information, that the individual meets the requirements

of paragraph [(v) or (v-1)] (C) OR (D) of subdivision four of section three hundred sixty-six of this title.

S 5. Subdivision 6 of section 364-i of the social services law, as added by chapter 484 of the laws of 2009 and paragraph (a-2) as added by section 76 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

6. (a) A pregnant woman shall be presumed to be eligible for [coverage of services described in paragraph (c) of this subdivision] MEDICAL ASSISTANCE UNDER THIS TITLE, EXCLUDING INPATIENT SERVICES AND INSTITUTIONAL LONG TERM CARE, beginning on the date that a prenatal care provider, licensed under article twenty-eight of the public health law or other prenatal care provider approved by the department of health determines, on the basis of preliminary information, that the pregnant woman's [family has: (i) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that does not exceed two hundred thirty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size, or (ii) in the absence of such approval, net income that does not exceed two hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size.] MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, AS DEFINED BY THIS CHAPTER.

(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.

(b) Such presumptive eligibility shall continue through the earlier of: the day on which eligibility is determined pursuant to this title; or the last day of the month following the month in which the provider makes preliminary determination, in the case of a pregnant woman who does not file an application for medical assistance on or before such day.

(c) [A presumptively eligible pregnant woman is eligible for coverage of:

(i) all medical care, services, and supplies available under the medical assistance program, excluding inpatient services and institutional long term care, if the woman's family has: (A) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that does not exceed one hundred twenty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size, or (B) in the absence of such approval, net income that does not exceed one hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size; or

(ii) prenatal care services as described in subparagraph four of paragraph (o) of subdivision four of section three hundred sixty-six of this title, if the woman's family has: (A) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that

exceeds one hundred twenty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for families of the same size, but does not exceed two hundred thirty percent of such federal poverty line, or (B) in the absence of such approval, net income that exceeds one hundred percent but does not exceed two hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size.

(d)] The department of health shall provide prenatal care providers licensed under article twenty-eight of the public health law and other approved prenatal care providers with such forms as are necessary for a pregnant woman to apply and information on how to assist such women in completing and filing such forms. A qualified provider which determines that a pregnant woman is presumptively eligible shall notify the social services district in which the pregnant woman resides of the determination within five working days after the date on which such determination is made and shall inform the woman at the time the determination is made that she is required to make application by the last day of the month following the month in which the determination is made.

[(e)] (D) Notwithstanding any other provision of law, care that is furnished to a pregnant woman pursuant to this subdivision during a presumptive eligibility period shall be deemed as medical assistance for purposes of payment and state reimbursement.

[(f)] (E) Facilities licensed under article twenty-eight of the public health law providing prenatal care services shall perform presumptive eligibility determinations and assist women in submitting appropriate documentation to the social services district as required by the commissioner; provided, however, that a facility may apply to the commissioner for exemption from this requirement on the basis of undue hardship.

[(g)] (F) All prenatal care providers enrolled in the medicaid program must provide prenatal care services to eligible service recipients determined presumptively eligible for medical assistance but not yet enrolled in the medical assistance program, and assist women in submitting appropriate documentation to the social services district as required by the commissioner.

S 6. Subdivision 1 and the opening paragraph of subdivision 2 of section 365-a of the social services law, subdivision 1 as amended by chapter 110 of the laws of 1971 and the opening paragraph of subdivision 2 as amended by chapter 41 of the laws of 1992, are amended to read as follows:

[1.] The amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "BENCHMARK COVERAGE" SHALL MEAN PAYMENT OF PART OR ALL OF THE COST OF MEDICALLY NECESSARY MEDICAL, DENTAL, AND REMEDIAL CARE, SERVICES, AND SUPPLIES DESCRIBED IN SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX OF THE INSURANCE LAW - HEALTHY NY, AND TO THE EXTENT NOT INCLUDED THEREIN, ANY ESSENTIAL BENEFITS AS DEFINED IN 42 U.S.C. 18022(B), SUCH CARE, SERVICES AND SUPPLIES SHALL BE PROVIDED THROUGH A MANAGED CARE PROGRAM.

["Medical assistance"] "STANDARD COVERAGE" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such

person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

S 7. Subdivision 1 of section 366-a of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

1. Any person requesting medical assistance may make application therefor [in person, through another in his behalf or by mail] BY A WRITTEN APPLICATION to the social services official of the county[, city or town, or to the service officer of the city or town] in which the applicant resides or is found OR TO THE DEPARTMENT OF HEALTH OR ITS AGENT; A PHONE APPLICATION; OR AN ON-LINE APPLICATION. [In addition, in the case of a person who is sixty-five years of age or older and is a patient in a state hospital for tuberculosis or for the mentally disabled, applications may be made to the department or to a social services official designated as the agent of the department.] Notwithstanding any provision of law to the contrary, [a personal] AN IN-PERSON interview with the applicant or with the person who made application on his or her behalf shall not be required as part of a determination of initial or continuing eligibility pursuant to this title.

S 8. Paragraph (a) of subdivision 2 of section 366-a of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(a) Upon receipt of such application, the appropriate social services official, or the department of health or its agent [when the applicant is a patient in a state hospital for the mentally disabled,] shall verify the eligibility of such applicant. In accordance with the regulations of the department of health, it shall be the responsibility of the applicant to provide information and documentation necessary for the determination of initial and ongoing eligibility for medical assistance. If an applicant or recipient is unable to provide necessary documentation, the [public welfare] SOCIAL SERVICES official OR THE DEPARTMENT OF HEALTH OR ITS AGENT shall promptly cause an investigation to be made. Where an investigation is necessary, sources of information other than public records will be consulted only with permission of the applicant or recipient. In the event that such permission is not granted by the applicant or recipient, or necessary documentation cannot be obtained, the social services official or the department of health or its agent may suspend or deny medical assistance until such time as it may be satisfied as to the applicant's or recipient's eligibility therefor.

S 9. The opening paragraph of subdivision 3 of section 366-a of the social services law, as added by chapter 256 of the laws of 1966, is amended to read as follows:

Upon the receipt of such application, and after the completion of any investigation that shall be deemed necessary, the appropriate [public welfare] SOCIAL SERVICES official[,] or the department OF HEALTH or its agent [when the applicant is a patient in a state hospital for tuberculosis or for the mentally disabled,] shall

S 10. Paragraphs (b) and (c) of subdivision 5 of section 366-a of the social services law, as added by section 52 of part A of chapter 1 of the laws of 2002, are amended to read as follows:

(b) The commissioner shall develop a simplified statewide recertification form for use in redetermining eligibility under this title. The form [shall] MAY include requests only for such information that is:

(i) reasonably necessary to determine continued eligibility for medical assistance under this title; and

(ii) subject to change since the date of the recipient's initial application.

(c) [A personal] THE REGULATIONS REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL PROVIDE THAT:

(I) THE REDETERMINATION OF ELIGIBILITY WILL BE MADE BASED ON RELIABLE INFORMATION POSSESSED OR AVAILABLE TO THE DEPARTMENT OF HEALTH OR ITS AGENT, INCLUDING INFORMATION ACCESSED FROM DATABASES PURSUANT TO SUBDIVISION EIGHT OF THIS SECTION;

(II) IF THE DEPARTMENT OF HEALTH OR ITS AGENT IS UNABLE TO RENEW ELIGIBILITY BASED ON AVAILABLE INFORMATION, THE RECIPIENT WILL BE REQUESTED TO SUPPLY ANY SUCH INFORMATION AS IS NECESSARY TO DETERMINE CONTINUED ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS TITLE; AND

(III) FOR PERSONS WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, ELIGIBILITY MUST BE RENEWED AT LEAST ONCE EVERY TWELVE MONTHS, UNLESS THE DEPARTMENT OF HEALTH OR ITS AGENT RECEIVES INFORMATION ABOUT A CHANGE IN A RECIPIENT'S CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY.

(D) AN IN-PERSON interview with the recipient shall not AUTOMATICALLY be required as part of a redetermination of eligibility pursuant to this subdivision UNLESS THE DEPARTMENT OF HEALTH DETERMINES OTHERWISE.

S 11. Paragraph (d) of subdivision 5 of section 366-a of the social services law is REPEALED.

S 12. Paragraph (e) of subdivision 5 of section 366-a of the social services law, as added by section 1 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(e) The commissioner of health shall verify the accuracy of the information provided by [the] AN APPLICANT OR recipient [pursuant to paragraph (d) of this subdivision] by matching it against information to which the commissioner of health has access, including under subdivision eight of this section. In the event there is an inconsistency between the information reported by the recipient and any information obtained by the commissioner of health from other sources and such inconsistency is material to medical assistance eligibility, the commissioner of health shall request that the recipient provide adequate documentation to verify his or her place of residence or income, as applicable. In addition to the documentation of residence and income authorized by this paragraph, the commissioner of health is authorized to periodically require a reasonable sample of recipients to provide documentation of residence and income at recertification. The commissioner of health shall consult with the medicaid inspector general regarding income and residence verification practices and procedures necessary to maintain program integrity and deter fraud and abuse.

S 13. Subdivision 11 of section 364-j of the social services law is REPEALED.

S 14. Clause (D) of subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by section 67 of part C of chapter 58 of the laws of 2009, is amended, and a new subparagraph (vi) is added to read as follows:

(D) is not described in clause (A), (B) or (C) of this subparagraph and has gross family income equal to or less than two hundred percent of the federal income official poverty line (as defined and updated by the

United States Department of Health and Human Services) for a family of the same size; provided, however, that eligibility under this clause is subject to sources of federal and non-federal funding for such purpose described in section sixty-seven-a of [the] PART C OF chapter FIFTY-EIGHT of the laws of two thousand nine [that added this clause] or as may be available under the waiver agreement entered into with the federal government under section eleven hundred fifteen of the federal social security act, as jointly determined by the commissioner and the director of the division of the budget. In no case shall state funds be utilized to support the non-federal share of expenditures pursuant to this subparagraph, provided however that the commissioner may demonstrate to the United States department of health and human services the existence of non-federally participating state expenditures as necessary to secure federal funding under an eleven hundred fifteen waiver for the purposes herein. Eligibility under this clause may be provided to residents of all counties or, at the joint discretion of the commissioner and the director of the division of the budget, a subset of counties of the state[.]; AND

(VI) CONTINGENT UPON THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BEING FULLY IMPLEMENTED BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND CONTINGENT UPON FULL IMPLEMENTATION OF THE STATE ENROLLMENT CENTER, MAKES APPLICATION FOR BENEFITS PURSUANT TO THIS TITLE ON OR BEFORE DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN.

S 14-a. Subdivision 5 of section 369-ee of the social services law is amended by adding a new paragraph (d) to read as follows:

(D) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION OR ANY OTHER PROVISION OF LAW, IN THE CASE OF A PERSON RECEIVING HEALTH CARE SERVICES PURSUANT TO THIS TITLE ON JANUARY FIRST, TWO THOUSAND FOURTEEN, SUCH PERSON'S ELIGIBILITY SHALL BE RECERTIFIED AS SOON AS PRACTICABLE THEREAFTER, AND SUCH PERSON'S COVERAGE UNDER THIS TITLE SHALL END ON THE EARLIEST OF: (I) THE DATE THE PERSON IS ENROLLED IN A QUALIFIED HEALTH PLAN OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTABLISHED IN ACCORDANCE WITH THE REQUIREMENTS OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION ACT OF 2010 (P.L. 111-152); (II) DECEMBER THIRTY-FIRST, TWO THOUSAND FOURTEEN; OR (III) THE DATE ON WHICH THE DEPARTMENT OF HEALTH CEASES TO HAVE ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION TO RECEIVE FEDERAL FINANCIAL PARTICIPATION, UNDER THE PROGRAM DESCRIBED IN TITLE ELEVEN OF THIS ARTICLE, IN THE COSTS OF HEALTH SERVICES PROVIDED PURSUANT TO THIS SECTION, AND CONTINGENT UPON THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BEING FULLY IMPLEMENTED BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND CONTINGENT UPON FULL IMPLEMENTATION OF THE STATE ENROLLMENT CENTER.

S 15. Section 369-ee of the social services law is REPEALED.

S 15-a. Section 369-ff of the social services law is REPEALED.

S 16. Subdivision 3 of section 367-a of the social services law is amended by adding a new paragraph (e) to read as follows:

(E) (1) PAYMENT OF PREMIUMS FOR ENROLLING INDIVIDUALS IN QUALIFIED HEALTH PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152), TOGETHER WITH THE COSTS OF APPLICABLE CO-INSURANCE, DEDUCTIBLE AMOUNTS, AND OTHER COST-SHARING OBLIGATIONS, SHALL BE AVAILABLE TO INDIVIDUALS WHO:

(I) IMMEDIATELY PRIOR TO BEING ENROLLED IN THE QUALIFIED HEALTH PLAN, OR TO THE EXPIRATION OR REPEAL OF THE FAMILY HEALTH PLUS PROGRAM, WERE ELIGIBLE UNDER SUCH PROGRAM AND ENROLLED IN A FAMILY HEALTH INSURANCE PLAN AS A PARENT OR STEPPARENT OF A CHILD UNDER THE AGE OF TWENTY-ONE, AND WHOSE MAGI HOUSEHOLD INCOME, AS DEFINED IN SUBPARAGRAPH EIGHT OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE, EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE;

(II) ARE NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE; AND

(III) ARE ENROLLED IN A STANDARD HEALTH PLAN IN THE SILVER LEVEL, AS DEFINED IN 42 U.S.C. 18022.

(2) CONTINGENT UPON FULL FEDERAL FINANCIAL PARTICIPATION, PAYMENT PURSUANT TO THIS PARAGRAPH SHALL BE FOR PREMIUMS, CO-INSURANCE, DEDUCTIBLES, AND OTHER COST-SHARING OBLIGATIONS OF THE INDIVIDUAL UNDER THE QUALIFIED HEALTH PLAN TO THE EXTENT THAT THEY EXCEED THE AMOUNT THAT WOULD HAVE BEEN THE INDIVIDUAL'S CO-PAYMENT OBLIGATION AMOUNT UNDER THE FAMILY HEALTH PLUS PROGRAM, AND SHALL CONTINUE ONLY IF AND FOR SO LONG AS THE INDIVIDUAL'S MAGI HOUSEHOLD INCOME EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT, BUT DOES NOT EXCEED ONE HUNDRED FIFTY PERCENT, OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE.

(3) THE COMMISSIONER OF HEALTH 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 AS MAY BE NECESSARY TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF PAYMENTS MADE PURSUANT TO THIS PARAGRAPH.

(4) THIS PARAGRAPH SHALL BE CONTINGENT UPON THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BEING FULLY IMPLEMENTED BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND CONTINGENT UPON FULL IMPLEMENTATION OF THE STATE ENROLLMENT CENTER.

S 17. Section 2510 of the public health law amended by adding a new subdivision 13 to read as follows:

13. "HOUSEHOLD INCOME" MEANS THE SUM OF THE MODIFIED ADJUSTED GROSS INCOME OF EVERY INDIVIDUAL INCLUDED IN A CHILD'S HOUSEHOLD CALCULATED IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS, AS MAY BE AMENDED. THIS DEFINITION SHALL BE EFFECTIVE ON JANUARY FIRST, TWO THOUSAND FOURTEEN OR A LATER DATE CONCOMITANT WITH THE FULL IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

S 18. Section 2510 of the public health law is amended by adding two new subdivisions 14 and 15 to read as follows:

14. "STATE ENROLLMENT CENTER" MEANS THE CENTRALIZED SYSTEM AND OPERATION OF ELIGIBILITY DETERMINATIONS BY THE STATE OR ITS CONTRACTOR FOR ALL INSURANCE AFFORDABILITY PROGRAMS, INCLUDING THE CHILD HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO THIS TITLE. THE STATE ENROLLMENT CENTER SHALL BE SUBJECT TO THE PROVISIONS OF SECTION EIGHT OF THE STATE FINANCE LAW.

15. "INSURANCE AFFORDABILITY PROGRAMS" MEANS THOSE PROGRAMS SET FORTH IN SECTION 435.4 OF TITLE 42 OF THE CODE OF FEDERAL REGULATIONS.

S 19. Subparagraphs (iv) and (vi) of paragraph (f) of subdivision 2 of section 2511 of the public health law, subparagraph (iv) as added by section 44 of part A of chapter 1 of the laws of 2002 and subparagraph (vi) as added by section 45-b of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(iv) In the event a household does not provide income documentation required by subparagraph (iii) of this paragraph within two months of the approved organization's OR STATE ENROLLMENT CENTER'S request, WHICHEVER IS APPLICABLE, the approved organization OR STATE ENROLLMENT CENTER shall disenroll the child at the end of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments made by the state on behalf of children enrolled during this two month period.

(vi) Any income verification response by the department of taxation and finance pursuant to subparagraphs (i) and (ii) of this paragraph shall not be a public record and shall not be released by the commissioner, the department of taxation and finance [or], an approved organization, OR THE STATE ENROLLMENT CENTER, except pursuant to this paragraph. Information disclosed pursuant to this paragraph shall be limited to information necessary for verification. Information so disclosed shall be kept confidential by the party receiving such information. Such information shall be expunged within a reasonable time to be determined by the commissioner and the department of taxation and finance.

S 20. Paragraph (j) of subdivision 2 of section 2511 of the public health law, as added by section 45 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(j) Where an application for recertification of coverage under this title contains insufficient information for a final determination of eligibility for continued coverage, a child shall be presumed eligible for a period not to exceed the earlier of two months beyond the preceding period of eligibility or the date upon which a final determination of eligibility is made based on the submission of additional data. In the event such additional information is not submitted within two months of the approved organization's OR STATE ENROLLMENT CENTER'S request, WHICHEVER IS APPLICABLE, the approved organization OR STATE ENROLLMENT CENTER shall disenroll the child following the expiration of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments received on behalf of children enrolled during this two month period.

S 21. Subdivision 4 of section 2511 of the public health law, as amended by section 70 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

4. Households shall report to the approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, within thirty days, any changes in New York state residency or health care coverage under insurance that may make a child ineligible for subsidy payments pursuant to this section. Any individual who, with the intent to obtain benefits, willfully misstates income or residence to establish eligibility pursuant to subdivision two of this section or willfully fails to notify an approved organization OR STATE ENROLLMENT CENTER of a change in residence or health care coverage pursuant to this subdivision shall repay such subsidy to the commissioner. Individuals seeking to enroll children for coverage shall be informed that such willful misstatement or failure to notify shall result in such liability.

S 22. The subdivision heading and paragraphs (a) and (b) of subdivision 5-a of section 2511 of the public health law, the subdivision heading and paragraph (a) as added by chapter 170 of the laws of 1994 and paragraph (b) as amended by section 71 of part B of chapter 58 of the laws of 2005, are amended to read as follows:

Obligations of approved organizations OR THE STATE ENROLLMENT CENTER. (a) An approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, shall have the obligation to review all information provided pursuant to subdivision two of this section and shall not certify or recertify a child as eligible for a subsidy payment unless the child meets the eligibility criteria.

(b) An approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, shall promptly review all information relating to a potential change in eligibility based on information provided pursuant to subdivision four of this section. Within at least thirty days after receipt of such information, the approved organization OR STATE ENROLLMENT CENTER shall make a determination whether the child is still eligible for a subsidy payment and shall notify the household and the commissioner if it determines the child is not eligible for a subsidy payment.

S 23. Paragraph (a) of subdivision 11 of section 2511 of the public health law, as amended by section 37 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(a) An approved organization shall submit required reports and information to the commissioner in such form and at times, at least annually, as may be required by the commissioner and specified in contracts and official department of health administrative guidance, in order to evaluate the operations and results of the program and quality of care being provided by such organizations. Such reports and information shall include, but not be limited to, enrollee demographics (APPLICABLE ONLY UNTIL THE STATE ENROLLMENT CENTER IS IMPLEMENTED), program utilization and expense, patient care outcomes and patient specific medical information, including encounter data maintained by an approved organization for purposes of quality assurance and oversight. Any information or data collected pursuant to this paragraph shall be kept confidential in accordance with Title XXI of the federal social security act or any other applicable state or federal law.

S 24. Subdivision 12 of section 2511 of the public health law, as amended by chapter 2 of the laws of 1998, is amended to read as follows:

12. The commissioner shall, in consultation with the superintendent, establish procedures to coordinate the child health insurance plan with the medical assistance program, including but not limited to, procedures to maximize enrollment of eligible children under those programs by identification and transfer of children who are eligible or who become eligible to receive medical assistance and procedures to facilitate changes in enrollment status for children who are ineligible for subsidies under this section and for children who are no longer eligible for medical assistance in order to facilitate and ensure continuity of coverage. The commissioner shall review, on an annual basis, the eligibility verification and recertification procedures of approved organizations under this title to insure the appropriate enrollment of children. Such review shall include, but not be limited to, an audit of a statistically representative sample of cases from among all approved organizations AND SHALL BE APPLICABLE TO ANY PERIOD DURING WHICH AN APPROVED ORGANIZATION'S RESPONSIBILITIES INCLUDE DETERMINING ELIGIBILITY. In the event such review and audit reveals cases which do not meet the eligibility criteria for coverage set forth in this section, that information shall be forwarded to the approved organization and the commissioner for appropriate action.

S 25. Paragraph (e) of subdivision 12-a of section 2511 of the public health law, as added by chapter 2 of the laws of 1998, is amended and a new paragraph (f) is added to read as follows:

(e) standards and procedures for the imposition of penalties for substantial noncompliance, which may include, but not be limited to, financial penalties in addition to penalties set forth in section twelve of this chapter and consistent with applicable federal standards, as specified in contracts, and contract termination[.]; PROVIDED HOWEVER

(F) AUDIT STANDARDS AND PROCEDURES ESTABLISHED PURSUANT TO THIS SECTION, INCLUDING PENALTIES, SHALL BE APPLICABLE TO ELIGIBILITY DETERMINATIONS MADE BY APPROVED ORGANIZATIONS ONLY FOR PERIODS DURING WHICH AN APPROVED ORGANIZATION'S RESPONSIBILITIES INCLUDE MAKING SUCH ELIGIBILITY DETERMINATIONS.

S 26. Paragraph (e) and subparagraphs (i), (ii), (iii) and (v) of paragraph (f) of subdivision 2 of section 2511 of the public health law, paragraph (e) as added by chapter 170 of the laws of 1994 and relettered by chapter 2 of the laws of 1998, and subparagraphs (i) and (ii) of paragraph (f) as amended by section 6 of part B of chapter 58 of the laws of 2010, subparagraph (iii) of paragraph (f) as amended by chapter 535 of the laws of 2010, and subparagraph (v) of paragraph (f) as amended by section 7 of part J of chapter 82 of the laws of 2002, are amended to read as follows:

(e) is a resident of New York state. Such residency shall be [demonstrated by] ATTESTED TO BY THE APPLICANT FOR INSURANCE, PROVIDED HOWEVER, THE COMMISSIONER SHALL REQUIRE adequate proof[, as determined by the commissioner,] of a New York state street address IN ANY CIRCUMSTANCES WHEN THERE IS AN INCONSISTENCY WITH RESIDENCY INFORMATION FROM OTHER DATA SOURCES. [If the child has no street address, such proof may include, but not be limited to, school records or other documentation determined by the commissioner.]

(i) In order to establish income eligibility under this subdivision at initial application, a household shall provide [such documentation specified in subparagraph (iii) of this paragraph, as necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title] THE SOCIAL SECURITY NUMBERS FOR EACH PARENT AND LEGALLY RESPONSIBLE ADULT WHO IS A MEMBER OF THE HOUSEHOLD, SUBJECT TO SUBPARAGRAPH (V) OF THIS PARAGRAPH. The commissioner [may verify the accuracy of such income information provided by the household by matching it against] SHALL DETERMINE ELIGIBILITY BASED ON income information contained in databases to which the commissioner has access, including the state's wage reporting system pursuant to subdivision five of section one hundred seventy-one-a of the tax law and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law. THE COMMISSIONER SHALL REQUIRE AN ATTESTATION BY THE HOUSEHOLD THAT THE INCOME INFORMATION OBTAINED FROM ELECTRONIC DATA SOURCES IS ACCURATE. SUCH ATTESTATION SHALL INCLUDE ANY OTHER HOUSEHOLD INCOME INFORMATION NOT OBTAINED FROM AN ELECTRONIC DATA SOURCE THAT IS NECESSARY TO DETERMINE A CHILD'S FINANCIAL ELIGIBILITY FOR A SUBSIDY PAYMENT UNDER THIS TITLE. IF THE ATTESTATION IS INCONSISTENT WITH INFORMATION OBTAINED FROM AVAILABLE DATA SOURCES, DOCUMENTATION SHALL BE REQUIRED AS SPECIFIED IN SUBPARAGRAPH (III) OF THIS PARAGRAPH.

(ii) In order to establish income eligibility under this subdivision at recertification, a household shall attest to all information regarding the household's income that is necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title and shall provide the social security numbers for each parent and legally responsible adult who is a member of the household and whose income

is available to the child, subject to subparagraph (v) of this paragraph. The commissioner may verify the accuracy of such income information provided by the household by matching it against income information contained in databases to which the commissioner has access, including the state's wage reporting system and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law, AND MAY MAKE A REDETERMINATION OF ELIGIBILITY BASED ON RELIABLE INFORMATION CONTAINED IN DATABASES TO WHICH THE COMMISSIONER HAS ACCESS. THE COMMISSIONER SHALL REQUIRE AN ATTESTATION BY THE HOUSEHOLD THAT THE INCOME INFORMATION CONTAINED IN THE ENROLLMENT FILE OR OBTAINED FROM ELECTRONIC DATA SOURCES IS ACCURATE. SUCH ATTESTATION SHALL INCLUDE ANY OTHER HOUSEHOLD INCOME INFORMATION NOT OBTAINED FROM AN ELECTRONIC DATA SOURCE. In the event that there is an inconsistency between the income information attested to by the household and any information obtained by the commissioner from other sources pursuant to this subparagraph, and such inconsistency is material to the household's eligibility for a subsidy payment under this title, the commissioner shall require the [approved organization to obtain] HOUSEHOLD TO PROVIDE income documentation [from the household] as specified in subparagraph (iii) of this paragraph.

(iii) IF THE ATTESTATION OF HOUSEHOLD INCOME REQUIRED BY SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH IS IN ANY WAY INCONSISTENT WITH INFORMATION OBTAINED FROM DATA SOURCES, FURTHER DOCUMENTATION SHALL BE REQUIRED. Income documentation shall include, but not be limited to, one or more of the following for each parent and legally responsible adult who is a member of the household and whose income is available to the child;

(A) current annual income tax returns;

(B) paycheck stubs;

(C) written documentation of income from all employers; or

(D) written documentation of income eligibility of a child for free or reduced breakfast or lunch through the school meal program certified by the child's school, provided that:

(I) the commissioner may verify the accuracy of the information provided in the same manner and way as provided for in subparagraph (ii) of this paragraph; and

(II) such documentation may not be suitable proof of income in the event of a material inconsistency in income after the commissioner has performed verification pursuant to subparagraph (ii) of this paragraph; or

(E) other documentation of income (earned or unearned) as determined by the commissioner, provided, however, such documentation shall set forth the source of such income.

(v) In the event a household chooses not to provide the social security numbers required by [subparagraph] SUBPARAGRAPHS (I) AND (ii) of this paragraph, such household shall provide income documentation specified in subparagraph (iii) of this paragraph as a condition of the child's enrollment. Nothing in this paragraph shall be construed as obligating a household to provide social security numbers of parents or legally responsible adults as a condition of a child's enrollment or eligibility for a subsidy payment under this title.

S 27. Subparagraph (ii) of paragraph (g) of subdivision 2 of section 2511 of the public health law, as amended by section 29 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(ii) Effective September first two thousand seven, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN OR A LATER DATE CONCOMITANT WITH THE FULL IMPLEMENTATION OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BY THE DATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, temporary enrollment pursuant to subparagraph (i) of this paragraph shall be provided only to children who apply for recertification of coverage under this title who appear to be eligible for medical assistance under title eleven of article five of the social services law.

S 28. Paragraph (a) of subdivision 2-b of section 2511 of the public health law, as added by section 5 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(a) Effective October first, two thousand ten, for purposes of claiming federal financial participation under paragraph nine of subsection (c) of section twenty-one hundred five of the federal social security act[,] for individuals declaring to be citizens at initial application, AND, EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN OR A LATER DATE TO BE DETERMINED BY THE COMMISSIONER CONTINGENT UPON THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BEING FULLY IMPLEMENTED BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, a household shall provide:

(i) the social security number for the applicant to be verified by the commissioner in accordance with a process established by the social security administration pursuant to federal law, or

(ii) documentation of citizenship and identity of the applicant consistent with requirements under the medical assistance program, as specified by the commissioner on the initial application.

S 29. Paragraph (d) of subdivision 9 of section 2510 of the public health law, as added by section 72-a of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(d) for periods on or after July first, two thousand nine, amounts as follows:

(i) no payments are required for eligible children whose family [gross] household income is less than one hundred sixty percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the U.S. Department of Health and Human Services, whose family [gross] household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) nine dollars per month for each eligible child whose family [gross] household income is between one hundred sixty percent and two hundred twenty-two percent of the non-farm federal poverty level, but no more than twenty-seven dollars per month per family; and

(iii) fifteen dollars per month for each eligible child whose family [gross] household income is between two hundred twenty-three percent and two hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iv) thirty dollars per month for each eligible child whose family [gross] household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family;

(v) forty-five dollars per month for each eligible child whose family [gross] household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(vi) sixty dollars per month for each eligible child whose family [gross] household income is between three hundred fifty-one percent and four hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

S 30. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 2511 of the public health law, as amended by section 32 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(iii) effective September first, two thousand eight, resides in a household having a [gross] household income at or below four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services);

S 31. Subparagraph (ii) of paragraph (d) of subdivision 2 of section 2511 of the public health law, as amended by section 33 of part A of chapter 58 of the laws of 2007, clause (B) as amended by section 3 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

(ii) (A) The implementation of this paragraph for a child residing in a household having a [gross] household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall take effect only upon the commissioner's finding that insurance provided under this title is substituting for coverage under group health plans in excess of a percentage specified by the secretary of the federal department of health and human services. The commissioner shall notify the legislature prior to implementation of this paragraph.

(B) The implementation of clauses (A), (B), (C), (D), (E), (F), (G) and (I) of subparagraph (i) of this paragraph for a child residing in a household having a [gross] household income between two hundred fifty-one and four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall take effect September first, two thousand eight; provided however, the entirety of subparagraph (i) of this paragraph shall take effect and be applied to such children on the date federal financial participation becomes available for such population in accordance with the state's Title XXI child health plan. The commissioner shall monitor the number of children who are subject to the waiting period established pursuant to this clause.

S 32. Clauses (A) and (B) of subparagraph (i) of paragraph (b) of subdivision 18 of section 2511 of the public health law, as added by section 31 of part A of chapter 58 of the laws of 2007, are amended to read as follows:

(A) participation in the program for a child who resides in a household having a [gross] household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall be voluntary and an eligible child may disenroll from the premium assistance program at any time and enroll in individual coverage under this title; and

(B) participation in the program for a child who resides in a household having a [gross] household income between two hundred fifty-one and four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) and meets certain eligibility criteria shall be mandatory. A child in this income group who meets the criteria for enrollment in the premium assistance program shall not be eligible for individual coverage under this title;

S 33. Subparagraph (iv) of paragraph (b) and paragraph (d) of subdivision 9 of section 2511 of the public health law, as amended by section 18-a of chapter 2 of the laws of 1998, are amended to read as follows:

(iv) outstationing of persons who are authorized to provide assistance to families in completing the enrollment application process under this title and title eleven of article five of the social services law, [including the conduct of personal interviews pursuant to section three hundred sixty-six-a of the social services law and personal interviews required upon recertification under such section of the social services law,] in locations, such as community settings, which are geographically accessible to large numbers of children who may be eligible for benefits under such titles, and at times, including evenings and weekends, when large numbers of children who may be eligible for benefits under such titles are likely to be encountered. Persons outstationed in accordance with this subparagraph shall be authorized to make determinations of presumptive eligibility in accordance with paragraph (g) of subdivision two of section two thousand five hundred and eleven of this title; and

(d) Subject to the availability of funds therefor, training shall be provided for outstationed persons and employees of approved organizations to enable them to disseminate information, AND facilitate the completion of the application process under this subdivision[, and conduct personal interviews required by section three hundred sixty-six-a of the social services law and personal interviews required upon recertification under such section of the social services law].

S 33-a. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (s) to read as follows:

(S) ISSUE A READINESS REPORT TO THE LEGISLATURE, DETAILING THE STATUS OF THE STATEWIDE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER ESTABLISHED UNDER EXECUTIVE ORDER NUMBER FORTY-TWO OF TWO THOUSAND TWELVE, BY AUGUST THIRTIETH, TWO THOUSAND THIRTEEN. THE READINESS REPORT MAY BE PROVIDED IN ELECTRONIC FORMAT AND SHALL BE DISTRIBUTED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. THE READINESS REPORT SHALL OUTLINE THE PROGRESS AND PREPAREDNESS OF THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER AND DETAIL HOW THE EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL CARRY OUT THEIR RESPECTIVE FUNCTIONS INCLUDING BUT NOT LIMITED TO:

(I) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL BEGIN ACCEPTING APPLICATIONS ON OCTOBER FIRST, TWO THOUSAND THIRTEEN;

(II) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL CERTIFY QUALIFIED HEALTH PLANS;

(III) THE ANTICIPATED COST OF INDIVIDUAL AND SMALL GROUP PLANS BEING OFFERED IN THE HEALTH BENEFIT EXCHANGE;

(IV) THE NUMBER OF NAVIGATORS APPROVED;

(V) THE PLAN FOR FULL OPERATION BY JANUARY FIRST, TWO THOUSAND FOURTEEN; AND

(VI) THE PLAN TO BECOME FISCALLY SELF-SUSTAINING BY JANUARY FIRST, TWO THOUSAND FIFTEEN.

S 34. Paragraphs 9 and 10 of subsection (a) of section 2101 of the insurance law, as added by chapter 687 of the laws of 2003, are amended and a new paragraph 11 is added to read as follows:

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; [or]

(10) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission[.]; OR

(11) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE, AND PROVIDED THE PERSON DOES NOT SELL, SOLICIT, OR NEGOTIATE INSURANCE.

S 35. Paragraphs 8 and 9 of subsection (c) of section 2101 of the insurance law, paragraph 8 as amended and paragraph 9 as added by section 5 of part I of chapter 61 of the laws of 2011, are amended and a new paragraph 10 is added to read as follows:

(8) a person who is not a resident of this state who sells, solicits or negotiates a contract for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; [or]

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state[.]; OR

(10) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE, AND PROVIDED THE PERSON DOES NOT SELL, SOLICIT, OR NEGOTIATE INSURANCE.

S 36. Paragraphs 10 and 11 of subsection (k) of section 2101 of the insurance law, paragraph 10 as amended and paragraph 11 as added by section 6 of part I of chapter 61 of the laws of 2011, are amended and a new paragraph 12 is added to read as follows:

(10) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; [or]

(11) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not

authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state[.]; OR

(12) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031 TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE, AND PROVIDED THE PERSON DOES NOT SELL, SOLICIT, OR NEGOTIATE INSURANCE.

S 37. Intentionally omitted.

S 37-a. The section heading and subsections (a) and (c) of section 2120 of the insurance law is amended to read as follows:

Fiduciary capacity of insurance agents, insurance brokers, NAVIGATORS and reinsurance intermediaries. (a) Every insurance agent and every insurance broker acting as such in this state AND ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR shall be responsible in a fiduciary capacity for all funds received or collected as insurance agent [or], insurance broker, OR NAVIGATOR and shall not, without the express consent of his or its principal, mingle any such funds with his or its own funds or with funds held by him or it in any other capacity.

(c) This section shall not require any such agent, broker, NAVIGATOR or reinsurance intermediary to maintain a separate bank deposit for the funds of each such principal, if and as long as the funds so held for each such principal are reasonably ascertainable from the books of account and records of such agent, broker or reinsurance intermediary, as the case may be.

S 37-b. Subsections (a) and (d) of section 2123 of the insurance law, as amended by chapter 540 of the laws of 1996, paragraph 3 of subsection (a) as added by chapter 616 of the laws of 1997, the opening paragraph of paragraph 3 of subsection (a) as amended by chapter 13 of the laws of 2002, are amended to read as follows:

(a) (1) No agent or representative of any insurer or health maintenance organization authorized to transact life, accident or health insurance or health maintenance organization business in this state and no insurance broker, and no other person, firm, association or corporation, INCLUDING, BUT NOT LIMITED TO, ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, shall issue or circulate or cause or permit to be issued or circulated, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any policy or contract of life, accident or health insurance, any annuity contract or any health maintenance organization contract, delivered or issued for delivery or to be delivered or issued for delivery, in this state, or shall make any misleading estimate as to the dividends or share of surplus or additional amounts to be received in the future on such policy or contract, or shall make any false or misleading statement as to the dividends or share of surplus or additional amounts previously paid by any such insurer or health maintenance organization on similar policies or contracts, or shall make any misleading representation, or any misrepresentation, as to the financial condition of any such insurer

or health maintenance organization, or as to the legal reserve system upon which such insurer or health maintenance organization operates.

(2) No such person, firm, association or corporation shall make to any person or persons any incomplete comparison of any such policies or contracts of any insurer, insurers, or health maintenance organization, for the purpose of inducing, or tending to induce, such person or persons to lapse, forfeit or surrender any insurance policy or health maintenance organization contract.

(3) Any replacement of individual life insurance policies or individual annuity contracts of an insurer by an agent, representative of the same or different insurer or broker shall conform to standards promulgated by regulation by the superintendent. Such regulation shall:

(A) specify what constitutes the replacement of a life insurance policy or annuity contract and the proper disclosure and notification procedures to replace a policy or contract;

(B) require notification of the proposed replacement to the insurer whose policies or contracts are intended to be replaced;

(C) require the timely exchange of illustrative and cost information required by section three thousand two hundred nine of this chapter and necessary for completion of a comparison of the proposed and replaced coverage; and

(D) provide for a sixty-day period following issuance of the replacement policies or contracts during which the policy or contract owner may return the policies or contracts and reinstate the replaced policies or contracts.

(d) Any agent or representative of an insurer or health maintenance organization, any insurance broker and any other person, firm, association or corporation INCLUDING, BUT NOT LIMITED TO, ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, who, or which, shall violate any of the provisions of this section and shall knowingly receive any compensation or commission for the sale OR PLACEMENT of any insurance policy, health maintenance organization or annuity contract induced by a violation of this section shall also be liable for a civil penalty in the amount received by such violator as compensation or commission, which penalty may be sued for and recovered for his own use and benefit by any person induced to purchase an insurance policy, health maintenance organization or annuity contract by such violation. In addition, such agent, representative, broker, person, firm, association or corporation violating this section shall be liable for a civil penalty in the amount of any compensation or commission lost by any agent, representative or broker as a result of a violation of this section or the making of such false or misleading statement, which penalty may be sued for and recovered for his own use and benefit by such agent, representative or broker.

S 38. Subparagraph (B) of paragraph 25 of subsection (i) of section 3216 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(B) Every policy [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deduct-

ibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per POLICY OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 39. Subparagraph (B) of paragraph 17 of subsection (1) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(B) Every group or blanket policy [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the group or blanket policy. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per POLICY OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the group or blanket policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 40. Paragraph 2 of subsection (ee) of section 4303 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(2) Every contract [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this [subsection] PARAGRAPH and shall not exclude coverage for the screening, diagnosis or treatment of medical

conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per CONTRACT OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 40-a. Paragraph 1 of subsection (d) of section 3221 of the insurance law is amended to read as follows:

(1) The superintendent may approve any form of certificate to be issued under a blanket accident and health insurance policy as defined in section four thousand two hundred thirty-seven of this chapter, which omits or modifies any of the provisions hereinbefore required, if [he] THE SUPERINTENDENT deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. CERTIFICATES ISSUED UNDER A POLICY OR CONTRACT OF STUDENT ACCIDENT AND HEALTH INSURANCE AS DEFINED IN SECTION THREE THOUSAND TWO HUNDRED FORTY OF THIS ARTICLE SHALL COMPLY WITH SUCH SECTION.

S 41. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. STUDENT ACCIDENT AND HEALTH INSURANCE. (A) IN THIS SECTION:

(1) "STUDENT ACCIDENT AND HEALTH INSURANCE" MEANS A POLICY OR CONTRACT OF HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BY AN INSURER OR A CORPORATION, TO AN INSTITUTION OF HIGHER EDUCATION COVERING STUDENTS ENROLLED IN THE INSTITUTION AND THE STUDENTS' DEPENDENTS.

(2) "INSTITUTION OF HIGHER EDUCATION" OR "INSTITUTION" SHALL HAVE THE MEANING SET FORTH IN THE HIGHER EDUCATION ACT OF 1965, 20 U.S.C. S 1001.

(3) "INSURER" MEANS AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE PURSUANT TO THIS CHAPTER.

(4) "CORPORATION" MEANS A CORPORATION ORGANIZED IN ACCORDANCE WITH ARTICLE FORTY-THREE OF THIS CHAPTER.

(B) AN INSURER OR CORPORATION SHALL NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT. AN INSURER OR CORPORATION SHALL NOT CONDITION ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, FOR A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT ON HEALTH STATUS, MEDICAL CONDITION, INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES, CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE, MEDICAL HISTORY, GENETIC INFORMATION, EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE, OR DISABILITY.

(C) AN INSURER OR CORPORATION SHALL CONDITION ELIGIBILITY INCLUDING CONTINUING ELIGIBILITY, ON THE COVERED INDIVIDUAL BEING ENROLLED AS A STUDENT IN AN INSTITUTION OF HIGHER EDUCATION TO WHICH THE STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT IS ISSUED.

(D) A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT SHALL PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS AS DEFINED IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

(E) AN INSURER OR CORPORATION SHALL NOT REFUSE TO RENEW OR OTHERWISE TERMINATE A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT EXCEPT FOR ONE OR MORE OF THE REASONS SET FORTH IN:

(1) SUBPARAGRAPHS (A), (B), (D) OR (G) OF PARAGRAPH TWO OF SUBSECTION (P) OF SECTION THREE THOUSAND TWO HUNDRED TWENTY-ONE OF THIS ARTICLE; OR

(2) SUBPARAGRAPHS (A), (B), (D) OR (G) OF PARAGRAPH TWO OF SUBSECTION (J) OF SECTION FOUR THOUSAND THREE HUNDRED FIVE OF THIS CHAPTER.

(F) THIS SECTION SHALL NOT APPLY TO COVERAGE UNDER A STUDENT HEALTH PLAN ISSUED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER.

(G) THE RATIO OF BENEFITS TO PREMIUMS SHALL BE NOT LESS THAN EIGHTY-TWO PERCENT AS CALCULATED IN A MANNER TO BE DETERMINED BY THE SUPERINTENDENT.

S 42. Intentionally omitted.

S 43. Intentionally omitted.

S 43-a. Item (i) of subparagraph (C) of paragraph 2 of subsection (c) of section 4304 of the insurance law, as amended by section 9 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(i) Discontinuance of a class of contract upon not less than five months' prior written notice[, except for subscribers to direct pay major medical or similar comprehensive-type coverage issued by a corporation organized pursuant to this article, or any successor corporation organized through a conversion pursuant to subsection (j) of section four thousand three hundred one of this article, and in effect prior to January first, nineteen hundred ninety-six who are ineligible to purchase policies offered after such date pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this article due to the provisions of 42 U.S.C. 1395ss in effect on the effective date of this item. In the event any such subscriber becomes eligible to purchase policies offered pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this article, then such subscriber may be discontinued upon not less than five months' prior written notice]. In exercising the option to discontinue coverage pursuant to this item, the corporation must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and must offer to subscribers or group remitting agents, as may be appropriate, the option to purchase all other individual health insurance coverage currently being offered by the corporation to applicants in that market.

S 44. The section heading and subsection (a) of section 4321 of the insurance law, the section heading as added by chapter 504 of the laws of 1995 and subsection (a) as amended by chapter 342 of the laws of 2004, are amended to read as follows:

Standardization of individual enrollee direct payment contracts offered by health maintenance organizations PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. (a) On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN all health maintenance organizations issued a certificate of authority under

article forty-four of the public health law or licensed under this article shall offer a standardized individual enrollee contract on an open enrollment basis as prescribed by section forty-three hundred seventeen of this article and section forty-four hundred six of the public health law, and regulations promulgated thereunder, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, the enrollee contracts issued pursuant to this section and section four thousand three hundred twenty-two of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-two of this article shall also be the only contracts issued by health maintenance organizations for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prevent health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

S 45. The section heading and subsection (a) of section 4322 of the insurance law, the section heading as added by chapter 504 of the laws of 1995 and subsection (a) as amended by chapter 342 of the laws of 2004, are amended to read as follows:

Standardization of individual enrollee direct payment contracts offered by health maintenance organizations which provide out-of-plan benefits PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. (a) On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer to individuals, in addition to the standardized contract required by section four thousand three hundred twenty-one of this article, a standardized individual enrollee direct payment contract on an open enrollment basis as prescribed by section four thousand three hundred seventeen of this article and section four thousand four hundred six of the public health law, and regulations promulgated thereunder, with an out-of-plan benefit system, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an indi-

vidual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. The out-of-plan benefit system shall either be provided by the health maintenance organization pursuant to subdivision two of section four thousand four hundred six of the public health law or through an accompanying insurance contract providing out-of-plan benefits offered by a company appropriately licensed pursuant to this chapter. On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, the contracts issued pursuant to this section and section four thousand three hundred twenty-one of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-one of this article shall also be the only contracts issued by the health maintenance organization for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prohibit health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

S 46. The insurance law is amended by adding a new section 4328 to read as follows:

S 4328. INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS OFFERED BY HEALTH MAINTENANCE ORGANIZATION ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN. (A) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, EVERY HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTICLE, OR AN AFFILIATED INSURER OR HEALTH MAINTENANCE ORGANIZATION SHALL OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION; PROVIDED, HOWEVER, THAT THIS REQUIREMENT SHALL NOT APPLY TO A HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW, EXCEPT AS OTHERWISE REQUIRED UNDER SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS ARTICLE, OR A HEALTH MAINTENANCE ORGANIZATION EXCLUSIVELY SERVING INDIVIDUALS ENROLLED PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW OR TITLE EIGHTEEN OF THE FEDERAL SOCIAL SECURITY ACT. THE ENROLLEE CONTRACTS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION UNDER THIS SECTION ALSO SHALL BE THE ONLY CONTRACTS ISSUED BY THE HEALTH MAINTENANCE ORGANIZATION FOR PURPOSES OF CONVERSION PURSUANT TO SECTIONS FOUR THOUSAND THREE HUNDRED FOUR AND FOUR THOUSAND THREE HUNDRED FIVE OF THIS ARTICLE.

(B) (1) WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, A HEALTH MAINTENANCE ORGANIZATION MAY OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT THAT IS A CATASTROPHIC HEALTH PLAN AS DEFINED IN SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), OR ANY REGULATIONS PROMULGATED THEREUNDER.

(2) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL HAVE THE SAME ENROLLMENT PERIODS, INCLUDING

SPECIAL ENROLLMENT PERIODS, AS REQUIRED FOR AN INDIVIDUAL DIRECT PAYMENT CONTRACT OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER.

(3) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL BE ISSUED WITHOUT REGARD TO EVIDENCE OF INSURABILITY AND WITHOUT AN EXCLUSION FOR PRE-EXISTING CONDITIONS.

(4) A HEALTH MAINTENANCE ORGANIZATION OFFERING AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT PURSUANT TO THIS SECTION SHALL NOT ESTABLISH RULES FOR ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, OF ANY INDIVIDUAL OR DEPENDENT OF THE INDIVIDUAL TO ENROLL UNDER THE CONTRACT BASED ON ANY OF THE FOLLOWING HEALTH STATUS-RELATED FACTORS:

(A) HEALTH STATUS;

(B) MEDICAL CONDITION, INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES;

(C) CLAIMS EXPERIENCE;

(D) RECEIPT OF HEALTH CARE;

(E) MEDICAL HISTORY;

(F) GENETIC INFORMATION;

(G) EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE; OR

(H) DISABILITY.

(5) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL BE COMMUNITY RATED. FOR PURPOSES OF THIS PARAGRAPH, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUM FOR ALL PERSONS COVERED BY A CONTRACT FORM IS THE SAME, BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS, WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE, OR OCCUPATION.

(C) IN ADDITION TO OR IN LIEU OF THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS REQUIRED UNDER THIS SECTION, ALL HEALTH MAINTENANCE ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTICLE MAY OFFER INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER.

(D)(1) NOTHING IN THIS SECTION SHALL BE DEEMED TO REQUIRE HEALTH MAINTENANCE ORGANIZATIONS TO DISCONTINUE INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN OR PREVENT HEALTH MAINTENANCE ORGANIZATIONS FROM DISCONTINUING INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. IF A HEALTH MAINTENANCE ORGANIZATION DISCONTINUES INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN, REGARDLESS OF WHETHER IT IS A GRANDFATHERED HEALTH PLAN, THEN THE HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH THE REQUIREMENTS OF SUBSECTION (C) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS ARTICLE.

(2) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 46-a. Paragraph 5 of subsection (c) of section 3216 of the insurance law is amended to read as follows:

(5) (A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy

but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to [him] THAT PERSON by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within thirty-one days after such insurance shall have terminated, an individual conversion policy. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

(B) Written notice of entitlement to a conversion policy shall be given by the insurer to the policyholder at least fifteen and not more than sixty days prior to the termination of coverage due to the initial limiting age of the covered dependent. Such notice shall include an explanation of the rights of the dependent with respect to [his] THE DEPENDENT being enrolled in an accredited institution of learning or his incapacity for self-sustaining employment by reason of mental illness, developmental disability or mental retardation as defined in the mental hygiene law or physical handicap.

(C) Such individual conversion policy shall be subject to the following terms and conditions:

(i) The premium shall be that applicable to the [class of risk to which such person belongs, to the age of such person and to the] form and amount of insurance therefor.

(ii) [Such policy shall provide, on a basis specified in the family policy, the same or substantially the same benefits as those provided in the family policy or such benefits as are provided in a policy specifically approved as an individual conversion policy by the superintendent.

(iii)] The benefits provided under such policy shall become effective upon the date that such person was no longer eligible under the family policy.

[(iv) The policy may exclude any condition excluded by the family policy for such person at the time of the termination of his insurance thereunder. The policy shall not exclude any other pre-existing conditions, but the benefits paid under such policy may be reduced by the amount of any such benefits payable under the family policy after the termination of such person's insurance thereunder and, during the first policy year of the conversion policy, the benefits payable under the policy may be reduced so that they are not in excess of those that would have been payable had such person's insurance under the family policy remained in force and effect.

(v)] (III) No insurer shall be required to issue a conversion policy if it appears that the person applying for such policy shall have at that time in force another insurance policy or hospital service or medical expense indemnity contract providing similar benefits or is covered by or is eligible for coverage by a group insurance policy or contract providing similar benefits or shall be covered by similar benefits required by any statute or provided by any welfare plan or program, which together with the conversion policy would result in over insurance or duplication of benefits according to standards on file with the superintendent relating to individual policies.

[(vi)] (IV) The policy may include a provision whereby the insurer may request information at any premium due date of the policy of the person covered thereunder as to whether he is then covered by another policy or hospital service or medical expense indemnity corporation subscriber contract providing similar benefits or is then covered by a group contract or policy providing similar benefits or is then provided with

similar benefits required by any statute or provided by any welfare plan or program. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits payable under the conversion policy may be based on the hospital surgical or medical expenses actually incurred after excluding expenses to the extent they are payable under such other coverage or provided under such statute, plan, or program.

S 46-b. Subdivision 1 of section 4406 of the public health law, as amended by chapter 342 of the laws of 2004, is amended to read as follows:

1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual [and any group of fifty or fewer employees or members, exclusive of spouses and dependents, or any employee or member of the group, including dependents,] applying for such contract at any time throughout the year, and may include a pre-existing condition provision as provided for in section four thousand three hundred eighteen of the insurance law, provided, however, [that] THE OBLIGATION OF THE HEALTH MAINTENANCE ORGANIZATION SHALL BE DEEMED SATISFIED IF such COVERAGE IS OFFERED BY AN AFFILIATE OR SUBSIDIARY. THE requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of [this article] THE INSURANCE LAW due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condition provision, elect to offer contracts without a pre-existing condition provision to [such groups] INDIVIDUALS but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care services or benefits during such period and no premium shall be charged for any coverage during the period. After January first, nineteen hundred ninety-six, all individual direct payment contracts shall be issued only pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of the insurance law. Such contracts may not, with respect to an eligible individual (as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. S 300gg-41(b), impose any pre-existing condition exclusion.

S 47. Paragraphs 4, 6, 9 and 10 of subsection (e) of section 3221 of the insurance law are REPEALED, paragraphs 5, 7, 8, 11 and 12 are renum-

bered paragraphs 4, 5, 6, 7 and 8 and paragraph 1, as amended by chapter 306 of the laws of 1987, is amended to read as follows:

(1) A group policy providing hospital, MEDICAL or surgical expense insurance for other than specific diseases or accident only, shall provide that if the insurance on an employee or member insured under the group policy ceases because of termination of [(I)] (A) employment or of membership in the class or classes eligible for coverage under the policy or [(II)] (B) the policy, for any reason whatsoever, unless the policyholder has replaced the group policy with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group policy [for at least three months] shall be entitled to have issued to [him] THE INSURED by the insurer without evidence of insurability upon application made to the insurer within forty-five days after such termination, and payment of the quarterly, or, at the option of the employee or member, a less frequent premium applicable to the [class of risk to which the person belongs, the age of such person, and the] form and amount of insurance, an individual policy of insurance. The insurer may, at its option elect to provide the insurance coverage under a group insurance policy, delivered in this state, in lieu of the issuance of a converted individual policy of insurance. Such individual policy, or group policy, as the case may be is hereafter referred to as the converted policy. The benefits provided under the converted policy shall be those required by subsection (f)[, (g), (h) or (i) hereof] OF THIS SECTION, [whichever is applicable and,] in the event of termination of the converted group policy of insurance, each insured thereunder shall have a right of conversion to a converted individual policy of insurance.

S 48. Paragraph 3 of subsection (e) of section 3221 of the insurance law, as separately amended by chapters 370 and 869 of the laws of 1984, is amended to read as follows:

(3) The converted policy shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group policy. Provided, however, that if the employee or member chooses the option of dependent coverage then dependents acquired after the permitted time to convert stated in paragraph one of this subsection shall be added to the converted family policy in accordance with the provisions of subsection (c) of section thirty-two hundred sixteen of this article and any regulations promulgated or guidelines issued by the superintendent. The converted policy need not provide benefits in excess of those provided for such persons under the group policy from which conversion is made [and may contain any exclusion or benefit limitation contained in the group policy or customarily used in individual policies]. The effective date of the individual's coverage under the converted policy shall be the date of the termination of the individual's insurance under the group policy as to those persons covered under the group policy.

S 49. Subsections (f) and (g) of section 3221 of the insurance law are REPEALED and a new subsection (f) is added to read as follows:

(F) IF THE GROUP INSURANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, OR IF THE GROUP INSURANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, THEN THE CONVERSION PRIVILEGE SHALL ENTITLE THE EMPLOYEE OR MEMBER TO OBTAIN COVERAGE UNDER A CONVERTED POLICY PROVIDING, AT THE INSURED'S OPTION, COVERAGE ON AN EXPENSE INCURRED BASIS.

S 50. Subparagraph (D) of paragraph 4 of subsection (l) of section 3221 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state [which] WHERE THE policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in such policy, by physicians, psychiatrists or psychologists, [must] SHALL provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior [which] THAT are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous or emotional disorders or ailments[, or]; (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection [(h)] (E) of this section, or (iii) a combination of the experience specified in items (i) and (ii) OF THIS SUBPARAGRAPH totaling three years, satisfactory to the state board for social work.

(E) The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under [this] subparagraph (D) OF THIS PARAGRAPH.

S 51. Paragraph 3 of subsection (e) of section 4304 of the insurance law is REPEALED and paragraphs 4 and 5 are renumbered paragraphs 3 and 4, and paragraphs 1 and 2 of such subsection (e), paragraph 1 as amended by chapter 661 of the laws of 1997, and as further amended by section 104 of part A of chapter 62 of the laws of 2011, are amended to read as follows:

(1) If any such contract is terminated in accordance with the provisions of paragraph one of subsection (c) [hereof] OF THIS SECTION, or any such contract is terminated because of a default by the remitting agent in the payment of premiums not cured within the grace period and the remitting agent has not replaced the contract with similar and continuous coverage for the same group whether insured or self-insured, or any such contract is terminated in accordance with the provisions of subparagraph (E) of paragraph two of subsection (c) [hereof] OF THIS SECTION, or if an individual other than the contract holder is no longer covered under a "family contract" because [he] THE INDIVIDUAL is no longer within the definition set forth in the contract, or a spouse is no longer covered under the contract because of divorce from the contract holder or annulment of the marriage, or any such contract is terminated because of the death of the contract holder, then such individual, former spouse, or in the case of the death of the contract holder the surviving spouse or other dependents of the deceased contract holder covered under the contract, as the case may be, shall be entitled to convert, without evidence of insurability, upon application therefor

and the making of the first payment thereunder within thirty-one days after the date of termination of such contract, to a contract [of a type which provides coverage most nearly comparable to the type of coverage under the contract from which the individual converted, which coverage shall be no less than the minimum standards for basic hospital, basic medical, or major medical as provided for in department of financial services regulation; provided, however, that if the corporation does not issue such a major medical contract, then to a comprehensive or comparable type of coverage which is most commonly being sold to group remitting agents. Notwithstanding the previous sentence, a corporation may elect to issue a standardized individual enrollee contract pursuant to section four thousand three hundred twenty-two of this article in lieu of a major medical contract, comprehensive or comparable type of coverage required to be offered upon conversion from an indemnity contract] THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS ARTICLE. The effective date of the coverage provided by the converted direct payment contract shall be the date of the termination of coverage under the contract from which conversion was made.

(2) The corporation shall not be required to issue any such converted individual direct payment contract if its issuance would result in overinsurance or duplication of benefits according to standards on file with the superintendent and approved by [him] THE SUPERINTENDENT with regard to such contracts. The individual direct payment contract may include a provision whereby the corporation may request information when any payment is due under the contract of the person covered thereunder as to whether he is then covered by another individual contract providing similar benefits or is then covered by a group contract policy providing similar benefits or is then provided with similar benefits required by any statute or provided by any welfare plan or program which together with the converted individual direct payment contract would result in overinsurance or duplication of benefits according to the standards on file with the superintendent relating to individual contracts. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits provided under the converted individual direct payment contract may be based on the hospital, surgical or medical expenses actually incurred after excluding expenses to the extent they are payable under such other coverage or provided under such statute, plan or program.

S 52. Paragraphs 1 and 2 of subsection (d) of section 4305 of the insurance law, paragraph 1 as amended by chapter 504 of the laws of 1995 and paragraphs 1 and 2 as further amended by section 104 of part A of chapter 62 of the laws of 2011, are amended to read as follows:

(1) (A) A group contract issued pursuant to this section shall contain a provision to the effect that in case of a termination of coverage under such contract of any member of the group because of [(I)] (I) termination for any reason whatsoever of [his] THE MEMBER'S employment or membership, [if he has been covered under the group contract for at least three months,] or [(II)] (II) termination for any reason whatsoever of the group contract itself unless the group contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, [he] THE MEMBER shall be entitled to have issued to [him] THE MEMBER by the corporation, without evidence of insurability, upon application therefor and payment of the first premium made to the corporation within forty-five days after termination of the coverage, an individual direct payment contract,

covering such member and [his] THE MEMBER'S eligible dependents who were covered by the group contract, which provides coverage [most nearly comparable to the type of coverage under the group contract, which coverage shall be no less than the minimum standards for basic hospital, basic medical, or major medical as provided for in department of financial services regulation; provided, however, that if the corporation does not issue such a major medical contract, then to a comprehensive or comparable type of coverage which is most commonly being sold to group remitting agents. Notwithstanding the previous sentence, a corporation may elect to issue a standardized individual enrollee contract pursuant to section four thousand three hundred twenty two of this article in lieu of a major medical contract, comprehensive or comparable type of coverage required to be offered upon conversion from an indemnity contract] THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS ARTICLE.

(B) The conversion privilege afforded [herein] IN THIS PARAGRAPH shall also be available: [(A)] (I) upon the divorce or annulment of the marriage of a member, to the divorced spouse or former spouse of such member[, (B)]; (II) upon the death of the member, to the surviving spouse and other dependents covered under the contract[,]; and [(C)] (III) to a dependent if no longer within the definition in the contract.

(2) The effective date of the coverage provided by the individual direct payment contract shall be the date of the termination of the individual's coverage under the group contract. [The individual direct payment converted contract may exclude any condition excluded by the group contract. The individual direct payment contract shall not exclude any other pre-existing conditions but the benefits provided under the individual direct payment converted contract may be reduced by the amount of any such benefits provided under the group contract after the termination of the individual's coverage thereunder and during the first contract year of such individual direct payment converted contract the benefits provided under the contract may be reduced so that they are not in excess of those that would have been provided had the individual's contract under the group contract remained in force and effect.] The corporation shall not be required to issue such individual direct payment converted contract covering any person if it appears that such person shall then be covered by another individual contract providing similar coverage or if it shall appear that such person is covered by or eligible to be covered by a group contract or policy providing similar benefits or is provided with similar benefits required by any statute or provided by any welfare plan or program, which together with the individual direct payment converted contract would result in over-insurance or duplication of benefits according to standards on file with the superintendent of financial services relating to individual contracts. The individual direct payment converted contract may include a provision whereby the corporation may request information when any payment is due under the contract of any person covered thereunder as to whether he is then covered by another contract or by a policy providing similar benefits or is then covered by a group contract or policy providing similar benefits or is then provided with similar benefits required by any statute or provided by any welfare plan or program. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits payable under the individual direct payment converted contract may be based on the hospital, surgical or medical expenses actually incurred after excluding expenses to the extent they

are payable under such other coverage or provided under such statute, plan or program.

In the event the benefits provided or payable are reduced in accordance with the provisions of this subsection the corporation shall return such portion of the premium paid as shall exceed the pro rata portion of the benefits thus determined.

S 53. Intentionally omitted.

S 54. Intentionally omitted.

S 55. Intentionally omitted.

S 56. Section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (b) as amended by chapter 342 of the laws of 2004, subparagraph (A) of paragraph 1 and subparagraph (C) of paragraph 3 of subsection (c) as amended by chapter 419 of the laws of 2000, paragraphs 13 and 14 of subsection (d), paragraphs 6 and 7 of subsection (e) and subsection (k) as amended and paragraph 15 of subsection (d) as added by chapter 219 of the laws of 2011 and subsections (d-1), (d-2) and (d-3) as added by chapter 645 of the laws of 2005, is amended to read as follows:

S 4326. Standardized health insurance contracts for qualifying small employers and individuals. (a) A program is hereby established for the purpose of making standardized health insurance contracts available to qualifying small employers [and qualifying individuals] as defined in this section. Such program is designed to encourage small employers to offer health insurance coverage to their employees [and to also make coverage available to uninsured employees whose employers do not provide group health insurance].

(b) Participation in the program established by this section and section four thousand three hundred twenty-seven of this article is limited to corporations or insurers organized or licensed under this article or article forty-two of this chapter and health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article. Participation by all health maintenance organizations is mandatory, provided, however, that such requirements shall not apply to a HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW OR A health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. On and after January first, two thousand one, all health maintenance organizations shall offer qualifying group health insurance contracts [and qualifying individual health insurance contracts] as defined in this section. For the purposes of this section and section four thousand three hundred twenty-seven of this article, article forty-three corporations or article forty-two insurers which voluntarily participate in compliance with the requirements of this program shall be eligible for reimbursement from the stop loss funds created pursuant to section four thousand three hundred twen-

ty-seven of this article under the same terms and conditions as health maintenance organizations.

(c) The following definitions shall be applicable to the insurance contracts offered under the program established by this section:

(1) (A) A qualifying small employer is [an employer that is either:

(A) An individual proprietor who is the only employee of the business:

(i) without health insurance which provides benefits on an expense reimbursed or prepaid basis in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(ii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income;

(iii) except that the requirements set forth in item (i) of this subparagraph shall not be applicable where an individual proprietor had health insurance coverage during the previous twelve months and such coverage terminated due to one of the reasons set forth in items (i) through (viii) of subparagraph (C) of paragraph three of subsection (c) of this section; or

(B) An] AN employer with:

(i) not more than fifty eligible employees;

(ii) no group health insurance [which] THAT provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(iii) at least thirty percent of its eligible employees receiving annual wages from the employer at a level equal to or less than thirty thousand dollars. The thirty thousand dollar figure shall be adjusted periodically pursuant to subparagraph [(F)] (D) of this paragraph.

[(C) The requirements set forth in item (i) of subparagraph (A) of this paragraph and in item (ii) of subparagraph (B) of this paragraph shall not be applicable where an individual proprietor or employer is transferring from a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or from health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(D)] (B) The twelve month period set forth [in item (i) of subparagraph (A) of this paragraph and] in item (ii) of subparagraph [(B)] (A) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of [other health insurance contracts for] qualifying group health insurance contracts FOR OTHER HEALTH INSURANCE CONTRACTS.

[(E)] (C) An [individual proprietor or] employer shall cease to be a qualifying small employer if any health insurance [which] THAT provides benefits on an expense reimbursed or prepaid basis covering [the individual proprietor or] an employer's employees, other than qualifying group health insurance purchased pursuant to this section, is purchased or otherwise takes effect subsequent to purchase of qualifying group health insurance under the program established by this section.

[(F)] (D) The wage levels utilized in subparagraph [(B)] (A) of this paragraph shall be adjusted annually, beginning in two thousand two. The

adjustment shall take effect on July first of each year. For July first, two thousand two, the adjustment shall be a percentage of the annual wage figure specified in subparagraph [(B)] (A) of this paragraph. For subsequent years, the adjustment shall be a percentage of the annual wage figure [which] THAT took effect on July first of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal department of health and human services, for a family unit of four persons for the forty-eight contiguous states and Washington, D.C., changed from the same level established for the prior year.

(2) A qualifying group health insurance contract is a group contract purchased from a health maintenance organization, corporation or insurer by a qualifying small employer [which] THAT provides the benefits set forth in subsection (d) of this section. The contract must insure not less than fifty percent of the employees [eligible for coverage].

[(3)(A) A qualifying individual is an employed person:

(i) who does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the twelve month period prior to the individual's application for health insurance under the program established by this section;

(ii) whose employer does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to the individual's application for health insurance under the program established by this section;

(iii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income; and

(iv) is ineligible for Medicare.

(B) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual is transferring from a health insurance contract issued pursuant to the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(C) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual had health insurance coverage during the previous twelve months and such coverage terminated due to:

(i) loss of employment due to factors other than voluntary separation;

(ii) death of a family member which results in termination of coverage under a health insurance contract under which the individual is covered;

(iii) change to a new employer that does not provide group health insurance with benefits on an expense reimbursed or prepaid basis;

(iv) change of residence so that no employer-based health insurance with benefits on an expense reimbursed or prepaid basis is available;

(v) discontinuation of a group health insurance contract with benefits on an expense reimbursed or prepaid basis covering the qualifying individual as an employee or dependent;

(vi) expiration of the coverage periods established by the continuation provisions of the Employee Retirement Income Security Act, 29

U.S.C. section 1161 et seq. and the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the continuation provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of this chapter;

(vii) legal separation, divorce or annulment which results in termination of coverage under a health insurance contract under which the individual is covered; or

(viii) loss of eligibility under a group health plan.

(D) The twelve month period set forth in items (i) and (ii) of subparagraph (A) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(4) A qualifying individual health insurance contract is an individual contract issued directly to a qualifying individual and which provides the benefits set forth in subsection (d) of this section. At the option of the qualifying individual, such contract may include coverage for dependents of the qualifying individual.]

(d) [The contracts issued pursuant to this section by health maintenance organizations, corporations or insurers and approved by the superintendent shall only provide in-plan benefits, except for emergency care or where services are not available through a plan provider. Covered services shall include only the following:

(1) inpatient hospital services consisting of daily room and board, general nursing care, special diets and miscellaneous hospital services and supplies;

(2) outpatient hospital services consisting of diagnostic and treatment services;

(3) physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services (including breast reconstruction surgery after a mastectomy), anesthesia services, second surgical opinion, and a second opinion for cancer treatment;

(4) outpatient surgical facility charges related to a covered surgical procedure;

(5) preadmission testing;

(6) maternity care;

(7) adult preventive health services consisting of mammography screening; cervical cytology screening; periodic physical examinations no more than once every three years; and adult immunizations;

(8) preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations;

(9) equipment, supplies and self-management education for the treatment of diabetes;

(10) diagnostic x-ray and laboratory services;

(11) emergency services;

(12) therapeutic services consisting of radiologic services, chemotherapy and hemodialysis;

(13) blood and blood products furnished in connection with surgery or inpatient hospital services;

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, health maintenance organizations may utilize a mail order prescription drug program.

Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician; and

(15) for a contract that is not a grandfathered health plan, the following additional preventive health services:

(A) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(B) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(C) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration; and

(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this paragraph as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e)] A QUALIFYING GROUP HEALTH INSURANCE CONTRACT SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS SUBSECTION "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A).

(d-1) Covered services shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by corporations, insurers or health maintenance organizations for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations, corporations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(d-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages for any decision or action pursuant to subsection (d-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(d-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the standardized health insurance contract established by

this section for those persons required to register as sex offenders pursuant to article six-C of the correction law.

(e) [The benefits provided in the contracts described in subsection (d) of this section shall be subject to the following deductibles and copayments:

(1) in-patient hospital services shall have a five hundred dollar copayment for each continuous hospital confinement;

(2) surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence;

(3) outpatient surgical facility charges shall be subject to a facility copayment charge of seventy-five dollars per occurrence;

(4) emergency services shall have a fifty dollar copayment which must be waived if hospital admission results from the emergency room visit;

(5) prescription drugs shall have a one hundred dollar calendar year deductible per individual. After the deductible is satisfied, each thirty-four day supply of a prescription drug will be subject to a copayment. The copayment will be ten dollars if the drug is generic. The copayment for a brand name drug will be twenty dollars plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, a twenty dollar copayment shall be imposed on a ninety day supply of generic prescription drugs. A forty dollar copayment plus the difference in cost between the brand name drug and the equivalent generic drug shall be imposed on a ninety day supply of brand name prescription drugs. In no event shall the copayment exceed the cost of the prescribed drug;

(6) (A) the maximum coverage for prescription drugs in an individual contract that is a grandfathered health plan shall be three thousand dollars per individual in a calendar year; and

(B) the maximum dollar amount on coverage for prescription drugs in an individual contract that is not a grandfathered health plan or in any group contract shall be consistent with section 2711 of the Public Health Service Act, 42 U.S.C. S 300gg-11 or any regulations thereunder.

(C) For purposes of this paragraph, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e); and

(7) all other services shall have a twenty dollar copayment with the exception of prenatal care which shall have a ten dollar copayment or preventive health services provided pursuant to paragraph fifteen of subsection (d) of this section, for which no copayment shall apply] A QUALIFYING GROUP HEALTH INSURANCE CONTRACT ISSUED TO A QUALIFYING SMALL EMPLOYER PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DOES NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A), SHALL BE DISCONTINUED. A QUALIFYING SMALL EMPLOYER SHALL BE TRANSITIONED TO A PLAN THAT PROVIDES: (1) A LEVEL OF COVERAGE THAT IS DESIGNED TO PROVIDE BENEFITS THAT ARE ACTUARIALLY EQUIVALENT TO EIGHTY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN; AND (2) COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). THE SUPERINTENDENT SHALL STANDARDIZE THE BENEFIT PACKAGE AND COST SHARING REQUIREMENTS OF QUALIFIED GROUP HEALTH INSURANCE CONTRACTS CONSISTENT WITH COVERAGE OFFERED THROUGH THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031.

(f) [Except as included in the list of covered services in subsection (d) of this section, the] THE mandated and make-available benefits set forth in sections [three thousand two hundred sixteen,] three thousand two hundred twenty-one of this chapter and four thousand three hundred three of this article shall not be applicable to the contracts issued pursuant to this section. [Mandated benefits included in such contracts shall be subject to the deductibles and copayments set forth in subsection (e) of this section.]

(g) [The superintendent shall be authorized to modify, by regulation, the copayment and deductible amounts described in this section if the superintendent determines such amendments are necessary to facilitate implementation of this section. On or after January first, two thousand two, the superintendent shall be authorized to establish, by regulation, one or more additional standardized health insurance benefit packages if the superintendent determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public.

(h)] A health maintenance organization, corporation or insurer must offer the benefit package without change or additional benefits. [Qualifying] A QUALIFYING small [employers] EMPLOYER shall be issued the benefit package in a qualifying group health insurance contract. [Qualifying individuals shall be issued the benefit package in a qualifying individual health insurance contract.

(i)] (H) A health maintenance organization, corporation or insurer shall obtain from the employer [or individual] written certification at the time of initial application and annually thereafter ninety days prior to the contract renewal date that such employer [or individual] meets the requirements of a qualifying small employer [or a qualifying individual] pursuant to this section. A health maintenance organization, corporation or insurer may require the submission of appropriate documentation in support of the certification.

[(j)] (I) Applications for qualifying group health insurance contracts [and qualifying individual health insurance contracts] must be accepted from [any qualifying individual and] any qualifying small employer at all times throughout the year. The superintendent, by regulation, may require health maintenance organizations, corporations or insurers to give preference to qualifying small employers whose eligible employees have the lowest average salaries.

[(k) (1) All coverage under a qualifying group health insurance contract or a qualifying individual health insurance contract must be subject to a pre-existing condition limitation provision as set forth in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, including the crediting requirements thereunder. The underwriting of such contracts may not involve more than the imposition of a pre-existing condition limitation. However, as provided in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, a corporation shall not impose a pre-existing condition limitation provision on any person under age nineteen, except may impose such a limitation on those persons covered by a qualifying individual health insurance contract that is a grandfathered health plan.

(2)] (J) Beginning January first, two thousand fourteen, pursuant to section 2704 of the Public Health Service Act, 42 U.S.C. S 300gg-3, a corporation shall not impose any pre-existing condition limitation in a qualifying group health insurance contract [or a qualifying individual health insurance contract except may impose such a limitation in a qual-

ifying individual health insurance contract that is a grandfathered health plan].

[(3) For purposes of paragraphs one and two of this subsection, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e).

(l)] (K) A qualifying small employer shall elect whether to make coverage under the qualifying group health insurance contract available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

[(m)] (L) A qualifying small employer must pay at least fifty percent of the premium for employees covered under a qualifying group health insurance contract and must offer coverage to all employees receiving annual wages at a level of thirty thousand dollars or less, and at least one such employee shall accept such coverage. The thirty thousand dollar wage level shall be adjusted periodically in accordance with subparagraph [(F)] (D) of paragraph one of subsection (c) of this section. The employer premium contribution must be the same percentage for all covered employees.

[(n)] (M) Premium rate calculations for qualifying group health insurance contracts [and qualifying individual health insurance contracts] shall be subject to the following:

(1) coverage must be community rated [and include rate tiers for individuals, two adult families and at least one other family tier. The rate differences must be based upon the cost differences for the different family units and the rate tiers must be uniformly applied. The rate tier structure used by a health maintenance organization, corporation or insurer for the contracts issued to qualifying small employers and to qualifying individuals must be the same] AND ALL RATING TIERS AND STANDARD RATING RELATIVITIES BETWEEN TIERS SHALL BE FILED WITH THE SUPERINTENDENT;

(2) [if geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must be the same for the contracts issued to qualifying small employers and to qualifying individuals. The superintendent shall not require the inclusion of any specific geographic region within the proposed community rated region selected by the health maintenance organization, corporation or insurer so long as the health maintenance organization, corporation or insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the health maintenance organization, corporation or insurer's community rates.] BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, EVERY POLICY SUBJECT TO THIS SECTION SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTENDENT PROVIDED, HOWEVER, THAT THE COUNTIES OF NASSAU AND SUFFOLK SHALL TOGETHER CONSIST OF THEIR OWN STANDARDIZED REGION; AND

(3) claims experience under contracts issued to qualifying small employers [and to qualifying individuals] must be pooled WITH THE HEALTH MAINTENANCE ORGANIZATION, CORPORATION OR INSURER'S SMALL GROUP BUSINESS for rate setting purposes. [The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.

(o)] (N) A health maintenance organization, corporation or insurer shall submit reports to the superintendent in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance program established by this section.

[(p) Notwithstanding any other provision of law, all individuals and small businesses that are participating in or covered by insurance contracts or policies issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law, the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, or uninsured pilot programs established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight shall be eligible for participation in the standardized health insurance contracts established by this section, regardless of any of the eligibility requirements established pursuant to subsection (c) of this section.]

S 57. The insurance law is amended by adding a new section 4326-a to read as follows:

S 4326-A. TRANSITION OF HEALTHY NEW YORK ENROLLEES. (A) ON DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, COVERAGE ISSUED TO QUALIFYING INDIVIDUALS AND QUALIFYING SMALL EMPLOYERS WHO ARE SOLE PROPRIETORS AS DEFINED IN SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX SHALL END, CONTINGENT UPON THE REQUIREMENTS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 BEING FULLY IMPLEMENTED BY THE STATE AND AS APPROVED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND CONTINGENT UPON FULL IMPLEMENTATION OF THE STATE ENROLLMENT CENTER.

(B) A HEALTH MAINTENANCE ORGANIZATION, CORPORATION, OR INSURER SHALL PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCONTINUANCE TO EACH ENROLLED INDIVIDUAL AND INDIVIDUAL PROPRIETOR AT LEAST ONE HUNDRED EIGHTY DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. THE WRITTEN NOTICE SHALL INCLUDE AN EXPLANATION, IN PLAIN LANGUAGE, OF AVAILABLE HEALTH INSURANCE OPTIONS.

(C) QUALIFYING GROUP HEALTH INSURANCE CONTRACTS ISSUED TO SMALL EMPLOYERS PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DO NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A); SHALL BE DISCONTINUED. SMALL EMPLOYERS THAT ARE IMPACTED BY THE DISCONTINUANCE SHALL BE TRANSITIONED TO A PLAN THAT MEETS THE REQUIREMENTS OF SUBSECTION (E) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX OF THIS CHAPTER. A HEALTH MAINTENANCE ORGANIZATION, CORPORATION, OR INSURER SHALL PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCONTINUANCE TO EACH ENROLLED SMALL EMPLOYER AT LEAST ONE HUNDRED EIGHTY DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. THE WRITTEN NOTICE SHALL INCLUDE AN EXPLANATION, IN PLAIN LANGUAGE, OF THE ABILITY TO TRANSITION TO A NEW SMALL GROUP HEALTH INSURANCE CONTRACT OFFERED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX OF THIS ARTICLE.

S 58. Section 4327 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (h) as amended by chapter 419 of the laws of 2000, subsection (m-1) as added by section 12 of part B of chapter 58 of the laws of 2010, subsection (s) as amended and subsection (t) as added by chapter 441 of the laws of 2006, is amended to read as follows:

S 4327. Stop loss funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals. (a) The superintendent shall establish a fund from which health maintenance

organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "small employer stop loss fund". [The superintendent shall establish a separate and distinct fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "qualifying individual stop loss fund".]

(b) [Commencing on January first, two thousand one, health] HEALTH maintenance organizations, corporations or insurers shall be eligible to receive reimbursement for ninety percent of claims paid between [thirty] FIVE thousand and [one hundred] SEVENTY-FIVE thousand dollars in a calendar year for any member covered under a standardized contract issued pursuant to section four thousand three hundred twenty-six of this article. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the small employer stop loss fund. [Claims paid for members covered under qualifying individual health insurance contracts shall be reimbursable from the qualifying individual stop loss fund.] For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized contracts.

(c) The superintendent shall promulgate regulations that set forth procedures for the operation of the small employer stop loss fund [and the qualifying individual stop loss fund] and distribution of monies therefrom.

(d) [The small employer stop loss fund shall operate separately from the qualifying individual stop loss fund. Except as specified in subsection (b) of this section with respect to calendar year two thousand one, the level of stop loss coverage for the qualifying group health insurance contracts and the qualifying individual health insurance contracts need not be the same. The two stop loss funds need not be structured or operated in the same manner, except as specified in this section. The monies available for distribution from the stop loss funds may be reallocated between the small employer stop loss fund and the qualifying individual stop loss fund if the superintendent determines that such reallocation is warranted due to enrollment trends] THE SUPERINTENDENT MAY ADJUST THE LEVEL OF STOP LOSS COVERAGE SPECIFIED IN SUBSECTION (B) OF THIS SECTION.

(e) Claims shall be reported and funds shall be distributed from the small employer stop loss fund [and from the qualifying individual stop loss fund] on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each health maintenance organization, corporation or insurer shall submit a request for reimbursement from [each of] the stop loss [funds] FUND on forms prescribed by the superintendent. [Each of the] THE

requests for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement requests are being made. The superintendent may require health maintenance organizations, corporations or insurers to submit such claims data in connection with the reimbursement requests as he deems necessary to enable him to distribute monies and oversee the operation of the small employer [and qualifying individual] stop loss [funds] FUND. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis. [Data shall be reported separately for qualifying group health insurance contracts and qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article.]

(g) For [each] THE stop loss fund, the superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations, corporations or insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization, corporation or insurer shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's, corporation's or insurer's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations, corporations or insurers.

(2) In the event that funds available for distribution for claims paid by all health maintenance organizations, corporations or insurers during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations, corporations or insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. Such excess funds shall be in addition to the monies appropriated for the stop loss fund in the next calendar year.

(h) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the small employer [and qualifying individual] stop loss [funds] FUND. Such data shall be furnished in a form prescribed by the superintendent. Each health maintenance organization, corporation or insurer shall provide the superintendent with monthly reports of the total enrollment under the qualifying group health insurance contracts [and the qualifying individual health insurance contracts] issued pursuant to section four thousand three hundred twenty-six of this article. The reports shall be in a form prescribed by the superintendent.

(i) The superintendent shall separately estimate the per member annual cost of total claims reimbursement from each stop loss fund for [qualifying individual health insurance contracts and for] qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each health maintenance organization, corporation or insurer shall furnish to the superintendent claims experience data for use in such estimations.

(j) The superintendent shall determine total eligible enrollment under qualifying group health insurance contracts [and qualifying individual health insurance contracts]. [For qualifying group health insurance contracts, the] THE total eligible enrollment shall be determined by dividing the total funds available for distribution from the small

employer stop loss fund by the estimated per member annual cost of total claims reimbursement from the small employer stop loss fund. [For qualifying individual health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the qualifying individual stop loss fund by the estimated per member annual cost of total claims reimbursement from the qualifying individual stop loss fund.]

(k) The superintendent shall suspend the enrollment of new employers under qualifying group health insurance contracts if [he] THE SUPERINTENDENT determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the small employer stop loss fund in excess of the total funds available for distribution from such stop loss fund. [The superintendent shall suspend the enrollment of new individuals under qualifying individual health insurance contracts if he determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the qualifying individual stop loss fund in excess of the total funds available for distribution from such stop loss fund.]

(l) The superintendent shall provide the health maintenance organizations, corporations or insurers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data. [The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.]

(m) If at any point during a suspension of enrollment of new qualifying small employers [and/or qualifying individuals], the superintendent determines that funds are sufficient to provide for the addition of new enrollments, the superintendent shall be authorized to reactivate new enrollments and to notify all health maintenance organizations, corporations or insurers that enrollment of new employers [and/or individuals] may again commence. [The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.]

(m-1) In the event that the superintendent suspends the enrollment of new individuals for qualifying group health insurance contracts [or qualifying individual health insurance contracts], the superintendent shall ensure that small employers [or sole proprietors] seeking to enroll in a qualified group [or individual] health insurance contract pursuant to section forty-three hundred twenty-six of this article are provided information on and directed to [the family health plus employer partnership program under section three hundred sixty-nine-ff of the social services law] COVERAGE OPTIONS AVAILABLE THROUGH THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031.

(n) The suspension of issuance of qualifying group health insurance contracts to new qualifying small employers shall not preclude the addition of new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.

(o) [The suspension of issuance of qualifying individual health insurance contracts to new qualifying individuals shall not preclude the

addition of new dependents to an existing qualifying individual health insurance contract.

(p)] The premiums for qualifying group health insurance contracts must factor in the availability of reimbursement from the small employer stop loss fund. [The premiums for qualifying individual health insurance contracts must factor in the availability of reimbursement from the qualifying individual stop loss funds.

(q)] (P) The superintendent may obtain the services of an organization to administer the stop loss funds established by this section. [If the superintendent deems it appropriate, he or she may utilize a separate organization for administration of the small employer stop loss fund and the qualifying individual stop loss fund.] The superintendent shall establish guidelines for the submission of proposals by organizations for the purposes of administering the funds. The superintendent shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the funds. An organization approved to administer the funds shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the funds, including[, but not limited to,] an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and the assembly ways and means committee. An organization approved to administer the funds shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the stop loss coverage funds. An organization approved to administer the funds may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

[(r)] (Q) If the superintendent deems it appropriate for the proper administration of the small employer stop loss fund [and/or the qualifying individual stop loss fund], the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss funds established by this section.

[(s)] (R) The superintendent may access funding from the small employer stop loss fund [and/or the qualifying individual stop loss fund] for the purposes of developing and implementing public education, outreach and facilitated enrollment strategies targeted to small employers [and working adults] without health insurance. The superintendent may contract with marketing organizations to perform or provide assistance with such education, outreach, and enrollment strategies. The superintendent shall determine the amount of funding available for the purposes of this subsection which in no event shall exceed eight percent of the annual funding amounts for the small employer stop loss fund [and the qualifying individual stop loss fund].

[(t)] (S) Brooklyn healthworks pilot program and upstate healthworks pilot program. Commencing on July first, two thousand six, the superintendent shall access funding from the small employer stop loss fund [and the qualifying individual stop loss fund] for the purpose of

support and expansion of the existing pilot program Brooklyn healthworks approved by the superintendent and for the establishment and operation of a pilot program to be located in upstate New York. For the purpose of this subsection, in no event shall the amount of funding available exceed two percent of the annual funding [amounts] AMOUNT for the small employer stop loss fund [and the qualifying individual stop loss fund].

S 59. Paragraph 1 of subsection (d) of section 4235 of the insurance law is amended to read as follows:

(1) In this section, for the purpose of insurance OTHER THAN FOR GROUP HOSPITAL, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF EXPENSE REIMBURSED INSURANCE hereunder: "employees" includes the officers, managers, employees and retired employees of the employer and of subsidiary or affiliated corporations of a corporate employer, and the individual proprietors, partners, employees and retired employees of affiliated individuals and firms controlled by the insured employer through stock ownership, contract or otherwise; "employees" may be deemed to include the individual proprietor or partners if the employer is an individual proprietor or a partnership; and "employees" as used in subparagraph (A) of paragraph one of subsection (c) hereof may also include the directors of the employer and of subsidiary or affiliated corporations of a corporate employer.

S 60. Subsection (d) of section 4235 of the insurance law is amended by adding a new paragraph 3 to read as follows:

(3) IN THIS SECTION, FOR THE PURPOSE OF GROUP HOSPITAL, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF EXPENSE REIMBURSED INSURANCE HEREUNDER, "EMPLOYEE" SHALL HAVE THE MEANING SET FORTH IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-91(D)(5) OR ANY REGULATIONS PROMULGATED THEREUNDER.

S 61. Subparagraph (B) of paragraph 1 of subsection (e) of section 3231 of the insurance law, as amended by chapter 107 of the laws of 2010, is amended to read as follows:

(B) The expected minimum loss ratio for a policy form subject to this section, for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance policy, or, with the approval of the superintendent, an aggregation of policy forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than [June thirtieth] JULY THIRTY-FIRST of each year, every insurer subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the insurer to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

S 62. Subparagraph (A) of paragraph 3 of subsection (c) of section 4308 of the insurance law, as added by chapter 107 of the laws of 2010, is amended to read as follows:

(A) The expected minimum loss ratio for a contract form subject to this subsection for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance contract, or, with the approval of the superintendent, an aggregation of

contract forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than [June thirtieth] JULY THIRTY-FIRST of each year, every corporation subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the corporation to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

S 63. Intentionally omitted.

S 64. Subparagraph (D) of paragraph 2 of subsection (p) of section 3221 of the insurance law, as added by chapter 661 of the laws of 1997, is amended to read as follows:

(D) The insurer is ceasing to offer group or blanket policies in a market in accordance with paragraph three OR SEVEN of this subsection.

S 65. Subsection (p) of section 3221 of the insurance law is amended by adding a new paragraph 7 to read as follows:

(7) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, AN INSURER MAY DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET POLICY OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL OR LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET POLICY OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42 U.S.C. 300GG-6 THAT BECOME APPLICABLE TO SUCH POLICY AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, PROVIDED THAT THE INSURER:

(A) DISCONTINUES THE EXISTING CLASS OF POLICY IN SUCH MARKET AS OF EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE POLICY RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS CHAPTER;

(B) PROVIDES WRITTEN NOTICE TO EACH POLICYHOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE;

(C) OFFERS TO EACH POLICYHOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE GROUP MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY THE INSURER TO A GROUP IN THAT MARKET;

(D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARAGRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE POLICYHOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

(E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCONTINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR OF THE INSURER THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE THE COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42 U.S.C. 300GG-6 THAT BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN.

S 66. Item (iii) of subparagraph (C) of paragraph 2 of subsection (c) of section 4304 of the insurance law, as amended by chapter 661 of the laws of 1997, is amended to read as follows:

(iii) Discontinuance of all individual hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small group market, or the large group market, or both markets, in this state, in conjunction with a withdrawal from the small group market, or the large group market, or both markets, in this state. Withdrawal from the small group market, or the large group market, or both markets, shall be governed by the requirements of subparagraphs [(B)] (E) and [(C)] (F) of paragraph three of subsection (j) of section four thousand three hundred five of this article. For purposes of this item, "withdrawal" from a market means that no coverage is offered or maintained in such market under contracts issued pursuant to this section or contracts issued pursuant to section four thousand three hundred five of this article.

S 67. Subparagraph (D) of paragraph 2 of subsection (j) of section 4305 of the insurance law, as added by chapter 661 of the laws of 1997, is amended to read as follows:

(D) The corporation is ceasing to offer group or blanket contracts in a market in accordance with paragraph three OR PARAGRAPH SIX of this subsection.

S 68. Subsection (j) of section 4305 of the insurance law is amended by adding a new paragraph 6 to read as follows:

(6) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, A CORPORATION MAY DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET CONTRACT OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL OR LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET CONTRACT OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH CONTRACT AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, PROVIDED THAT THE CORPORATION:

(A) DISCONTINUES THE EXISTING CLASS OF CONTRACT IN SUCH MARKET AS OF EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE CONTRACT RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS CHAPTER;

(B) PROVIDES WRITTEN NOTICE TO EACH CONTRACT HOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE;

(C) OFFERS TO EACH CONTRACT HOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE GROUP MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY THE CORPORATION TO A GROUP IN THAT MARKET;

(D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARA-

GRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE CONTRACT HOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

(E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCONTINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR OF THE CORPORATION THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE THE COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN.

S 69. Subsections (a), (b) and (c) of section 3231 of the insurance law, subsection (a) as amended by chapter 661 of the laws of 1997, subsection (b) as amended by chapter 557 of the laws of 2002, subsection (c) as added by chapter 501 of the laws of 1992, are amended to read as follows:

(a) (1) No individual health insurance policy and no group health insurance policy covering between [two] ONE and fifty employees or members of the group OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR MEMBERS OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation [as] IF OTHERWISE permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual health insurance coverage, including medicare supplemental coverage, [or small group health insurance coverage, including medicare supplemental insurance,] OR SMALL GROUP HEALTH INSURANCE COVERAGE, INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVERAGE ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, SPECIFIED IN SUBSECTION (L) OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN OF THIS ARTICLE must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (g) of section three thousand two hundred sixteen or subsection (p) of section three thousand two hundred twenty-one of this article. Group hospital and/or medical coverage, including medicare supplemental insurance, obtained through an out-of-state trust covering a group of fifty or fewer employees, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, or participating persons who are residents of this state must be community rated regardless of the situs of delivery of the policy. Notwithstanding any other provisions of law, the underwriting of such policy may involve no more than the imposition of a pre-existing condition limitation [as] IF permitted by this article, and once accepted for coverage, an individual or small group cannot be terminated due to claims experience.

Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (p) of section three thousand two hundred twenty-one of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy [or contract] form is the same based on the experience of the entire pool of risks [covered by that policy or contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED BY THE INSURER without regard to age, sex, health status, TOBACCO USAGE or occupation, EXCLUDING THOSE INDIVIDUALS OR SMALL GROUPS COVERED BY MEDICARE SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE COVERAGE, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUMS FOR ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE SAME BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT POLICY OR CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE POLICIES ISSUED PURSUANT TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

(b) [Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL POLICIES SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY SET A STANDARD RELATIVITY APPLICABLE TO CHILD-ONLY POLICIES ISSUED PURSUANT TO SECTION 1302(F) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVITY FOR CHILD-ONLY POLICIES SHALL BE ACTUARIALLY JUSTIFIABLE USING THE AGGREGATE EXPERIENCE OF INSURERS. (2) AN INSURER SHALL ESTABLISH separate community rates for individuals as opposed to small groups. (3) If an insurer is required to issue a [contract] POLICY to individual proprietors pursuant to subsection (i) of this section, such policy shall be subject to subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the insurer in its rate filing so long as the insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the insurer's community rates. (2) BEGINNING ON JANUARY FIRST, TWO THOUSAND FOURTEEN, FOR EVERY POLICY SUBJECT TO THIS SECTION THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENT PLANS, INSURERS SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTENDENT PROVIDED, HOWEVER, THAT THE COUNTIES OF NASSAU AND SUFFOLK SHALL TOGETHER CONSIST OF THEIR OWN STANDARDIZED REGION.

S 70. Subsection (g) of section 3231 of the insurance law, as added by chapter 501 of the laws of 1992, is amended to read as follows:

(g) (1) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have fifty or fewer employees or members exclusive of spouses and dependents. FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, IF THE GROUP INCLUDES ONE OR MORE MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR COVERAGE SUBJECT TO THIS SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE CLASSIFIED AS SMALL GROUPS

FOR RATING PURPOSES AND THE REMAINING MEMBERS SHALL BE RATED CONSISTENT WITH THE RATING RULES APPLICABLE TO SUCH REMAINING MEMBERS PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION.

(2) IF A POLICY IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, INCLUDING AN ASSOCIATION GROUP, THAT INCLUDES ONE OR MORE INDIVIDUAL OR INDIVIDUAL PROPRIETOR MEMBERS, FOR RATING PURPOSES THE INSURER SHALL INCLUDE SUCH MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING PREMIUM RATES FOR SUCH MEMBERS.

S 71. Paragraph 2 of subsection (i) of section 3231 of the insurance law, as amended by chapter 183 of the laws of 2011, is amended to read as follows:

(2) For coverage purchased pursuant to this subsection, THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand [fourteen] THIRTEEN, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. COVERAGE PURCHASED OR RENEWED PURSUANT TO THIS SUBSECTION ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SHALL BE CLASSIFIED IN THE INDIVIDUAL RATING CATEGORY.

S 72. Section 4317 of the insurance law, as added by chapter 501 of the laws of 1992, subsection (a) as amended by chapter 661 of the laws of 1997, subsection (b) as amended and subsection (f) as added by chapter 557 of the laws of 2002, subsection (d) as amended by section 2 of part A of chapter 494 of the laws of 2009, paragraph 2 of subsection (f) as amended by chapter 183 of the laws of 2011, is amended to read as follows:

S 4317. Rating of individual and small group health insurance contracts. (a) (1) No individual health insurance contract and no group health insurance contract covering between [two] ONE and fifty employees or members of the group, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR MEMBERS OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN exclusive of spouses and dependents, including contracts for which the premiums are paid by a remitting agent for a group, hereinafter referred to as a small group, providing hospital and/or medical benefits, including Medicare supplemental insurance, shall be issued in this state unless such contract is community rated and, notwithstanding any other provisions of law, the underwriting of such contract involves no more than the imposition of a pre-existing condition limitation [as] IF OTHERWISE permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual or small group health insurance coverage INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVERAGE ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SPECIFIED IN SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR, AND SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER, must be accepted at all times throughout the year for any hospital and/or medical coverage[, including Medicare supplemental insurance,] offered by the corporation to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of coverage for individuals or small groups may be based only on one or more of the reasons set forth in subsection (c) of section four thousand

three hundred four or subsection (j) of section four thousand three hundred five of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks [covered by that policy or contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED BY THE CORPORATION without regard to age, sex, health status, TOBACCO USAGE or occupation EXCLUDING THOSE INDIVIDUALS OF SMALL GROUPS COVERED BY MEDICARE SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE COVERAGE, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUMS FOR ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE SAME BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT POLICY OR CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE CONTRACTS ISSUED PURSUANT TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

(b) [Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL CONTRACTS SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY ALSO SET A STANDARD RELATIVITY APPLICABLE TO CHILD-ONLY CONTRACTS ISSUED PURSUANT TO SECTION 1302(F) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVITY FOR CHILD-ONLY CONTRACTS MUST BE ACTUARIALLY JUSTIFIABLE USING THE AGGREGATE EXPERIENCE OF CORPORATIONS TO PREVENT THE CHARGING OF UNJUSTIFIED PREMIUMS. THE SUPERINTENDENT MAY ADJUST SUCH PREMIUM TIERS AND RELATIVITIES PERIODICALLY BASED UPON THE AGGREGATE EXPERIENCE OF CORPORATIONS ISSUING CONTRACT FORMS SUBJECT TO THIS SECTION. (2) A CORPORATION SHALL ESTABLISH separate community rates for individuals as opposed to small groups. (3) If a corporation is required to issue a contract to individual proprietors pursuant to subsection (f) of this section, such contract shall be subject to the requirements of subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the corporation in its rate filing so long as the corporation's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the corporation's community rates. (2) BEGINNING ON JANUARY FIRST, TWO THOUSAND FOURTEEN, FOR EVERY CONTRACT SUBJECT TO THIS SECTION THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENTAL INSURANCE, CORPORATIONS SHALL USE STANDARDIZED REGIONS.

(d) (1) This section shall also apply to [contracts] A CONTRACT issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have fifty or fewer employees or members exclusive of spouses and dependents. FOR CONTRACTS ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, IF THE GROUP INCLUDES ONE OR MORE MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR COVERAGE SUBJECT TO THIS SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE CLASSIFIED AS SMALL GROUPS FOR RATING PURPOSES AND THE REMAINING MEMBERS

SHALL BE RATED CONSISTENT WITH THE RATING RULES APPLICABLE TO SUCH REMAINING MEMBERS PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION.

(2) IF A CONTRACT IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER INCLUDING ASSOCIATION GROUPS, THAT INCLUDES ONE OR MORE INDIVIDUAL MEMBERS, THEN FOR RATING PURPOSES THE CORPORATION SHALL INCLUDE SUCH MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING PREMIUM RATES FOR SUCH MEMBERS.

(3) A corporation shall provide specific claims experience to a municipal corporation, as defined in subsection (f) of section four thousand seven hundred two of this chapter, covered by the corporation under a community rated contract when the municipal corporation requests its claims experience for purposes of forming or joining a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter. Notwithstanding the foregoing provisions, no corporation shall be required to provide more than three years' claims experience to a municipal corporation making this request.

(e) (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section.

(2) This subsection shall not apply to coverage insuring a plan [which] THAT was in effect on or before December thirty-first, nineteen hundred ninety-one and was issued to a group [which] THAT includes member small employers or other member small groups, including but not limited to association groups, provided that (A) acceptance of additional small member employers (or other member groups comprised of fifty or fewer employees or members, exclusive of spouses and dependents) into the group on or after June first, nineteen hundred ninety-two and before April first, nineteen hundred ninety-four does not exceed an amount equal to ten percent per year of the total number of persons covered under the group as of June first, nineteen hundred ninety-two, but nothing in this subparagraph shall limit the addition of larger member employers; (B) (i) after April first, nineteen hundred ninety-four, the group thereafter accepts member small employers and member small groups without underwriting by any more than the imposition of a pre-existing condition limitation as permitted by this article and the cost for participation in the group for all persons covered shall be the same based on the experience of the entire pool of risks covered under the entire group, without regard to age, sex, health status or occupation; and; (ii) once accepted for coverage, an individual or small group cannot be terminated due to claims experience; (C) the [insurer] CORPORATION has registered the names of such groups, including the total number of persons covered as of June first, nineteen hundred ninety-two, with the superintendent, in a form prescribed by the superintendent, on or before April first, nineteen hundred ninety-three and shall report annually thereafter until such groups comply with the provisions of subparagraph (B) of this paragraph; and (D) the types or categories of employers or groups eligible to join the association are not altered or expanded after June first, nineteen hundred ninety-two.

(3) A corporation may apply to the superintendent for an extension or extensions of time beyond April first, nineteen hundred ninety-four in which to implement the provisions of this subsection as they relate to

groups registered with the superintendent pursuant to subparagraph (C) of paragraph two of this subsection; any such extension or extensions may not exceed two years in aggregate duration, and the ten percent per year limitation of subparagraph (A) of paragraph two of this subsection shall be reduced to five percent per year during the period of any such extension or extensions. Any application for an extension shall demonstrate that a significant financial hardship to such group would result from such implementation.

(f)(1) If the [insurer] CORPORATION issues coverage to an association group (including chambers of commerce), as defined in subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, THEN the [insurer must] CORPORATION SHALL issue the same coverage to individual proprietors [which] WHO purchase coverage through the association group as the [insurer] CORPORATION issues to groups [which] THAT purchase coverage through the association group; provided, however, that [an insurer which] A CORPORATION THAT, on the effective date of this subsection, is issuing coverage to individual proprietors not connected with an association group, may continue to issue such coverage provided that the coverage is otherwise in accordance with this subsection and all other applicable provisions of law.

(2) For coverage purchased pursuant to this subsection THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand [fourteen] THIRTEEN, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. COVERAGE PURCHASED OR RENEWED PURSUANT TO THIS SUBSECTION ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SHALL BE CLASSIFIED IN THE INDIVIDUAL RATING CATEGORY.

(3) The [insurer] CORPORATION may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance [policy] CONTRACT, and (C) present a copy of the following documentation to the [insurer] CORPORATION or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an unincorporated business, the prior year's federal income tax Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations.

S 73. 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 74. 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 75. 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.

S 76. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2013; provided that:

a. sections thirty-eight, thirty-nine, forty, forty-a, forty-one, forty-six-a, forty-seven, forty-eight, forty-nine, fifty, fifty-one and fifty-two of this act shall take effect January 1, 2014, and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

b. sections forty-three-a, forty-four, forty-five and forty-six of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after October 1, 2013;

c. section fifty-six of this act shall take effect January 1, 2014, contingent upon the requirements of the Patient Protection and Affordable Care Act of 2010 being fully implemented by the state and as approved by the secretary of health and human services, and contingent upon full implementation of the state enrollment center;

d. section fifty-seven of this act shall be deemed repealed January 1, 2014;

e. sections fifteen, fifty-eight, sixty-one and sixty-two of this act shall take effect January 1, 2015, contingent upon the requirements of the Patient Protection and Affordable Care Act of 2010 being fully implemented by the state and as approved by the secretary of health and human services, and contingent upon full implementation of the state enrollment center provided that the amendments made to subsection (d) of section 4327 of the insurance law by section fifty-eight of this act shall expire one year after the effective date of such section;

e-1. section fifteen-a of this act shall take effect January 1, 2014, contingent upon the requirements of the Patient Protection and Affordable Care Act of 2010 being fully implemented by the state and as approved by the secretary of health and human services, and contingent upon full implementation of the state enrollment center;

f. sections fifty-nine and sixty of this act shall take effect January 1, 2016 and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date;

g. sections fourteen and fourteen-a of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013;

h. the amendments to paragraphs (e) and (f) of subdivision 2 of section 2511 of the public health law made by sections nineteen and twenty-six of this act shall take effect January 1, 2014 or a later date to be determined by the commissioner of health contingent upon the requirements of the Patient Protection and Affordable Care Act of 2010 being fully implemented by the state and as approved by the secretary of the department of health and human services; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in sections nineteen and twenty-six of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

h-1. provided however, the amendments to subparagraph (ii) of paragraph (f) of subdivision 2 of section 2511 of the public health law made by section twenty-six of this act shall take effect April 1, 2014;

i. the amendments to subdivision 4 of section 2511 of the public health law made by section twenty-one of this act shall not affect the expiration and reversion of such subdivision and shall be deemed to expire therewith;

j. the amendments to subparagraph (ii) of paragraph (g) of subdivision 2 of section 2511 of the public health law made by section twenty-seven of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

j-1. the amendments to subparagraph (iii) of paragraph (a) of subdivision 2 of section 2511 of the public health law made by section thirty of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

j-2. the amendments to subparagraph (iv) of paragraph (b) and paragraph (d) of subdivision 9 of section 2511 of the public health law made by section thirty-three of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

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

l. 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;

m. the commissioner of health and the superintendent of financial services and any appropriate council may take any steps necessary to implement this act prior to its effective date;

n. 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 financial services 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;

o. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act; and

p. the amendments made to subparagraph (7) of paragraph (b) of subdivision 1 of section 366 of the social services law made by section one of this act shall expire and be deemed repealed October 1, 2019.

PART E

Section 1. Intentionally omitted.

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

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. Intentionally omitted.

S 13. Intentionally omitted.

S 14. Section 600 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 600. State aid; general requirements. In order to be eligible for state aid under this title, a municipality shall be required to do the following in accordance with the provisions of this article:

1. submit an application to the department for state aid WHICH IS APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH SECTION SIX HUNDRED ONE OF THIS TITLE;

[2. submit a municipal public health services plan to the department for approval;

3. implement and adhere to the municipal public health services plan, as approved;

4. submit a detailed report to the department of all expenditures on services funded by this title for the immediately preceding fiscal year of such municipality;

5. employ a person to supervise the provision of public health services in accordance with the provisions of section six hundred four of this chapter; and

6.] 2. SUBSTANTIALLY PROVIDE CORE PUBLIC HEALTH SERVICES, AS DEFINED IN SECTION SIX HUNDRED TWO OF THIS TITLE;

3. SUBMIT A COMMUNITY HEALTH ASSESSMENT IN ACCORDANCE WITH SECTION SIX HUNDRED TWO-A OF THIS TITLE;

4. ESTABLISH, COLLECT AND REPORT FEES AND REVENUE FOR SERVICES PROVIDED BY THE MUNICIPALITY, IN ACCORDANCE WITH SECTION SIX HUNDRED SIX OF THIS TITLE; AND

5. appropriate or otherwise make funds available to finance a prescribed share of the cost of public health services.

S 15. Section 601 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 601. Application for state aid. 1. The governing body of each municipality desiring to make application for state aid under this title shall annually, on such dates as may be fixed by the commissioner, submit an application for such aid.

2. The application shall be in such form as the commissioner shall prescribe, and shall include, but not be limited to:

(a) an organizational chart of the municipal health agency, AND A STATEMENT PROVIDING THE NUMBER OF EMPLOYEES, BY JOB TITLE, PROPOSED TO PROVIDE PUBLIC HEALTH SERVICES FUNDED BY THIS TITLE;

(b) a [detailed] budget of proposed expenditures for services funded by this title;

[(c) a description of proposed program activities for services funded by this title;

(d) a copy of the municipal public health services plan prepared and submitted pursuant to section six hundred two of this title;

(e) a certification by the chief executive officer of the municipality, or in those municipalities with no chief executive officer the chairman of the county legislature, that the proposed expenditures and program activities are consistent with the public health services plan; and

(f)] (C) A DESCRIPTION OF HOW THE MUNICIPALITY WILL PROVIDE PUBLIC HEALTH SERVICES;

(D) AN ATTESTATION BY THE CHIEF EXECUTIVE OFFICER OF THE MUNICIPALITY THAT SUFFICIENT FUNDS HAVE BEEN APPROPRIATED TO PROVIDE THE PUBLIC HEALTH SERVICES FOR WHICH THE MUNICIPALITY IS SEEKING STATE AID;

(E) AN ATTESTATION BY THE MUNICIPAL OFFICER IN CHARGE OF ADMINISTERING PUBLIC HEALTH THAT THE MUNICIPALITY HAS DILIGENTLY REVIEWED ITS STATE AID APPLICATION AND THAT THE APPLICATION SEEKS STATE AID ONLY FOR ELIGIBLE PUBLIC HEALTH SERVICES;

(F) A LIST OF PUBLIC HEALTH SERVICES PROVIDED BY THE MUNICIPALITY THAT ARE NOT ELIGIBLE FOR STATE AID, AND THE COST OF EACH SERVICE;

(G) A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR PUBLIC HEALTH SERVICES ELIGIBLE FOR STATE AID, IN ACCORDANCE WITH SECTION SIX HUNDRED SIX OF THIS TITLE; AND

(H) such other information as the commissioner may require.

3. THE COMMISSIONER SHALL APPROVE THE STATE AID APPLICATION TO THE EXTENT THAT IT IS CONSISTENT WITH THIS SECTION AND ANY OTHER CONDITIONS OR LIMITATIONS ESTABLISHED IN, OR REGULATIONS PROMULGATED PURSUANT TO, THIS ARTICLE.

4. A MUNICIPALITY MAY AMEND ITS STATE AID APPLICATION WITH THE APPROVAL OF THE COMMISSIONER, AND SUBJECT TO ANY RULES AND REGULATIONS THAT THE COMMISSIONER MAY ADOPT.

S 16. Section 602 of the public health law is REPEALED and a new section 602 is added to read as follows:

S 602. CORE PUBLIC HEALTH SERVICES. 1. TO BE ELIGIBLE FOR STATE AID, A MUNICIPALITY MUST SUBSTANTIALLY PROVIDE THE FOLLOWING CORE PUBLIC HEALTH SERVICES:

(A) FAMILY HEALTH, WHICH SHALL INCLUDE ACTIVITIES DESIGNED TO REDUCE PERINATAL, INFANT AND MATERNAL MORTALITY AND MORBIDITY AND TO PROMOTE THE HEALTH OF INFANTS, CHILDREN, ADOLESCENTS, AND PEOPLE OF CHILDBEARING AGE. SUCH ACTIVITIES SHALL INCLUDE FAMILY CENTERED PERINATAL SERVICES AND OTHER SERVICES APPROPRIATE TO PROMOTE THE BIRTH OF A HEALTHY BABY TO A HEALTHY MOTHER, AND SERVICES TO ASSURE THAT INFANTS, YOUNG CHILDREN, AND SCHOOL AGE CHILDREN ARE ENROLLED IN APPROPRIATE HEALTH INSURANCE PROGRAMS AND OTHER HEALTH BENEFIT PROGRAMS FOR WHICH THEY ARE ELIGIBLE, AND THAT THE PARENTS OR GUARDIANS OF SUCH CHILDREN ARE PROVIDED WITH INFORMATION CONCERNING HEALTH CARE PROVIDERS IN THEIR AREA THAT ARE WILLING AND ABLE TO PROVIDE HEALTH SERVICES TO SUCH CHILDREN.

(B) COMMUNICABLE DISEASE CONTROL, WHICH SHALL INCLUDE ACTIVITIES TO CONTROL AND MITIGATE THE EXTENT OF INFECTIOUS DISEASES. SUCH ACTIVITIES

SHALL INCLUDE, BUT NOT BE LIMITED TO, SURVEILLANCE AND EPIDEMIOLOGICAL PROGRAMS, PROGRAMS TO DETECT DISEASES IN THEIR EARLY STAGES, IMMUNIZATIONS AGAINST INFECTIOUS DISEASES, INVESTIGATION OF DISEASES AND PREVENTION OF TRANSMISSION, PREVENTION AND TREATMENT OF SEXUALLY TRANSMISSIBLE DISEASES, AND ARTHROPOD VECTOR-BORNE DISEASE PREVENTION.

(C) CHRONIC DISEASE PREVENTION, WHICH SHALL INCLUDE PROMOTING PUBLIC, HEALTH CARE PROVIDER AND OTHER COMMUNITY SERVICE PROVIDER ACTIVITIES THAT ENCOURAGE CHRONIC DISEASE PREVENTION, EARLY DETECTION AND QUALITY CARE DELIVERY. SUCH ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, THOSE THAT PROMOTE HEALTHY COMMUNITIES AND REDUCE RISK FACTORS SUCH AS TOBACCO USE, POOR NUTRITION AND PHYSICAL INACTIVITY. PROVISION OF CLINICAL SERVICES SHALL NOT BE ELIGIBLE FOR STATE AID, SUBJECT TO SUCH EXCEPTIONS AS THE COMMISSIONER MAY DEEM APPROPRIATE.

(D) COMMUNITY HEALTH ASSESSMENT, AS DESCRIBED IN SECTION SIX HUNDRED TWO-A OF THIS ARTICLE.

(E) ENVIRONMENTAL HEALTH, WHICH SHALL INCLUDE ACTIVITIES THAT PROMOTE HEALTH AND PREVENT ILLNESS AND INJURY BY ASSURING THAT SAFE AND SANITARY CONDITIONS ARE MAINTAINED AT PUBLIC DRINKING WATER SUPPLIES, FOOD SERVICE ESTABLISHMENTS, AND OTHER REGULATED FACILITIES; INVESTIGATING PUBLIC HEALTH NUISANCES TO ASSURE ABATEMENT BY RESPONSIBLE PARTIES; PROTECTING THE PUBLIC FROM UNNECESSARY EXPOSURE TO RADIATION, CHEMICALS, AND OTHER HARMFUL CONTAMINANTS; AND CONDUCTING INVESTIGATIONS OF INCIDENTS THAT RESULT IN ILLNESS, INJURY OR DEATH IN ORDER TO IDENTIFY AND MITIGATE THE ENVIRONMENTAL CAUSES TO PREVENT ADDITIONAL MORBIDITY AND MORTALITY.

(F) PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE, INCLUDING PLANNING, TRAINING, AND MAINTAINING READINESS FOR PUBLIC HEALTH EMERGENCIES.

2. THE MUNICIPALITY MUST INCORPORATE INTO EACH CORE PUBLIC HEALTH SERVICE THE FOLLOWING GENERAL ACTIVITIES:

(A) ONGOING ASSESSMENT OF COMMUNITY HEALTH NEEDS;

(B) EDUCATION ON PUBLIC HEALTH ISSUES;

(C) DEVELOPMENT OF POLICIES AND PLANS TO ADDRESS HEALTH NEEDS;

(D) ACTIONS TO ASSURE THAT SERVICES NECESSARY TO ACHIEVE AGREED UPON GOALS ARE PROVIDED; AND

(E) THE EXTENT TO WHICH THE CORE SERVICES, ONCE IMPLEMENTED, WILL SATISFY STANDARDS WHICH THE COMMISSIONER HAS PROMULGATED THROUGH RULES AND REGULATIONS AFTER CONSULTING WITH THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL AND COUNTY HEALTH COMMISSIONERS, BOARDS AND PUBLIC HEALTH DIRECTORS. SUCH STANDARDS SHALL BE FOR SERVICES FUNDED UNDER THIS TITLE AND SHALL INCLUDE BUT NOT BE LIMITED TO THE EFFECTS SUCH SERVICES SHALL HAVE ON MORTALITY AND MORBIDITY AND THE REDUCTION OF POTENTIAL PUBLIC HEALTH HAZARDS. THE COMMISSIONER SHALL NOT HAVE THE POWER TO PRESCRIBE THE NUMBER OF PERSONS TO BE EMPLOYED IN ANY MUNICIPALITY.

3. A MUNICIPALITY MAY PROVIDE FEWER SERVICES THAN THOSE SET FORTH IN SUBDIVISION ONE OF THIS SECTION, IF THE COMMISSIONER DETERMINES WITHIN HIS DISCRETION THAT ANOTHER ENTITY IS WILLING AND ABLE TO PROVIDE SUCH SERVICES.

S 17. The public health law is amended by adding a new section 602-a to read as follows:

S 602-A. COMMUNITY HEALTH ASSESSMENT. 1. EVERY MUNICIPALITY SHALL SUBMIT TO THE DEPARTMENT NO MORE FREQUENTLY THAN EVERY TWO YEARS A COMMUNITY HEALTH ASSESSMENT.

2. THE COMMUNITY HEALTH ASSESSMENT SHALL BE IN SUCH FORM AS THE COMMISSIONER SHALL PRESCRIBE, AND SHALL INCLUDE, BUT NOT BE LIMITED TO:

(A) AN ESTIMATE AND DESCRIPTION OF THE HEALTH STATUS OF THE POPULATION AND FACTORS THAT CONTRIBUTE TO HEALTH ISSUES;

(B) IDENTIFICATION OF PRIORITY AREAS FOR HEALTH IMPROVEMENT, IN CONJUNCTION WITH THE STATE HEALTH IMPROVEMENT PLAN;

(C) IDENTIFICATION OF PUBLIC HEALTH SERVICES IN THE MUNICIPALITY AND IN THE COMMUNITY AND OTHER RESOURCES THAT CAN BE MOBILIZED TO IMPROVE POPULATION HEALTH, PARTICULARLY IN THOSE PRIORITY AREAS IDENTIFIED IN PARAGRAPH (B) OF THIS SUBDIVISION; AND

(D) A COMMUNITY HEALTH IMPROVEMENT PLAN CONSISTING OF ACTIONS, POLICIES, STRATEGIES AND MEASURABLE OBJECTIVES THROUGH WHICH THE MUNICIPALITY AND ITS COMMUNITY PARTNERS WILL ADDRESS AREAS FOR HEALTH IMPROVEMENT AND TRACK PROGRESS TOWARD IMPROVEMENT OF PUBLIC HEALTH OUTCOMES.

S 18. Section 603 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 603. [Municipal public health services plan] CORE PUBLIC HEALTH SERVICES; implementation. 1. In order to be eligible for state aid under this title, each municipality shall administer its CORE public health [programs] SERVICES in accordance with [its approved municipal public health services plan and] THE standards of performance established by the commissioner through rules and regulations [and] PURSUANT TO SECTION SIX HUNDRED NINETEEN OF THIS ARTICLE. EACH MUNICIPALITY shall, in particular, ensure that public health services are provided in an efficient and effective manner to all persons in the municipality.

2. The commissioner may withhold state aid reimbursement under this title for the appropriate services if, on ANY audit [and], review OF A STATE AID APPLICATION OR PERIODIC CLAIM FOR STATE AID, OR OTHER INFORMATION AVAILABLE TO THE DEPARTMENT, the commissioner finds that such services are not furnished or rendered in conformance with the rules and regulations established by the commissioner, INCLUDING BUT NOT LIMITED TO THE STANDARDS OF PERFORMANCE ESTABLISHED PURSUANT TO SECTION SIX HUNDRED NINETEEN OF THIS ARTICLE, or that the expenditures were not [made according to the approved public health services plan required by] FOR AN ACTIVITY SET FORTH IN section six hundred two of this title. In such cases, the commissioner, in order to ensure that the public health is promoted as defined in [paragraph (b) of subdivision three of] section six hundred two of this title, may use any proportionate share of a municipality's per capita or base grant that is withheld to contract with agencies, associations, or organizations. The health department may use any such withheld share to provide services upon approval of the director of the division of the budget. Copies of such transactions shall be filed with the fiscal committees of the legislature.

3. CONSISTENT WITH PARAGRAPH (H) OF SUBDIVISION TWO OF SECTION SIX HUNDRED ONE OF THIS TITLE, WHEN DETERMINING WHETHER TO APPROVE A STATE AID APPLICATION OR PERIODIC CLAIM FOR STATE AID, THE COMMISSIONER SHALL HAVE AUTHORITY TO REQUEST ANY AND ALL FINANCIAL AND OTHER DOCUMENTS NECESSARY OR RELEVANT TO VERIFY THAT THE CLAIMED EXPENDITURES ARE ELIGIBLE FOR STATE AID UNDER THIS ARTICLE.

S 19. Section 604 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 604. Supervision of public health programs. In order to be eligible for state aid, under this title, each municipality shall employ a full-time local commissioner of health or public health director to supervise the provision of public health services [and to implement the approved public health services plan] for that municipality, SUBJECT TO THE FOLLOWING EXCEPTIONS:

1. SUCH PERSON MAY SERVE AS THE HEAD OF A MERGED AGENCY OR MULTIPLE AGENCIES, IF THE APPROVAL OF THE COMMISSIONER IS OBTAINED; AND

2. SUCH PERSON MAY SERVE AS THE LOCAL COMMISSIONER OF HEALTH OR PUBLIC HEALTH DIRECTOR OF ADDITIONAL COUNTIES, WHEN AUTHORIZED PURSUANT TO SECTION THREE HUNDRED FIFTY-ONE OF THIS CHAPTER.

S 20. Section 605 of the public health law, as added by chapter 901 of the laws of 1986, subdivision 1 as amended by section 6 of part B of chapter 57 of the laws of 2006, subdivision 2 as amended by section 13 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 605. State aid; amount of reimbursement. 1. A state aid base grant shall be reimbursed to municipalities for the [base] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title, in an amount of the greater of [fifty-five] SIXTY-FIVE cents per capita, for each person in the municipality, or [five] SIX hundred fifty thousand dollars provided that the municipality expends at least [five] SIX hundred fifty thousand dollars for such [base] CORE public health services. A municipality must provide all the [basic] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title to qualify for such base grant unless the municipality has the approval of the commissioner to expend the base grant on a portion of such [base] CORE public health services. If [any] services in such [paragraph (b)] SECTION are not [approved in the plan or if no plan is submitted for such services] SUBSTANTIALLY PROVIDED, the commissioner may limit the municipality's per capita or base grant to [that proportionate share which will fund those services that are submitted in a plan and subsequently approved] REFLECT THE SCOPE OF THE REDUCED SERVICES. The commissioner may use the [proportionate share] AMOUNT that is not granted to contract with agencies, associations, or organizations to provide such services; or the health department may use such proportionate share to provide the services upon approval of the director of the division of the budget.

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the [basic] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title, pursuant to an approved [plan] APPLICATION FOR STATE AID, 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] THAT ARE NOT ELIGIBLE FOR STATE AID PURSUANT TO THIS ARTICLE.

3. Municipalities shall make every reasonable effort to collect payments for public health services provided. All such revenues shall be reported to the commissioner PURSUANT TO SECTION SIX HUNDRED SIX OF THIS TITLE and will be deducted from expenditures identified under subdivision two of this section to produce a net cost eligible for state aid.

S 21. Section 606 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 606. Assessment of fees; THIRD-PARTY COVERAGE OR INDEMNIFICATION. 1. Assessment of fees by municipalities. [Each municipality shall assess fees for services provided by such municipality in accordance with a fee and revenue plan which shall include a schedule of fees that the municipality proposes to charge for each service identified by the

commissioner and each additional service identified by the municipality for which a fee is to be charged. In accordance with the provisions of subdivision four of section six hundred two of this chapter, the commissioner shall review each fee and revenue plan submitted to him and, on the basis of such review, issue a notice of intent to disapprove the plan or approve the plan, with or without conditions, within ninety days of his receipt of the plan. In determining whether to approve or disapprove a plan, the commissioner shall consider the extent to which the plan, once implemented, will satisfy standards which the commissioner has promulgated through rules and regulations after consulting with the public health council and county health commissioners, boards and public health directors. Such standards shall include a list of those environmental, personal health and other services for which fees shall be charged, the calculation of cost by each municipality and the relationship of cost to fees, and provisions for prohibiting the assessment of fees which would impede the delivery of services deemed essential to the protection of the health of the public.] EACH MUNICIPALITY SHALL ESTABLISH A SCHEDULE OF FEES FOR PUBLIC HEALTH SERVICES PROVIDED BY THE MUNICIPALITY AND SHALL MAKE EVERY REASONABLE EFFORT TO COLLECT SUCH FEES. Fees for personal health services shall be reflective of an individual's ability to pay and shall not be inconsistent with the reimbursement guidelines of articles twenty-eight and thirty-six of this chapter and applicable federal laws and regulations. To the extent possible revenues generated shall be used to enhance or expand public health services. IN ITS STATE AID APPLICATION, EACH MUNICIPALITY SHALL PROVIDE THE DEPARTMENT WITH A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR THAT YEAR. EACH MUNICIPALITY SHALL PERIODICALLY REPORT TO THE DEPARTMENT FEES AND REVENUE ACTUALLY COLLECTED.

2. Assessment of fees by the commissioner. In each municipality, the commissioner shall establish a fee and revenue plan for services provided by the department in a manner consistent with the standards and regulations established pursuant to subdivision one of this section.

3. THIRD PARTY COVERAGE OR INDEMNIFICATION. FOR ANY PUBLIC HEALTH SERVICE FOR WHICH COVERAGE OR INDEMNIFICATION FROM A THIRD PARTY IS AVAILABLE, THE MUNICIPALITY MUST SEEK SUCH COVERAGE OR INDEMNIFICATION AND REPORT ANY ASSOCIATED REVENUE TO THE DEPARTMENT IN ITS STATE AID APPLICATION.

S 22. Subdivisions 1 and 2 of section 609 of the public health law, as amended by chapter 474 of the laws of 1996, are amended to read as follows:

1. Where a laboratory shall have been or is hereafter established pursuant to article five of this chapter, the state, through the legislature and within the limits to be prescribed by the commissioner, shall provide aid at a per centum, determined in accordance with the provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the actual cost of [installation,] REPAIR, RELOCATION, equipment and maintenance of the laboratory or laboratories FOR SERVICES ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED IN SECTION SIX HUNDRED TWO OF THIS TITLE. Such cost shall be the excess, if any, of such expenditures over available revenues of all types, including adequate and reasonable fees, derived from or attributable to the performance of laboratory services.

2. Where a county or city provides or shall have provided for laboratory service by contracting with an established laboratory FOR SERVICES ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED IN SUBDIVISION THREE OF SECTION SIX HUNDRED TWO OF THIS TITLE, with the approval

of the commissioner, it shall be entitled to state aid at a per centum, determined in accordance with the provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the cost of the contracts. [State aid shall be available for a district laboratory supply station maintained and operated in accordance with article five of this chapter in the same manner and to the same extent as for laboratory services.]

S 23. Intentionally omitted.

S 24. Paragraphs (a) and (c) of subdivision 1 and subdivision 4 of section 613 of the public health law, paragraphs (a) and (c) of subdivision 1 as amended by chapter 36 of the laws of 2010, subdivision 4 as amended by chapter 207 of the laws of 2004, are amended to read as follows:

(a) The commissioner shall develop and supervise the execution of a program of immunization, surveillance and testing, to raise to the highest reasonable level the immunity of the children of the state against communicable diseases including, but not limited to, influenza, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type b (Hib), diphtheria, pertussis, tetanus, varicella, hepatitis B, pneumococcal disease, and the immunity of adults of the state against diseases identified by the commissioner, including but not limited to influenza, smallpox, [and] hepatitis AND SUCH OTHER DISEASES AS THE COMMISSIONER MAY DESIGNATE THROUGH REGULATION. The commissioner shall encourage the municipalities in the state to develop and shall assist them in the development and the execution of local programs of [inoculation] IMMUNIZATION to raise the immunity of the children and adults of each municipality to the highest reasonable level. Such programs shall include ASSURANCE OF provision of vaccine, [surveillance of vaccine effectiveness by means of laboratory tests,] serological testing of individuals and educational efforts to inform health care providers and target populations or their parents, if they are minors, of the facts relative to these diseases and [inoculation] IMMUNIZATIONS to prevent their occurrence.

(c) The commissioner shall invite and encourage the active assistance and cooperation in such education activities of: the medical societies, organizations of other licensed health personnel, hospitals, corporations subject to article forty-three of the insurance law, trade unions, trade associations, parents and teachers and their associations, organizations of child care resource and referral agencies, the media of mass communication, and such other voluntary groups and organizations of citizens as he or she shall deem appropriate. The public health AND HEALTH PLANNING council, the department of education, the department of family assistance, and the department of mental hygiene shall provide the commissioner with such assistance in carrying out the program as he or she shall request. All other state agencies shall also render such assistance as the commissioner may reasonably require for this program. Nothing in this subdivision shall authorize mandatory immunization of adults or children, except as provided in sections twenty-one hundred sixty-four and twenty-one hundred sixty-five of this chapter.

4. The commissioner shall expend such funds as the legislature shall make available for the purchase of the vaccines described in subdivision one of this section. All immunization vaccines purchased with such funds shall be purchased by sealed competitive state bids through the office of general services. [Immunization vaccine] VACCINES purchased with funds made available under this section shall be made available without charge to licensed private physicians, hospitals, clinics and such

others as the commissioner shall determine [in accordance with regulations to be promulgated by the commissioner], and no charge shall be made to any patient for such vaccines.

S 25. Intentionally Omitted.

S 26. Subdivision 2 of section 614 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

2. "City", each city of the state having a population of [fifty thousand] ONE MILLION or more, according to the last preceding federal census[, but does not include any such city which is included as a part of a county health district pursuant to this chapter].

S 27. Section 616 of the public health law, as added by chapter 901 of the laws of 1986 and subdivision 1 as amended by section 9 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

S 616. Limitations on state aid. 1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by paragraph (a) of subdivision two of section six hundred five of this article, at least thirty-six per centum of the difference between the amount of moneys expended by the municipality for ELIGIBLE public health services [required by paragraph (b) of subdivision three of section six hundred two of this article] PURSUANT TO AN APPROVED APPLICATION FOR STATE AID during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article. [A municipality shall also receive not less than thirty-six per centum of the moneys expended for other public health services pursuant to paragraph (b) of subdivision two of section six hundred five of this article, and, at least the minimum amount so required for the services identified in title two of this article.]

2. No payments shall be made from moneys appropriated for the purpose of this article to a municipality for contributions by the municipality for indirect costs and fringe benefits, including but not limited to, employee retirement funds, health insurance and federal old age and survivors insurance.

S 28. Section 617 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 617. Maintenance of effort. Such amount of state aid provided will be used to support and to the extent practicable, to increase the level of funds that would otherwise be made available for such purposes and not to supplant the amount to be provided by the municipalities. If a municipality that is provided state aid pursuant to title one of this article reduces its expenditures beneath the amount expended in its base year, which is [the greater of its expenditures in its fiscal year ending in either nineteen hundred eighty-five or] the most recent fiscal year for which the municipality has filed [an annual] ALL expenditure [report] REPORTS to the department, state aid reimbursement provided pursuant to subdivision one of section six hundred five of this article will be reduced by the [difference between the reduction in local expenditures between its base year and its current fiscal year and the reduction in state aid between the base year and the current fiscal year pursuant to paragraphs (a) and (b) of subdivision two of section six hundred five of this article. A municipality may include revenue, excluding third party reimbursement, raised by the municipality in calculating its maintenance of effort] PERCENTAGE REDUCTION IN EXPENDITURES BETWEEN ITS BASE YEAR AND ITS CURRENT FISCAL YEAR. FOR PURPOSES OF THIS SECTION, REDUCTIONS IN EXPENDITURES SHALL BE ADJUSTED FOR: AN

ABSENCE OF EXTRAORDINARY EXPENDITURES OF A TEMPORARY NATURE, SUCH AS DISASTER RELIEF; UNAVOIDABLE OR JUSTIFIABLE PROGRAM REDUCTIONS, SUCH AS A PROGRAM BEING SUBSUMED BY ANOTHER AGENCY; OR IN CIRCUMSTANCES WHERE THE MUNICIPALITY CAN DEMONSTRATE, TO THE DEPARTMENT'S SATISFACTION, THAT THE NEED FOR THE EXPENDITURE NO LONGER EXISTS.

S 29. Intentionally omitted.

S 30. Section 619 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 619. Commissioner; regulatory powers. The commissioner shall adopt regulations to effectuate the provisions and purposes of this article, including, but not limited to:

1. setting standards of performance [and reasonable costs] for the provision of [basic] CORE public health services which shall include performance criteria to ensure that reimbursable health services are delivered in an efficient and effective manner by a municipality; and

2. monitoring, COLLECTING DATA and evaluating the provision of [basic] CORE public health services by the municipalities and the amounts expended by the municipalities for such services.

S 31. The public health law is amended by adding a new section 619-a to read as follows:

S 619-A. INCENTIVE STANDARDS OF PERFORMANCE. 1. THE COMMISSIONER SHALL ESTABLISH STATEWIDE INCENTIVE PERFORMANCE STANDARDS, SUBJECT TO LEGISLATIVE APPROVAL, FOR THE DELIVERY OF CORE PUBLIC HEALTH SERVICES ON OR BEFORE DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN.

2. WITHIN AMOUNTS APPROPRIATED, AND SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET, THE COMMISSIONER MAY INCREASE STATE AID TO ANY MUNICIPALITY THAT MEETS OR EXCEEDS STATEWIDE INCENTIVE PERFORMANCE STANDARDS ESTABLISHED UNDER THIS SECTION, PROVIDED THAT THE TOTAL OF SUCH PAYMENTS TO ALL MUNICIPALITIES MAY NOT EXCEED ONE MILLION DOLLARS ANNUALLY.

S 32. The article heading of article 23 of the public health law, as amended by chapter 878 of the laws of 1980, is amended to read as follows:

CONTROL OF SEXUALLY [TRANSMISSIBLE] TRANSMITTED DISEASES

S 33. Sections 2300, 2301, 2302 and 2303 of the public health law are REPEALED.

S 34. The section heading and subdivisions 1 and 2 of section 2304 of the public health law, as amended by chapter 878 of the laws of 1980, are amended and two new subdivisions 4 and 5 are added to read as follows:

Sexually [transmissible] TRANSMITTED diseases; treatment facilities; administration. 1. It shall be the responsibility of each board of health of a health district to provide adequate facilities for the [free] diagnosis and treatment of persons living within its jurisdiction who are suspected of being infected or are infected with a sexually [transmissible] TRANSMITTED disease.

2. The health officer of said health district shall administer these facilities DIRECTLY OR THROUGH CONTRACT, and shall promptly examine or arrange for the examination of persons suspected of being infected with a sexually [transmissible] TRANSMITTED disease, and shall promptly institute treatment or arrange for the treatment of those found or otherwise known to be infected with a sexually [transmissible] TRANSMITTED disease[,]; provided that any person may, at his OR HER option, be treated at his OR HER own expense by a licensed physician of his OR HER choice.

4. EACH BOARD OF HEALTH AND LOCAL HEALTH OFFICER SHALL ENSURE THAT DIAGNOSIS AND TREATMENT SERVICES ARE AVAILABLE AND, TO THE GREATEST EXTENT PRACTICABLE, SEEK THIRD PARTY COVERAGE OR INDEMNIFICATION FOR SUCH SERVICES; PROVIDED, HOWEVER, THAT NO BOARD OF HEALTH, LOCAL HEALTH OFFICER, OR OTHER MUNICIPAL OFFICER OR ENTITY SHALL REQUEST OR REQUIRE THAT SUCH COVERAGE OR INDEMNIFICATION BE UTILIZED AS A CONDITION OF PROVIDING DIAGNOSIS OR TREATMENT SERVICES.

5. THE TERM "HEALTH OFFICER" AS USED IN THIS ARTICLE SHALL MEAN A COUNTY HEALTH OFFICER, A CITY HEALTH OFFICER, A TOWN HEALTH OFFICER, A VILLAGE HEALTH OFFICER, THE HEALTH OFFICER OF A CONSOLIDATED HEALTH DISTRICT OR A STATE DISTRICT HEALTH OFFICER.

S 35. Intentionally omitted.

S 36. Section 2306 of the public health law, as amended by chapter 41 of the laws of 2010, is amended to read as follows:

S 2306. Sexually [transmissible] TRANSMITTED diseases; reports and information, confidential. All reports or information secured by a board of health or health officer under the provisions of this article shall be confidential except in so far as is necessary to carry out the purposes of this article. Such report or information may be disclosed by court order in a criminal proceeding in which it is otherwise admissible or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the prosecution and to the defense, or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the petitioner, respondent and attorney for the child, provided that the subject of the report or information has waived the confidentiality provided for by this section EXCEPT INSOFAR AS IS NECESSARY TO CARRY OUT THE PURPOSES OF THIS ARTICLE. INFORMATION MAY BE DISCLOSED TO THIRD PARTY REIMBURSERS OR THEIR AGENTS TO THE EXTENT NECESSARY TO REIMBURSE HEALTH CARE PROVIDERS FOR HEALTH SERVICES; PROVIDED THAT, WHEN NECESSARY, AN OTHERWISE APPROPRIATE AUTHORIZATION FOR SUCH DISCLOSURE HAS BEEN SECURED BY THE PROVIDER. A person waives the confidentiality provided for by this section if such person voluntarily discloses or consents to disclosure of such report or information or a portion thereof. If such person lacks the capacity to consent to such a waiver, his or her parent, guardian or attorney may so consent. An order directing disclosure pursuant to this section shall specify that no report or information shall be disclosed pursuant to such order which identifies or relates to any person other than the subject of the report or information. REPORTS AND INFORMATION MAY BE USED IN THE AGGREGATE IN PROGRAMS APPROVED BY THE COMMISSIONER FOR THE IMPROVEMENT OF THE QUALITY OF MEDICAL CARE PROVIDED TO PERSONS WITH SEXUALLY TRANSMITTED DISEASES; OR WITH PATIENT IDENTIFIERS WHEN USED WITHIN THE STATE OR LOCAL HEALTH DEPARTMENT BY PUBLIC HEALTH DISEASE PROGRAMS TO ASSESS CO-MORBIDITY OR COMPLETENESS OF REPORTING AND TO DIRECT PROGRAM NEEDS, IN WHICH CASE PATIENT IDENTIFIERS SHALL NOT BE DISCLOSED OUTSIDE THE STATE OR LOCAL HEALTH DEPARTMENT.

S 37. The section heading of section 2308 of the public health law is amended to read as follows:

[Venereal] SEXUALLY TRANSMITTED disease; pregnant women; blood test for syphilis.

S 38. Section 2308-a of the public health law, as amended by chapter 878 of the laws of 1980, is amended to read as follows:

S 2308-a. Sexually [transmissible] TRANSMITTED diseases; tests for sexually [transmissible] TRANSMITTED diseases. 1. The administrative officer or other person in charge of a clinic or other facility providing gynecological, obstetrical, genito-urological, contraceptive, steri-

lization or termination of pregnancy services or treatment shall require the staff of such clinic or facility to offer to administer to every resident of the state of New York coming to such clinic or facility for such services or treatment, appropriate examinations or tests for the detection of sexually [transmissible] TRANSMITTED diseases.

2. Each physician providing gynecological, obstetrical, genito-urological, contraceptive, sterilization, or termination of pregnancy services or treatment shall offer to administer to every resident of the state of New York coming to such physician for such services or treatment, appropriate examinations or tests for the detection of sexually [transmissible] TRANSMITTED diseases.

S 39. Sections 2309 and 2310 of the public health law are REPEALED.

S 40. Section 2311 of the public health law, as added by chapter 878 of the laws of 1980, is amended to read as follows:

S 2311. Sexually [transmissible] TRANSMITTED disease list. The commissioner shall promulgate a list of sexually [transmissible] TRANSMITTED diseases, such as gonorrhea and syphilis, for the purposes of this article. The commissioner, in determining the diseases to be included in such list, shall consider those conditions principally transmitted by sexual contact, OTHER SECTIONS OF THIS CHAPTER ADDRESSING COMMUNICABLE DISEASES and the impact of particular diseases on individual morbidity and the health of newborns.

S 41. Section 2 of chapter 577 of the laws of 2008, amending the public health law relating to expedited partner therapy for persons infected with chlamydia trachomatis, is amended to read as follows:

S 2. This act shall take effect on the one hundred twentieth day after it shall have become a law [and shall expire and be deemed repealed January 1, 2014].

S 42. Intentionally omitted.

S 43. Subdivisions 1, 2, 2-a, 2-b and 3 of section 2802 of the public health law, subdivisions 1, 2 and 2-b as amended by section 58 of part A of chapter 58 of the laws of 2010, subdivision 2-a as added and paragraph (e) of subdivision 3 as amended by chapter 731 of the laws of 1993, subdivision 3 as amended by chapter 609 of the laws of 1982, are amended to read as follows:

1. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the public health and health planning council, and the health systems agency, if any, having geographical jurisdiction of the area where the hospital is located.

2. The commissioner shall not act upon an application for construction of a hospital until the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations, and unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health and health planning council pursuant to the provisions of this article) provided, however, that the commissioner may act upon an application for construction by an applicant possessing a valid operating certificate when the application qualifies for review without the recommendation of the council pursuant to regulations adopted by the council and approved by the commissioner; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that[,] in the case of an application by: (I)

a hospital established or operated by an organization defined in subdivision one of section four hundred eighty-two-b of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need[.]; (II) A GENERAL HOSPITAL OR DIAGNOSTIC AND TREATMENT CENTER, ESTABLISHED UNDER THIS ARTICLE, TO CONSTRUCT A FACILITY TO PROVIDE PRIMARY CARE SERVICES, AS DEFINED IN REGULATION, THE CONSTRUCTION MAY BE APPROVED WITHOUT REGARD FOR PUBLIC NEED; OR (III) A GENERAL HOSPITAL OR A DIAGNOSTIC AND TREATMENT CENTER, ESTABLISHED UNDER THIS ARTICLE, TO UNDERTAKE CONSTRUCTION THAT DOES NOT INVOLVE: (A) A CHANGE IN CAPACITY, THE TYPES OF SERVICES PROVIDED, MAJOR MEDICAL EQUIPMENT; (B) FACILITY REPLACEMENT; OR (C) THE GEOGRAPHIC LOCATION OF SERVICES, THE CONSTRUCTION MAY BE APPROVED WITHOUT REGARD FOR PUBLIC NEED.

2-a. The council shall afford the applicant an opportunity to present information in person concerning an application to a committee designated by the council.

2-b. Beginning on January first, nineteen hundred ninety-four, and each year thereafter, a complete application received between January first and June thirtieth of each year shall be reviewed by the appropriate health systems agency and the department and presented to the public health and health planning council for its consideration prior to June thirtieth of the following year and a complete application received between July first and December thirty-first of each year shall be reviewed by the appropriate health systems agency and the department and presented to the public health and health planning council for consideration prior to December thirty-first of the following year.

3. Subject to the provisions of paragraph (b) of subdivision two, the commissioner in approving the construction of a hospital shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the proposed hospital construction;

(b) the need for special equipment in view of existing utilization of comparable equipment at the time and place and under the circumstances proposed;

(c) the possible economies and improvements in service to be anticipated from the operation of joint central services including, but not limited to laboratory, research, radiology, pharmacy, laundry and purchasing;

(d) the adequacy of financial resources and sources of future revenue, PROVIDED THAT THE COMMISSIONER MAY, BUT IS NOT REQUIRED TO, CONSIDER THE ADEQUACY OF FINANCIAL RESOURCES AND SOURCES OF FUTURE REVENUE IN RELATION TO APPLICATIONS UNDER SUBPARAGRAPHS (II) AND (III) OF PARAGRAPH (B) OF SUBDIVISION TWO OF THIS SECTION; and

(e) whether the facility is currently in substantial compliance with all applicable codes, rules and regulations, provided, however, that the commissioner shall not disapprove an application solely on the basis that the facility is not currently in substantial compliance, if the application is specifically:

(i) to correct life safety code or patient care deficiencies;

(ii) to correct deficiencies which are necessary to protect the life, health, safety and welfare of facility patients, residents or staff;

(iii) for replacement of equipment that no longer meets the generally accepted operational standards existing for such equipment at the time it was acquired; and

(iv) for decertification of beds and services.

S 44. Subdivisions 1, 2 and 3 of section 2807-z of the public health law, as amended by chapter 400 of the laws of 2012, are amended to read as follows:

1. Notwithstanding any provision of this chapter or regulations or any other state law or regulation, for any eligible capital project as defined in subdivision six of this section, the department shall have thirty days of receipt of the certificate of need OR CONSTRUCTION application, PURSUANT TO SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, for a limited or administrative review to deem such application complete. If the department determines the application is incomplete or that more information is required, the department shall notify the applicant in writing within thirty days of the date of the application's submission, and the applicant shall have twenty business days to provide additional information or otherwise correct the deficiency in the application.

2. For an eligible capital project requiring a limited or administrative review, within ninety days of the department deeming the application complete, the department shall make a decision to approve or disapprove the certificate of need OR CONSTRUCTION application for such project. If the department determines to disapprove the project, the basis for such disapproval shall be provided in writing; however, disapproval shall not be based on the incompleteness of the application. If the department fails to take action to approve or disapprove the application within ninety days of the certificate of need application being deemed complete, the application will be deemed approved.

3. For an eligible capital project requiring full review by the council, the certificate of need OR CONSTRUCTION application shall be placed on the next council agenda following the department deeming the application complete.

S 45. Intentionally omitted.

S 46. Section 2801-a of the public health law is amended by adding a new subdivision 3-b to read as follows:

3-B. NOTWITHSTANDING ANY OTHER PROVISIONS OF THIS CHAPTER TO THE CONTRARY, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MAY APPROVE THE ESTABLISHMENT OF DIAGNOSTIC OR TREATMENT CENTERS TO BE ISSUED OPERATING CERTIFICATES FOR THE PURPOSE OF PROVIDING PRIMARY CARE, AS DEFINED BY THE COMMISSIONER IN REGULATIONS, WITHOUT REGARD TO THE REQUIREMENTS OF PUBLIC NEED AND FINANCIAL RESOURCES AS SET FORTH IN SUBDIVISION THREE OF THIS SECTION.

S 47. Intentionally omitted.

S 48. Intentionally omitted.

S 49. Intentionally omitted.

S 50. Intentionally omitted.

S 51. The mental hygiene law is amended by adding a new section 32.20 to read as follows:

S 32.20 TEMPORARY OPERATOR. 1. FOR THE PURPOSES OF THIS SECTION:

(A) "CHEMICAL DEPENDENCE TREATMENT PROGRAM" SHALL MEAN A PROGRAM CERTIFIED PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

(B) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF A CHEMICAL DEPENDENCE TREATMENT PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

(C) "TEMPORARY OPERATOR" SHALL MEAN ANY OASAS STAFF MEMBER, PERSON OR ENTITY THAT:

(I) AGREES TO OPERATE A PROGRAM ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS PATIENTS AND THE COMMUNITY SERVED BY THE PROGRAM;

(II) HAS DEMONSTRATED THAT HE OR SHE HAS THE CHARACTER, COMPETENCE AND ABILITY TO OPERATE AN OASAS-CERTIFIED PROGRAM IN COMPLIANCE WITH APPLICABLE STANDARDS; AND

(III) PRIOR TO HIS OR HER APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS WITH GUIDANCE FROM THE COMMISSIONER A SATISFACTORY PLAN TO ADDRESS THE PROGRAM'S DEFICIENCIES;

(D) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING KEY COVENANTS OF BOND ISSUES, MISSED MORTGAGE PAYMENTS, GENERAL UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM AND/OR FACILITY, FAILURE TO MAINTAIN REQUIRED DEBT SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK; AND

(E) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

2. (A) IN THE EVENT THAT: (I) THE OFFICE IMPOSED A PENALTY ON A PROGRAM WITHIN THE PRIOR TWELVE MONTHS; (II) THE PROGRAM IS SEEKING EXTRAORDINARY FINANCIAL ASSISTANCE; (III) OFFICE COLLECTED DATA INDICATES THAT THE PROGRAM IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (IV) OFFICE COLLECTED DATA INDICATES THAT THE PROGRAM'S BOARD OF DIRECTORS OR ADMINISTRATION ARE UNABLE OR UNWILLING TO ENSURE THE PROPER OPERATION OF THE PROGRAM; (V) THE PROGRAM HAS VIOLATED THE TERMS OF ITS CONTRACT WITH THE STATE; OR (VI) OFFICE COLLECTED DATA INDICATES THERE ARE CONDITIONS THAT SERIOUSLY ENDANGER OR JEOPARDIZE CONTINUED ACCESS TO NECESSARY CHEMICAL DEPENDENCE TREATMENT SERVICES WITHIN THE COMMUNITY, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR OF HIS OR HER INTENTION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPONSIBILITY FOR THE PROGRAM'S TREATMENT OPERATIONS OF THAT FACILITY FOR A LIMITED PERIOD OF TIME. THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO THIS SECTION, AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW.

(B) THE ESTABLISHED OPERATOR OF A PROGRAM MAY AT ANY TIME REQUEST THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECESSARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN THE PROVISION OF QUALITY CARE TO THE PATIENTS UNTIL THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD; THE PATIENTS MAY BE TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS; OR THE PROGRAM OPERATIONS OF THAT FACILITY SHOULD BE COMPLETELY DISCONTINUED.

3. (A) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEVELOPED WITH THE GUIDANCE OF THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF CHEMICAL DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY SERVED BY THE PROGRAM.

(B) IF THE IDENTIFIED PROGRAM DEFICIENCIES CANNOT BE ADDRESSED IN THE TIME PERIOD DESIGNATED IN THE PLAN, THE PATIENTS SHALL BE TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS.

(C) DURING THE TERM OF HIS OR HER APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE AUTHORITY TO DIRECT THE PROGRAM STAFF OF THE FACILITY IN ALL ASPECTS NECESSARY TO APPROPRIATELY TREAT AND/OR TRANSFER THE PATIENTS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE PROGRAM IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF CHEMICAL DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY SERVED BY THE FACILITY UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME PROGRAM OPERATIONS OR UNTIL THE PATIENTS ARE APPROPRIATELY TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS.

(D) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE FACILITY OR CONTAINED WITHIN THE FACILITY OR IN ANY FIXTURE OF THE FACILITY, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPERTY.

4. THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER, AND NECESSARY EXPENSES INCURRED DURING HIS OR HER PERFORMANCE AS TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN HIS OR HER CAPACITY AS TEMPORARY OPERATOR OF THE PROGRAM FOR INJURY TO PERSON AND PROPERTY BY REASON OF HIS OR HER OPERATION OF SUCH PROGRAM; HE OR SHE SHALL NOT HAVE ANY LIABILITY IN HIS OR HER PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

5. (A) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, HEALTH CARE IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICIENCIES THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSIONER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH AUTHORIZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLUSION OF THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL TERM.

(B) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT DESCRIBING:

(I) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS: THE IDENTIFIED PROGRAM DEFICIENCIES; THE RESUMPTION OF PROGRAM OPERATIONS BY THE ESTABLISHED OPERATOR; OR THE TRANSFER OF THE PATIENTS TO OTHER OASAS-CERTIFIED PROVIDERS;

(II) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

(III) IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE PROGRAM SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

(C) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAPPOINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

6. (A) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER

DESIGNEE WITHIN TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTABLISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTABLISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE AGREED UPON TIMEFRAME.

(B) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPERATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

(C) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND SHALL OPERATE THE PROGRAM PURSUANT TO THE PROVISIONS OF THIS SECTION.

7. NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTABLISHED OPERATOR REMAINS OBLIGATED FOR THE CONTINUED OPERATION OF THE FACILITY SO THAT THE PROGRAM CAN FUNCTION IN A NORMAL MANNER. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER; NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF MORTGAGES OR LIENS.

S 52. Intentionally omitted.

S 53. Intentionally omitted.

S 54. Intentionally omitted.

S 55. Intentionally omitted.

S 56. Intentionally omitted.

S 57. Intentionally omitted.

S 58. Intentionally omitted.

S 59. Intentionally omitted.

S 60. Intentionally omitted.

S 61. Intentionally omitted.

S 62. Intentionally omitted.

S 63. Intentionally omitted.

S 64. Intentionally omitted.

S 65. Intentionally omitted.

S 66. Intentionally omitted.

S 67. Intentionally omitted.

S 68. Intentionally omitted.

S 69. Intentionally omitted.

S 70. Intentionally omitted.

S 71. Intentionally omitted.
S 72. Intentionally omitted.
S 73. Intentionally omitted.
S 74. Intentionally omitted.
S 75. Intentionally omitted.
S 76. Intentionally omitted.
S 77. Intentionally omitted.
S 78. Intentionally omitted.
S 79. Intentionally omitted.
S 80. Intentionally omitted.
S 81. Intentionally omitted.
S 82. Intentionally omitted.
S 83. Intentionally omitted.
S 84. Intentionally omitted.
S 85. Intentionally omitted.
S 86. Intentionally omitted.
S 87. Intentionally omitted.
S 88. Intentionally omitted.
S 89. Intentionally omitted.

S 90. Subdivision 1 of section 6605-b of the education law, as added by chapter 437 of the laws of 2001, is amended to read as follows:

1. [A] NOTWITHSTANDING ANY PROVISION HEREIN TO THE CONTRARY, A dental hygienist shall not administer or monitor nitrous oxide analgesia or local infiltration anesthesia in the practice of dental hygiene without a dental hygiene restricted local infiltration anesthesia/nitrous oxide analgesia certificate and except under the personal supervision of a dentist and in conjunction with the performance of dental hygiene procedures authorized by law and in accordance with regulations promulgated by the commissioner. Personal supervision, for purposes of this section, means that the supervising dentist remains in the dental office where the local infiltration anesthesia or nitrous oxide analgesia services are being performed, personally authorizes and prescribes the use of local infiltration anesthesia or nitrous oxide analgesia for the patient and, before dismissal of the patient, personally examines the condition of the patient after the use of local infiltration anesthesia or nitrous oxide analgesia is completed. It is professional misconduct for a dentist to fail to provide the supervision required by this section, and any dentist found guilty of such misconduct under the procedures prescribed in section sixty-five hundred ten of this title shall be subject to the penalties prescribed in section sixty-five hundred eleven of this title.

S 91. Subdivision 1 of section 6606 of the education law, as amended by chapter 437 of the laws of 2001, is amended to read as follows:

1. The practice of the profession of dental hygiene is defined as the performance of dental services which shall include removing calcareous deposits, accretions and stains from the exposed surfaces of the teeth which begin at the epithelial attachment and applying topical agents indicated for a complete dental prophylaxis, removing cement, placing or removing rubber dam, removing sutures, placing matrix band, providing patient education, applying topical medication, placing and exposing DIAGNOSTIC DENTAL X-ray films, performing topical fluoride applications and topical anesthetic applications, polishing teeth, taking medical history, charting caries, taking impressions for study casts, placing and removing temporary restorations, administering and monitoring nitrous oxide analgesia and administering and monitoring local infiltration anesthesia, subject to certification in accordance with section

sixty-six hundred five-b of this article, and any other function in the definition of the practice of dentistry as may be delegated by a licensed dentist in accordance with regulations promulgated by the commissioner. The practice of dental hygiene may be conducted in the office of any licensed dentist or in any appropriately equipped school or public institution but must be done EITHER under the supervision of a licensed dentist OR, IN THE CASE OF A REGISTERED DENTAL HYGIENIST WORKING FOR A HOSPITAL AS DEFINED IN ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, PURSUANT TO A COLLABORATIVE ARRANGEMENT WITH A LICENSED DENTIST PURSUANT TO REGULATIONS PROMULGATED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW.

S 92. Section 6608 of the education law, as amended by chapter 300 of the laws of 2006, is amended to read as follows:

S 6608. Definition of practice of certified dental assisting. The practice of certified dental assisting is defined as providing supportive services to a dentist in his/her performance of dental services authorized under this article. Such support shall include providing patient education, taking preliminary medical histories and vital signs to be reviewed by the dentist, placing and removing rubber dams, selecting and prefitting provisional crowns, selecting and prefitting orthodontic bands, removing orthodontic arch wires and ligature ties, placing and removing matrix bands, taking impressions for study casts or diagnostic casts, removing periodontal dressings, and such other dental supportive services authorized by the dentist consistent with regulations promulgated by the commissioner, provided that such functions are performed under the direct personal supervision of a licensed dentist in the course of the performance of dental services. Such services shall not include diagnosing and/or performing surgical procedures, irreversible procedures or procedures that would alter the hard or soft tissue of the oral and maxillofacial area or any other procedures determined by the department. The practice of certified dental assisting may be conducted in the office of any licensed dentist or in any appropriately equipped school or public institution but must be done under the direct personal supervision of a licensed dentist. Direct personal supervision, for purposes of this section, means supervision of dental procedures based on instructions given by a licensed dentist in the course of a procedure who remains in the dental office where the supportive services are being performed, personally diagnoses the condition to be treated, personally authorizes the procedures, and before dismissal of the patient, who remains the responsibility of the licensed dentist, evaluates the services performed by the dental assistant. Nothing herein authorizes a dental assistant to perform any of the services or functions defined as part of the practice of dental hygiene in accordance with the provisions of subdivision one of section sixty-six hundred six of this article, except those functions authorized pursuant to this section. All dental supportive services provided in this section may be performed by currently registered dental hygienists under a dentist's supervision OR BY A REGISTERED DENTAL HYGIENIST WORKING FOR A HOSPITAL AS DEFINED IN ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW WHO PRACTICES IN COLLABORATION WITH A LICENSED DENTIST IN ACCORDANCE WITH SUBDIVISION ONE OF SECTION SIXTY-SIX HUNDRED SIX OF THIS ARTICLE, as defined in regulations of the commissioner.

S 93. Subdivision 10 of section 6611 of the education law, as amended by chapter 65 of the laws of 2011, is amended to read as follows:

10. [Beginning January first, two thousand nine, each] EACH dentist AND REGISTERED DENTAL HYGIENIST WORKING FOR A HOSPITAL AS DEFINED IN

ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW WHO PRACTICES IN COLLABORATION WITH A LICENSED DENTIST shall become certified in cardiopulmonary resuscitation (CPR) from an approved provider and thereafter maintain current certification, which shall be included in the mandatory hours of continuing education acceptable for dentists to the extent provided in the commissioner's regulations. In the event the dentist OR REGISTERED DENTAL HYGIENIST cannot physically perform CPR, the commissioner's regulations shall allow the dentist OR REGISTERED DENTAL HYGIENIST to make arrangements for another individual in the office to administer CPR. All dental facilities shall have an automatic external defibrillator or other defibrillator at the facility.

S 94. Subdivision 2 of section 903 of the education law, as added by chapter 281 of the laws of 2007, is amended to read as follows:

2. a. A dental health certificate shall be requested from each student. Each student is requested to furnish a dental health certificate at the same time that health certificates are required. An [examination] ASSESSMENT and dental health history of any child may be requested by the local school authorities at any time in their discretion to promote the educational interests of such child. Each certificate shall be signed by a duly licensed dentist, OR A REGISTERED DENTAL HYGIENIST who is authorized by law to practice in this state, and consistent with any applicable written practice agreement, or by a duly licensed dentist OR REGISTERED DENTAL HYGIENIST who is authorized to practice in the jurisdiction in which the [examination] ASSESSMENT was given, provided that the commissioner has determined that such jurisdiction has standards of licensure and practice comparable to those of New York. Each such certificate shall describe the dental health condition of the student when the [examination] ASSESSMENT was made, which shall not be more than twelve months prior to the commencement of the school year in which the [examination] ASSESSMENT is requested, and shall state whether such student is in fit condition of dental health to permit his or her attendance at the public schools.

b. A notice of request for dental health certificates shall be distributed at the same time that parents or person in parental relationship to students are notified of health examination requirements and shall state that a list of DENTAL PRACTICES, dentists AND REGISTERED DENTAL HYGIENISTS to which children [who need comprehensive dental examinations] may be referred for [treatment] DENTAL SERVICES on a free or reduced cost basis is available upon request at the child's school. The department shall, in collaboration with the department of health, compile and maintain a list of DENTAL PRACTICES, dentists AND REGISTERED DENTAL HYGIENISTS to which children [who need comprehensive dental examinations] may be referred for [treatment] DENTAL SERVICES on a free or reduced cost basis. Such list shall be made available to all public schools and be made available to parents or person in parental relationship upon request. The department shall promulgate regulations to ensure the gathering and dissemination of the proper information to interested parties.

S 95. Intentionally omitted.

S 96. Subdivisions 3 and 5 of section 6542 of the education law, as amended by chapter 48 of the laws of 2012, are amended to read as follows:

3. No physician shall employ or supervise more than [two] FOUR physician assistants in his or her private practice.

5. Notwithstanding any other provision of this article, nothing shall prohibit a physician employed by or rendering services to the department

of corrections and community supervision under contract from supervising no more than [four] SIX physician assistants in his or her practice for the department of corrections and community supervision.

S 97. The opening paragraph, and paragraphs (k) and (l) of subdivision 1 of section 3510 of the public health law, as added by chapter 175 of the laws of 2006, are amended and four new paragraphs (m), (n), (o) and (p) are added to read as follows:

The license, registration or intravenous contrast administration certificate of a [radiological] RADIOLOGIC technologist may be suspended for a fixed period, revoked or annulled, or such licensee censured, reprimanded, subject to a civil penalty not to exceed two thousand dollars for every such violation, or otherwise disciplined, in accordance with the provisions and procedures defined in this article, upon decision after due hearing that the individual is guilty of the following misconduct:

(k) using the prefix "Dr.", the word "doctor" or any suffix or affix to indicate or imply that the licensee is a duly licensed practitioner as defined in this article when not so licensed; [or]

(l) incompetence or negligence[.];

(M) BEING CONVICTED OF COMMITTING AN ACT CONSTITUTING A CRIME UNDER (I) NEW YORK STATE LAW; (II) FEDERAL LAW; OR (III) THE LAW OF ANOTHER JURISDICTION AND WHICH, IF COMMITTED WITHIN THIS STATE, WOULD HAVE CONSTITUTED A CRIME UNDER NEW YORK STATE LAW;

(N) HAVING BEEN FOUND GUILTY OF IMPROPER PROFESSIONAL PRACTICE OR PROFESSIONAL MISCONDUCT BY A DULY AUTHORIZED PROFESSIONAL DISCIPLINARY AGENCY OF ANOTHER STATE WHERE THE CONDUCT UPON WHICH THE FINDING WAS BASED, IF COMMITTED IN NEW YORK STATE, WOULD CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE;

(O) HAVING BEEN FOUND GUILTY IN AN ADJUDICATORY PROCEEDING OF VIOLATING A STATE OR FEDERAL STATUTE OR REGULATION, PURSUANT TO A FINAL DECISION OR DETERMINATION, AND WHEN NO APPEAL IS PENDING, OR AFTER RESOLUTION OF THE PROCEEDING BY STIPULATION OR AGREEMENT, AND WHEN THE VIOLATION WOULD CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE; OR

(P) HAVING HIS OR HER LICENSE TO PRACTICE AS A RADIOLOGIC TECHNOLOGIST REVOKED, SUSPENDED OR HAVING OTHER DISCIPLINARY ACTION TAKEN, OR HAVING HIS OR HER APPLICATION FOR A LICENSE REFUSED, REVOKED OR SUSPENDED OR HAVING VOLUNTARILY OR OTHERWISE SURRENDERED HIS OR HER LICENSE AFTER A DISCIPLINARY ACTION WAS INSTITUTED BY A DULY AUTHORIZED PROFESSIONAL DISCIPLINARY AGENCY OF ANOTHER STATE, WHERE THE CONDUCT RESULTING IN THE REVOCATION, SUSPENSION OR OTHER DISCIPLINARY ACTION INVOLVING THE LICENSE OR REFUSAL, REVOCATION OR SUSPENSION OF AN APPLICATION FOR A LICENSE OR THE SURRENDER OF THE LICENSE WOULD, IF COMMITTED IN NEW YORK STATE, CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE. A RADIOLOGIC TECHNOLOGIST LICENSED IN NEW YORK STATE WHO IS ALSO LICENSED OR SEEKING LICENSURE IN ANOTHER STATE MUST IMMEDIATELY REPORT TO THE DEPARTMENT ANY REVOCATION, SUSPENSION OR OTHER DISCIPLINARY ACTION INVOLVING THE OUT-OF-STATE LICENSE OR REFUSAL, REVOCATION OR SUSPENSION OF AN APPLICATION FOR AN OUT-OF-STATE LICENSE OR THE SURRENDER OF THE OUT-OF-STATE LICENSE.

S 98. Intentionally omitted.

S 99. Intentionally omitted.

S 100. Intentionally omitted.

S 101. Section 2801-a of the public health law is amended by adding a new subdivision 17 to read as follows:

17. (A) DIAGNOSTIC OR TREATMENT CENTERS ESTABLISHED TO PROVIDE HEALTH CARE SERVICES WITHIN THE SPACE OF A RETAIL BUSINESS OPERATION, SUCH AS A PHARMACY, A STORE OPEN TO THE GENERAL PUBLIC OR A SHOPPING MALL, MAY BE OPERATED BY LEGAL ENTITIES FORMED UNDER THE LAWS OF NEW YORK WHOSE STOCKHOLDERS OR MEMBERS, AS APPLICABLE, ARE NOT NATURAL PERSONS AND WHOSE PRINCIPAL STOCKHOLDERS AND MEMBERS, AS APPLICABLE, AND CONTROLLING PERSONS COMPLY WITH ALL APPLICABLE REQUIREMENTS OF THIS SECTION AND DEMONSTRATE, TO THE SATISFACTION OF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, SUFFICIENT EXPERIENCE AND EXPERTISE IN DELIVERING HIGH QUALITY HEALTH CARE SERVICES. SUCH DIAGNOSTIC AND TREATMENT CENTERS SHALL BE REFERRED TO IN THIS SECTION AS "LIMITED SERVICES CLINICS". FOR PURPOSES OF THIS SUBDIVISION, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL ADOPT AND AMEND RULES AND REGULATIONS, NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, TO ADDRESS ANY MATTER IT DEEMS PERTINENT TO THE ESTABLISHMENT OF LIMITED SERVICES CLINICS; PROVIDED THAT SUCH RULES AND REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, PROVISIONS GOVERNING OR RELATING TO: (I) ANY DIRECT OR INDIRECT CHANGES OR TRANSFERS OF OWNERSHIP INTERESTS OR VOTING RIGHTS IN SUCH ENTITIES OR THEIR STOCKHOLDERS OR MEMBERS, AS APPLICABLE, AND PROVIDE FOR PUBLIC HEALTH AND HEALTH PLANNING COUNCIL APPROVAL OF ANY CHANGE IN CONTROLLING INTERESTS, PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, PARENT COMPANY OR SPONSORS; (II) OVERSIGHT OF THE OPERATOR AND ITS SHAREHOLDERS OR MEMBERS, AS APPLICABLE, INCLUDING LOCAL GOVERNANCE OF THE LIMITED SERVICES CLINICS; AND (III) RELATING TO THE CHARACTER AND COMPETENCE AND QUALIFICATIONS OF, AND CHANGES RELATING TO, THE DIRECTORS AND OFFICERS, THE OPERATOR AND ITS PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, COMPANY OR SPONSORS.

(B) THE FOLLOWING PROVISIONS OF THIS SECTION SHALL NOT APPLY TO LIMITED SERVICES CLINICS OPERATED PURSUANT TO THIS SUBDIVISION: (I) PARAGRAPH (B) OF SUBDIVISION THREE OF THIS SECTION, RELATING TO STOCKHOLDERS AND MEMBERS; (II) PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE DISPOSITION OF STOCK OR VOTING RIGHTS; AND (III) PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE OWNERSHIP OF STOCK OR MEMBERSHIP.

(C) A LIMITED SERVICES CLINIC SHALL BE DEEMED TO BE A "HEALTH CARE PROVIDER" FOR THE PURPOSES OF TITLE TWO-D OF ARTICLE TWO OF THIS CHAPTER. A PRESCRIBER PRACTICING IN A LIMITED SERVICES CLINIC SHALL NOT BE DEEMED TO BE IN THE EMPLOY OF A PHARMACY OR PRACTICING IN A HOSPITAL FOR PURPOSES OF SUBDIVISION TWO OF SECTION SIXTY-EIGHT HUNDRED SEVEN OF THE EDUCATION LAW.

(D) THE COMMISSIONER SHALL PROMULGATE REGULATIONS SETTING FORTH OPERATIONAL AND PHYSICAL PLANT STANDARDS FOR LIMITED SERVICES CLINICS, WHICH MAY BE DIFFERENT FROM THE REGULATIONS OTHERWISE APPLICABLE TO DIAGNOSTIC OR TREATMENT CENTERS, INCLUDING, BUT NOT LIMITED TO: DESIGNATING OR LIMITING THE DIAGNOSES AND SERVICES THAT MAY BE PROVIDED; PROHIBITING THE PROVISION OF SERVICES TO PATIENTS TWENTY-FOUR MONTHS OF AGE OR YOUNGER; AND REQUIREMENTS OR GUIDELINES FOR ADVERTISING AND SIGNAGE, DISCLOSURE OF OWNERSHIP INTERESTS, INFORMED CONSENT, RECORD KEEPING, REFERRAL FOR TREATMENT AND CONTINUITY OF CARE, CASE REPORTING TO THE PATIENT'S PRIMARY CARE OR OTHER HEALTH CARE PROVIDERS, DESIGN, CONSTRUCTION, FIXTURES, AND EQUIPMENT. IN MAKING REGULATIONS UNDER THIS SECTION, THE COMMISSIONER MAY CONSULT WITH A WORKGROUP INCLUDING BUT NOT LIMITED TO REPRESENTATIVES OF PROFESSIONAL SOCIETIES OF APPROPRIATE HEALTH CARE PROFESSIONALS, INCLUDING THOSE IN PRIMARY CARE AND OTHER SPECIALTIES AND SHALL PROMOTE AND STRENGTHEN PRIMARY CARE; THE INTEGRATION OF SERVICES PROVIDED BY LIMITED SERVICES CLINICS WITH THE SERVICES PROVIDED BY THE

PATIENT'S OTHER HEALTH CARE PROVIDERS; AND THE REFERRAL OF PATIENTS TO APPROPRIATE HEALTH CARE PROVIDERS, INCLUDING APPROPRIATE TRANSMISSION OF PATIENT HEALTH RECORDS.

(E) NOTWITHSTANDING THIS SUBDIVISION AND ANY OTHER LAW OR REGULATION TO THE CONTRARY AND SUBJECT TO THE PROVISIONS OF SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, A GENERAL HOSPITAL MAY OPERATE A LIMITED SERVICES CLINIC WHICH MEETS THE REGULATION PROMULGATED PURSUANT TO PARAGRAPH (D) OF THIS SUBDIVISION REGARDING OPERATIONAL AND PHYSICAL PLANT STANDARDS FOR LIMITED SERVICES CLINICS.

S 102. Intentionally omitted.

S 103. Intentionally omitted.

S 104. Section 2801-a of the public health law is amended by adding two new subdivisions 18 and 19 to read as follows:

18. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A PILOT PROGRAM TO ASSIST IN ESTABLISHING OR RESTRUCTURING HEALTH CARE DELIVERY SYSTEMS THROUGH INCREASED CAPITAL INVESTMENT IN HEALTH CARE FACILITIES. PURSUANT TO THE PILOT PROGRAM, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL APPROVE THE ESTABLISHMENT, IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION THREE OF THIS SECTION, OF NO MORE THAN TEN ENTITIES FORMED UNDER EITHER THIS SUBDIVISION OR SUBDIVISION NINETEEN OF THIS SECTION, AT LEAST ONE OF WHICH SHALL BE THE OPERATOR OF A HOSPITAL OR HOSPITALS IN KINGS COUNTY. SUCH ENTITIES SHALL AFFILIATE, THE EXTENT OF THE AFFILIATION TO BE DETERMINED BY THE COMMISSIONER, WITH AT LEAST ONE ACADEMIC MEDICAL INSTITUTION OR TEACHING HOSPITAL APPROVED BY THE COMMISSIONER.

(B) IN ORDER TO ACHIEVE SUCCESS IN THE PILOT PROGRAM WHILE MAINTAINING THE HEALTH AND COMMUNITY MISSION OF A HOSPITAL OR HOSPITALS, THE PILOT PROGRAM MAY ADOPT EITHER A PILOT PROGRAM USING THE PROVISIONS OF ARTICLE SEVENTEEN OF THE BUSINESS CORPORATION LAW PERTAINING TO BENEFIT CORPORATIONS OR, IN THE ALTERNATIVE, THE PROCESS SET FORTH HEREIN IN SUBDIVISION NINETEEN OF THIS SECTION. NOTWITHSTANDING ANY OTHER PROVISIONS TO THE CONTRARY, A PILOT PROGRAM MAY BE A HOSPITAL CORPORATION OWNED OR OPERATED THROUGH A BENEFIT CORPORATION BUT NOT A PUBLICLY TRADED CORPORATION.

(C) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, ENTITIES ESTABLISHED PURSUANT TO THIS SUBDIVISION OR SUBDIVISION NINETEEN OF THIS SECTION SHALL BE DEEMED ELIGIBLE TO PARTICIPATE IN DEBT FINANCING PROVIDED BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK, LOCAL DEVELOPMENT CORPORATIONS AND ECONOMIC DEVELOPMENT CORPORATIONS.

(D) THE FOLLOWING PROVISIONS OF THIS CHAPTER SHALL NOT APPLY TO ENTITIES ESTABLISHED PURSUANT TO THIS SUBDIVISION OR SUBDIVISION NINETEEN OF THIS SECTION: (I) PARAGRAPH (B) OF SUBDIVISIONS THREE OF THIS SECTION, RELATING TO STOCKHOLDERS; (II) PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE DISPOSITION OF STOCK OR VOTING RIGHTS; (III) PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE OWNERSHIP OF STOCK; AND (IV) PARAGRAPH (A) OF SUBDIVISION THREE OF SECTION FOUR THOUSAND FOUR OF THIS CHAPTER, RELATING TO THE OWNERSHIP OF STOCK. NOTWITHSTANDING THE FOREGOING, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MAY REQUIRE THE DISCLOSURE OF THE IDENTITY OF STOCKHOLDERS OR OTHER INDIVIDUALS SUCH AS LIMITED PARTNERS, PROVIDED THAT THE NUMBER OF STOCKHOLDERS DOES NOT EXCEED THIRTY-FIVE.

(E) THE CORPORATION POWERS AND PURPOSES OF A CORPORATION WHO IS AN OPERATOR PURSUANT TO THIS SUBDIVISION SHALL BE LIMITED TO THE OWNERSHIP AND OPERATION, OR OPERATION, OF A HOSPITAL OR HOSPITALS SPECIFICALLY NAMED AND THE LOCATION OR LOCATIONS OF WHICH ARE SPECIFICALLY DESIGNATED BY STREET ADDRESS, CITY, TOWN, VILLAGE OF LOCALITY AND COUNTY; PROVIDED, HOWEVER, THAT THE CORPORATE POWERS AND PURPOSES MAY ALSO INCLUDE THE

OWNERSHIP AND OPERATION, OR OPERATION, OF A CERTIFIED HOME HEALTH AGENCY OR LICENSED HOME CARE SERVICES AGENCY OR AGENCIES AS DEFINED IN ARTICLE THIRTY-SIX OF THIS CHAPTER OR A HOSPICE OR HOSPICES AS DEFINED IN ARTICLE FORTY OF THIS CHAPTER, IF THE CORPORATION HAS RECEIVED ALL APPROVALS REQUIRED UNDER SUCH LAW TO OWN AND OPERATE, OR OPERATE, SUCH HOME CARE SERVICE AGENCY OR AGENCIES OR HOSPICE OR HOSPICES. SUCH CORPORATE POWERS AND PURPOSES SHALL NOT BE MODIFIED, AMENDED OR DELETED WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER.

(F) (1) ENTITIES FORMED UNDER THIS SUBDIVISION OR SUBDIVISION NINETEEN OF THIS SECTION SHALL PROVIDE, THAT, IN DISCHARGING THE DUTIES OF THEIR RESPECTIVE POSITIONS, THE BOARD OF DIRECTORS, COMMITTEES OF THE BOARD AND INDIVIDUAL DIRECTORS AND OFFICERS OF AN ENTITY OPERATING PURSUANT TO THIS SUBDIVISION SHALL CONSIDER THE EFFECTS OF ANY ACTION UPON:

(A) THE ABILITY OF THE ENTITY TO ACCOMPLISH ITS PURPOSE;

(B) THE SHAREHOLDERS OF THE BUSINESS CORPORATION OR PARTNERS IN A PARTNERSHIP;

(C) THE EMPLOYEES AND WORKFORCE OF THE BUSINESS;

(D) THE INTERESTS OF PATIENTS OF THE HOSPITAL OR HOSPITALS;

(E) COMMUNITY AND SOCIETAL CONSIDERATIONS, INCLUDING THOSE OF ANY COMMUNITY IN WHICH FACILITIES OF THE CORPORATION ARE LOCATED;

(F) THE LOCAL AND GLOBAL ENVIRONMENT; AND

(G) THE SHORT-TERM AND LONG-TERM INTERESTS OF THE ENTITY, INCLUDING BENEFITS THAT MAY ACCRUE FROM ITS LONG TERM PLANS.

(2) THE CONSIDERATION OF INTERESTS AND FACTORS IN THE MANNER REQUIRED BY PARAGRAPH ONE OF THIS SUBDIVISION:

(A) SHALL NOT CONSTITUTE A VIOLATION OF THE PROVISIONS OF SECTION SEVEN HUNDRED FIFTEEN OR SEVEN HUNDRED SEVENTEEN OF THE BUSINESS CORPORATION LAW; AND

(B) IS IN ADDITION TO THE ABILITY OF DIRECTORS TO CONSIDER INTERESTS AND FACTORS AS PROVIDED IN SECTION SEVEN HUNDRED SEVENTEEN OF THE BUSINESS CORPORATION LAW.

(G) A SALE, LEASE, CONVEYANCE, EXCHANGE, TRANSFER, OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF THE CORPORATION SHALL NOT BE EFFECTIVE UNLESS THE TRANSACTION IS APPROVED BY THE COMMISSIONER.

(H) NO LATER THAN TWO YEARS AFTER THE ESTABLISHMENT OF A BUSINESS CORPORATION UNDER THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE THE GOVERNOR, THE MAJORITY LEADER OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY WITH A WRITTEN EVALUATION OF THE PROGRAM. SUCH EVALUATION SHALL ADDRESS THE OVERALL EFFECTIVENESS OF THE PROGRAM IN ALLOWING FOR ACCESS TO CAPITAL INVESTMENT IN HEALTH CARE FACILITIES AND THE IMPACT SUCH ACCESS MAY HAVE ON THE QUALITY OF CARE PROVIDED BY HOSPITALS OPERATED BY BUSINESS CORPORATIONS ESTABLISHED UNDER THIS SUBDIVISION.

19. (A) THE COMMISSIONER MAY ESTABLISH A PROGRAM WHEREBY THE DEPARTMENT ACCEPTS APPLICATIONS FOR DEMONSTRATION PROJECTS IN THE STATE TO DEVELOP, EVALUATE AND IMPLEMENT A FLEXIBLE APPROACH TO ALLOWING PRIVATE CAPITAL INVESTMENTS AND PRIVATE EQUITY INTERESTS IN HOSPITALS. IN LIGHT OF THE SEVERE CONSTRAINTS ON THE AVAILABILITY OF INVESTMENT CAPITAL FOR THE HEALTH CARE SYSTEM IN NEW YORK, DEMONSTRATION PROJECTS SHALL BE DESIGNED TO PROMOTE THE DEVELOPMENT OF NEW SOURCES OF CAPITAL FOR THE OPERATION OF HOSPITALS AND TO EVALUATE THE IMPACT PRIVATE EQUITY INVESTMENT HAS ON THE QUALITY OF CARE, ACCESS TO CARE AND BENEFIT TO THE HOSPITAL, ITS PATIENTS AND THE SURROUNDING COMMUNITY. THE COMMISSIONER MAY, IN APPROVING A DEMONSTRATION PROJECT, WAIVE THE PROVISIONS OF THIS ARTICLE WHICH RELATE TO THE OWNERSHIP STRUCTURE, PROVIDED THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL APPROVE SUCH PROJECT.

(B) APPLICANTS SHALL AT A MINIMUM DEMONSTRATE THAT:

(I) THE FACILITY OR FACILITIES HAVE HISTORIES OF PROVIDING CARE;
(II) THE PROJECT IS COMMITTED TO PRESERVING QUALITY, ACCESS TO CARE AND ACCEPTANCE OF A BROAD MIX OF PAYOR TYPES;
(III) THE PROJECT WILL PROVIDE A POSITIVE BENEFIT TO THE HOSPITAL, ITS PATIENTS AND THE COMMUNITY AT LARGE; AND
(IV) ALL APPLICABLE DUTIES, PROCEDURES, OBLIGATIONS AND REQUIREMENTS APPLICABLE TO PUBLIC HOSPITALS IN NEW YORK INCLUDING, BUT NOT LIMITED TO CHARITABLE CARE AND SUPPORT, COMMUNITY PLANS AND OBLIGATIONS, PROVISION OF CARE TO THOSE IN NEED AND ALL ATTAINMENT OF QUALITY CARE STANDARDS SET FORTH IN THIS CHAPTER WILL BE ADHERED TO.
(C) HOSPITALS PARTICIPATING IN THIS DEMONSTRATION PROGRAM SHALL BE SUBJECT TO ALL OPERATING STANDARDS AS SET FORTH IN THIS CHAPTER AND THE REGULATIONS PROMULGATED PURSUANT THERETO, AND SHALL BE SUBJECT TO ANY PROVISIONS OF THIS CHAPTER FOR FAILURE TO COMPLY WITH SUCH STANDARDS.
(D) DEMONSTRATION PROJECTS APPROVED BY THE COMMISSIONER SHALL PROVIDE DETAILED REPORTING NO LESS THAN ANNUALLY TO THE DEPARTMENT IN A FORM AND MANNER TO BE DETERMINED BY THE COMMISSIONER TO INSURE THE GOALS ARE BEING MET. THE COMMISSIONER SHALL PROVIDE THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY WITH A WRITTEN REPORT ON THE PROGRAM, INCLUDING DETAILS OF ALL APPLICATIONS RECEIVED, THE BASIS FOR APPROVAL OR DENIAL OF THE APPLICATIONS, AND A FULL EVALUATION OF DEMONSTRATION PROJECTS WHICH WERE APPROVED BASED ON THE GOALS OF THE PROGRAM NO LATER THAN TWO YEARS AFTER THE FIRST HOSPITAL MAKES APPLICATION UNDER THE DEMONSTRATION PROGRAM.
S 105. Intentionally omitted.
S 105-a. Intentionally omitted.
S 106. Part S of chapter 56 of the laws of 2012, relating to the excess medical malpractice liability coverage pool, is amended by adding a new section 2-a to read as follows:
S 2-A. NOTWITHSTANDING ANY LAW, RULE OR REGULATION TO THE CONTRARY, ONLY PHYSICIANS OR DENTISTS WHO WERE ELIGIBLE, AND FOR WHOM THE SUPERINTENDENT OF FINANCIAL SERVICES AND THE COMMISSIONER OF HEALTH, OR THEIR DESIGNEE, PURCHASED, WITH FUNDS AVAILABLE IN THE HOSPITAL EXCESS LIABILITY POOL, A FULL OR PARTIAL POLICY FOR EXCESS COVERAGE OR EQUIVALENT EXCESS COVERAGE FOR THE COVERAGE PERIODS ENDING THE THIRTIETH OF JUNE, TWO THOUSAND THIRTEEN, SHALL BE ELIGIBLE TO APPLY FOR SUCH COVERAGE FOR THE COVERAGE PERIOD BEGINNING THE FIRST OF JULY, TWO THOUSAND THIRTEEN. A GENERAL HOSPITAL MAY CERTIFY ADDITIONAL ELIGIBLE PHYSICIANS OR DENTISTS UP TO THE TOTAL NUMBER OF ELIGIBLE PHYSICIANS AND DENTISTS CERTIFIED BY THE GENERAL HOSPITAL FOR THE COVERAGE PERIOD ENDING THE THIRTIETH DAY OF JUNE, TWO THOUSAND THIRTEEN.
S 107. Intentionally omitted.
S 108. Intentionally omitted.
S 109. Intentionally omitted.
S 110. Intentionally omitted.
S 111. Intentionally omitted.
S 112. Intentionally omitted.
S 113. Intentionally omitted.
S 114. Intentionally omitted.
S 115. Intentionally omitted.
S 116. Intentionally omitted.
S 117. Intentionally omitted.
S 118. Intentionally omitted.
S 119. 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 120. 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 121. Intentionally omitted.

S 122. Section 2807 of the public health law is amended by adding a new subdivision 20 to read as follows:

20. MEDICAL ASSISTANCE RECOUPMENTS AND REDUCTIONS. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, ANY RECOUPMENTS OR REDUCTIONS IN MEDICAL ASSISTANCE PAYMENTS, INCLUDING BUT NOT LIMITED TO ARTICLE TWENTY-EIGHT FACILITIES LICENSED PURSUANT TO THIS ARTICLE OR FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW SHALL NOT BE SUBJECT TO INTEREST OR INTEREST PENALTIES.

S 123. Section 2808 of the public health law is amended by adding a new subdivision 27 to read as follows:

27. MEDICAL ASSISTANCE RECOUPMENTS AND REDUCTIONS. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, ANY RECOUPMENTS OR REDUCTIONS IN MEDICAL ASSISTANCE PAYMENTS, INCLUDING BUT NOT LIMITED TO ARTICLE TWENTY-EIGHT FACILITIES LICENSED PURSUANT TO THIS ARTICLE OR FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW SHALL NOT BE SUBJECT TO INTEREST OR INTEREST PENALTIES.

S 124. Short title. Sections one hundred twenty-four through one hundred twenty-six of this act shall be known and may be cited as the "home care stabilization act".

S 125. The public health law is amended by adding two new sections 3614-d and 3621 to read as follows:

S 3614-D. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR PAYMENTS FOR PERSONAL CARE, HOME HEALTH CARE SERVICES OR OTHER LONG TERM CARE SERVICES. 1. IN THE PROCESSING OF CLAIMS SUBMITTED UNDER CONTRACTS OR AGREEMENTS ISSUED OR ENTERED INTO OR BETWEEN CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES PROGRAMS, FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, INSURERS, MANAGED LONG TERM CARE PLANS, MANAGED CARE PLANS OR ORGANIZATIONS LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW OR THE INSURANCE LAW AND FOR ALL BILLS FOR PERSONAL CARE, HOME HEALTH CARE SERVICES, CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW OR OTHER LONG TERM CARE SERVICES RENDERED BY LICENSED HOME CARE SERVICES PROGRAMS, CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS OR A FISCAL INTERMEDIARY OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW PURSUANT TO SUCH CONTRACTS OR AGREEMENTS, ANY CERTIFIED HOME HEALTH CARE AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, INSURER, MANAGED LONG TERM CARE PLAN, MANAGED CARE PLAN OR ORGANIZATION LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW, THE EXECUTIVE LAW OR THE INSURANCE LAW, SHALL ADHERE TO THE FOLLOWING STANDARDS:

(A) SHALL PAY A CLEAN CLAIM SUBMITTED BY A LICENSED HOME CARE SERVICES PROGRAM, CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR A FISCAL INTERMEDIARY OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW WITHIN THIRTY DAYS OF RECEIPT OF THE CLEAN CLAIM FOR SERVICES RENDERED THAT IS TRANSMITTED VIA THE INTERNET OR ELECTRONIC MAIL, OR FORTY-FIVE DAYS OF RECEIPT OF THE CLEAN CLAIM FOR SERVICES RENDERED THAT IS SUBMITTED BY OTHER MEANS, SUCH AS PAPER OR FACSIMILE;

(B) SHALL PAY ANY UNDISPUTED PORTION OF A CLAIM AS A CLEAN CLAIM AS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION SUBMITTED BY A LICENSED HOME CARE SERVICES PROGRAM, CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR FISCAL INTERMEDIARY OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW;

(C) NOTIFY ANY SUCH AGENCY, PROGRAM OR FISCAL INTERMEDIARY IN WRITING WITHIN FIFTEEN CALENDAR DAYS OF THE RECEIPT OF AN INITIAL CLAIM OF ALL SPECIFIC DEFECTS OR DISPUTES OF SUCH CLAIM AND SPECIFICALLY REQUEST IN WRITING THE ADDITIONAL INFORMATION OR REMEDY NEEDED TO PROCESS ANY DISPUTED PORTIONS OF THE CLAIM; AND

(D) ANY DISPUTED CLAIM REMEDIED SHALL BE PAID AS A CLEAN CLAIM AS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION.

2. FOR THE PURPOSES OF THIS SECTION, A "CLEAN CLAIM" SHALL:

(A) IDENTIFY THE LICENSED HOME CARE SERVICES PROGRAM, CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR FISCAL INTERMEDIARY OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW;

(B) SUFFICIENTLY IDENTIFY THE ELIGIBLE COVERED PERSON;

(C) LIST THE DATE AND PLACE OF SERVICE;

(D) SUBSTANTIATE THE APPROPRIATENESS OF THE SERVICE PROVIDED;

(E) STATE IF PRIOR AUTHORIZATION IS REQUIRED FOR SUCH ELIGIBLE COVERED PERSON AND SERVICE; AND

(F) STATE ANY DOCUMENTATION AS REASONABLY REQUIRED BY ANY ENTITY REFERENCED IN THIS SECTION.

3. EACH CLEAN CLAIM OR PAYMENT FOR SERVICES PROCESSED IN VIOLATION OF THIS SECTION SHALL CONSTITUTE A SEPARATE VIOLATION. IN ADDITION TO THE PENALTIES PROVIDED IN THIS CHAPTER, ANY ORGANIZATION OR CORPORATION THAT FAILS TO ADHERE TO THE STANDARDS CONTAINED IN THIS SECTION SHALL BE OBLIGATED TO PAY TO CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME HEALTH CARE PROGRAMS OR FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW IN FULL SETTLEMENT OF THE BILL, CLAIM OR PAYMENT PLUS INTEREST ON THE AMOUNT OF SUCH BILL, CLAIM OR PAYMENT OF THE GREATER OF THE RATE EQUAL TO THE RATE SET BY THE COMMISSIONER OF TAXATION AND FINANCE FOR CORPORATE TAXES PURSUANT TO PARAGRAPH ONE OF SUBSECTION (E) OF SECTION ONE THOUSAND NINETY-SIX OF THE TAX LAW OR TWELVE PERCENT PER ANNUM, TO BE COMPUTED FROM THE DATE THE BILL, CLAIM OR PAYMENT WAS REQUIRED TO BE MADE.

S 3621. MEDICAL ASSISTANCE RECOUPMENTS AND REDUCTIONS. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, ANY RECOUPMENTS OR REDUCTIONS IN MEDICAL ASSISTANCE PAYMENTS FOR LICENSED HOME CARE SERVICES AGENCIES, CERTIFIED HOME HEALTH AGENCIES LICENSED PURSUANT TO THIS ARTICLE OR FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW SHALL NOT BE SUBJECT TO INTEREST OR INTEREST PENALTIES.

S 126. Section 4406-c of the public health law is amended by adding a new subdivision 9 to read as follows:

9. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, CONTRACTS WITH CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES PROGRAMS OR FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW TO PROVIDE HOME CARE AIDE SERVICES AS DEFINED IN SECTION THIRTY-SIX HUNDRED FOURTEEN-C OF THIS CHAPTER OR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES AS AUTHORIZED PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW SHALL AT A MINIMUM ENSURE THAT THE RESOURCES MADE AVAILABLE BY SUCH CONTRACTS SHALL SUPPORT COMPENSATION FOR PERSONS PROVIDING SUCH HOME CARE AIDE SERVICES AND CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES TO ENSURE THE RETENTION OF A QUALIFIED WORKFORCE CAPABLE OF PROVIDING HIGH QUALITY CARE TO RECIPIENTS OF SUCH SERVICES CONSISTENT WITH THE PROVISIONS OF SUCH SECTION.

S 126-a. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of section 3217-a of the insurance law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs 16-a, 18 and 19 are added to read as follows:

(11) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer may obtain a referral to a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the insured and the procedure by which the insured can obtain such referral;

(12) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained;

(16) notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization; [and]

(16-A) WHERE APPLICABLE, NOTICE THAT AN INSURED SHALL HAVE DIRECT ACCESS TO PRIMARY AND PREVENTIVE OBSTETRIC AND GYNECOLOGIC SERVICES INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, FROM A QUALIFIED PROVIDER OF SUCH SERVICES OF HER CHOICE FROM WITHIN THE PLAN OR FOR ANY CARE RELATED TO A PREGNANCY;

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and

in addition, in the case of physicians, board certification[.], LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE INSURER'S WEBSITE AND THE INSURER SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE INSURER'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(18) A DESCRIPTION OF THE METHOD BY WHICH AN INSURED MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

(19) WHERE APPLICABLE, WHEN A POLICY OFFERS OUT-OF-NETWORK COVERAGE PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO HUNDRED FORTY OF THIS ARTICLE:

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE INSURER TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) A DESCRIPTION OF THE AMOUNT THAT THE INSURER WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

S 127. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the insurance law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs 13, 14 and 15 are added to read as follows:

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the insurer for participation in the insurer's network for a managed care product; [and]

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(15) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN INSURED OR PROSPECTIVE INSURED TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE INSURER WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 128. Section 3217-a of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 129. Section 3217-d of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 130. Section 3224-a of the insurance law is amended by adding a new subsection (j) to read as follows:

(J) AN INSURER OR AN ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW SHALL ACCEPT CLAIMS SUBMITTED BY A POLICYHOLDER OR COVERED PERSON THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE.

S 131. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. NETWORK COVERAGE. (A) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, OR A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER THAT ISSUES A HEALTH INSURANCE POLICY OR CONTRACT WITH A NETWORK OF HEALTH CARE PROVIDERS SHALL ENSURE THAT THE NETWORK IS ADEQUATE TO MEET THE HEALTH NEEDS OF INSUREDS AND PROVIDE AN APPROPRIATE CHOICE OF PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE POLICY OR CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF HEALTH CARE PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S INITIAL APPROVAL OF A HEALTH INSURANCE POLICY OR CONTRACT; AT LEAST EVERY THREE YEARS THEREAFTER; AND UPON APPLICATION FOR EXPANSION OF ANY SERVICE AREA ASSOCIATED WITH THE POLICY OR CONTRACT. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED BY THE COMMISSIONER OF HEALTH TO MEET THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE BY THE SUPERINTENDENT.

(B) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES SHALL PROVIDE SIGNIFICANT COVERAGE OF THE USUAL AND CUSTOMARY COSTS OF OUT-OF-NETWORK HEALTH CARE SERVICES.

(C) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, THAT PROVIDES COVERAGE FOR OUT-OF-NETWORK SERVICES SHALL OFFER AT LEAST ONE POLICY OR CONTRACT OPTION IN EACH GEOGRAPHICAL REGION COVERED THAT PROVIDES COVERAGE FOR AT LEAST EIGHTY PERCENT OF THE USUAL AND CUSTOMARY COST OF OUT-OF-NETWORK HEALTH CARE SERVICES AFTER IMPOSITION OF A DEDUCTIBLE.

(D) FOR THE PURPOSES OF THIS SECTION "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY

AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS ARTICLE, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 132. Section 4306-c of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 133. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of section 4324 of the insurance law, as added by chapter 705 of the laws of 1996, paragraph 16-a as added by chapter 554 of the laws of 2002, are amended and two new paragraphs 19 and 20 are added to read as follows:

(11) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation may obtain a referral to a health care provider outside of the corporation's network or panel when the corporation does not have a health care provider with appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral;

(12) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(16-a) where applicable, notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification[; and], LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE CORPORATION'S WEBSITE AND THE CORPORATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE CORPORATION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation[.];

(19) A DESCRIPTION OF THE METHOD BY WHICH A SUBSCRIBER MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

(20) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO HUNDRED FORTY OF THIS CHAPTER:

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE CORPORATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) A DESCRIPTION OF THE AMOUNT THAT THE CORPORATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

S 134. Paragraphs 11 and 12 of subsection (b) of section 4324 of the insurance law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs 13, 14 and 15 are added to read as follows:

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the corporation for participation in the corporation's network for a managed care product; [and]

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(14) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(15) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS A SUBSCRIBER OR PROSPECTIVE SUBSCRIBER TO DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE CORPORATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH

CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 135. Section 4324 of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO THIS ARTICLE, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 136. Subsection (g-7) of section 4900 of the insurance law is redesignated subsection (g-8) and a new subsection (g-7) is added to read as follows:

(G-7) "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL UNDER A MANAGED CARE PRODUCT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REFERRAL PROVIDED TO AN INSURED SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE INSURED MUST SUBMIT IN ORDER TO APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBSECTION (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBSECTION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBSECTION (G-6) OF THIS SECTION.

S 137. Subsection (b) of section 4903 of the insurance law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. THE NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSIDERED IN-NETWORK OR OUT-OF-NETWORK.

S 138. Section 4904 of the insurance law is amended by adding a new subsection (a-2) to read as follows:

(A-2) AN INSURED OR THE INSURED'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE INSURED'S ATTENDING PHYSICIAN, WHO MUST BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT THAT: (1) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND (2) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 139. Subsection (b) of section 4910 of the insurance law is amended by adding a new paragraph 4 to read as follows:

(4) (A) THE INSURED HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(B) THE INSURED'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 140. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(I) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE INSURED, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE INSURED'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(II) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE INSURED; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 141. The public health law is amended by adding a new section 23 to read as follows:

S 23. DISCLOSURE. 1. A HEALTH CARE PROFESSIONAL SHALL DISCLOSE TO PATIENTS OR PROSPECTIVE PATIENTS THROUGH AN INTERNET WEBSITE OR, UPON REQUEST, IN WRITING THE HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROFESSIONAL IS A PARTICIPATING PROVIDER AND THE HOSPITALS WITH WHICH THE HEALTH CARE PROFESSIONAL IS AFFILIATED.

2. IF A HEALTH CARE PROFESSIONAL DOES NOT PARTICIPATE IN THE NETWORK OF A PATIENT'S OR PROSPECTIVE PATIENT'S HEALTH CARE PLAN, THE HEALTH CARE PROFESSIONAL SHALL, UPON RECEIPT OF A REQUEST FROM A PATIENT OR PROSPECTIVE PATIENT, DISCLOSE TO THE PATIENT OR PROSPECTIVE PATIENT IN WRITING A GOOD FAITH ESTIMATED AMOUNT THE HEALTH CARE PROFESSIONAL WILL BILL THE PATIENT OR PROSPECTIVE PATIENT FOR HEALTH CARE SERVICES PROVIDED OR ANTICIPATED TO BE PROVIDED TO THE PATIENT OR PROSPECTIVE PATIENT.

3. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROVIDER OF ANESTHESIOLOGY, LABORATORY, PATHOLOGY, RADIOLOGY OR ASSISTANT SURGEON SERVICES PERFORMED IN THE PHYSICIAN'S OFFICE OR COORDINATED OR REFERRED BY THE PHYSICIAN.

4. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL, FOR A PATIENT'S SCHEDULED HOSPITAL ADMISSION OR SCHEDULED OUTPATIENT HOSPITAL SERVICES, PROVIDE A PATIENT AND THE HOSPITAL WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY OTHER PHYSICIAN WHOSE SERVICES WILL BE ARRANGED BY THE PHYSICIAN AND ARE SCHEDULED AT THE TIME OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION.

5. A HOSPITAL SHALL ESTABLISH, UPDATE, MAKE PUBLIC AND POST ON THE HOSPITAL'S WEBSITE, A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR ITEMS AND SERVICES PROVIDED BY THE HOSPITAL, INCLUDING FOR DIAGNOSIS-RELATED GROUPS ESTABLISHED UNDER SECTION 1886(D)(4) OF THE FEDERAL SOCIAL SECURITY ACT.

6. A HOSPITAL SHALL POST ON THE HOSPITAL'S WEBSITE: (A) THE HEALTH CARE PLANS IN WHICH THE HOSPITAL IS A PARTICIPATING PROVIDER; AND (B) THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN AND WHOSE SERVICES WILL BE PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL CHARGES.

7. A HOSPITAL SHALL, AT THE EARLIER OF EITHER PRE-ADMISSION TESTING, OUTPATIENT REGISTRATION, OR A NON-EMERGENCY HOSPITAL ADMISSION: (A) PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN AND WHOSE SERVICES ARE REASONABLY ANTICIPATED AT THE TIME OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION AND WILL BE PROVIDED AT THE HOSPITAL, BUT WILL NOT BE BILLED AS PART OF THE HOSPITAL CHARGES, AS REPORTED BY THE PATIENT'S PHYSICIAN; AND (B) DISCLOSE WHETHER THE SERVICES OF HEALTH CARE PROFESSIONALS WHO ARE PHYSICIANS AND TYPICALLY PROVIDE HOSPITAL SERVICES SUCH AS, BUT NOT LIMITED TO, ANESTHESIOLOGY, PATHOLOGY OR RADIOLOGY ARE BILLED AS PART OF THE HOSPITAL CHARGES.

8. FOR PURPOSES OF THIS SECTION:

(A) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER; OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

(B) "HEALTH CARE PROFESSIONAL" MEANS AN APPROPRIATELY LICENSED, REGISTERED OR CERTIFIED HEALTH CARE PROFESSIONAL PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

S 142. Paragraphs (p-1), (q) and (r) of subdivision 1 of section 4408 of the public health law, paragraph (p-1) as added by chapter 554 of the

laws of 2002 and paragraphs (q) and (r) as added by chapter 705 of the laws of 1996, are amended and two new paragraphs (s) and (t) are added to read as follows:

(p-1) notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

(q) notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization; [and]

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification[.], LANGUAGES SPOKEN AND AFFILIATION WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE HEALTH MAINTENANCE ORGANIZATION'S WEBSITE AND THE HEALTH MAINTENANCE ORGANIZATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE HEALTH MAINTENANCE ORGANIZATION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(S) WHERE APPLICABLE, A DESCRIPTION OF THE METHOD BY WHICH AN ENROLLEE MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES, INCLUDING THROUGH THE INTERNET, ELECTRONIC MAIL OR BY FACSIMILE; AND

(T) WHERE APPLICABLE, WHEN A CONTRACT OFFERS OUT-OF-NETWORK COVERAGE PURSUANT TO SUBSECTIONS (B) AND (C) OF SECTION THREE THOUSAND TWO HUNDRED FORTY OF THE INSURANCE LAW:

(I) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE HEALTH MAINTENANCE ORGANIZATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(II) A DESCRIPTION OF THE AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(III) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES.

S 143. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the public health law, as added by chapter 705 of the laws of 1996, are amended and three new paragraphs (m), (n) and (o) are added to read as follows:

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization; [and]

(l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(M) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER;

(N) WHERE APPLICABLE, WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE; AND

(O) PROVIDE INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN ENROLLEE OR PROSPECTIVE ENROLLEE TO DETERMINE

THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 144. Section 4408 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT OF FINANCIAL SERVICES. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO THIS ARTICLE.

S 145. Subdivision 7-g of section 4900 of the public health law is renumbered subdivision 7-h and a new subdivision 7-g is added to read as follows:

7-G. "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF A DENIAL OF AN OUT-OF-NETWORK REFERRAL PROVIDED TO AN ENROLLEE SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE ENROLLEE MUST SUBMIT IN ORDER TO APPEAL THE DENIAL OF AN OUT-OF-NETWORK REFERRAL PURSUANT TO SUBDIVISION ONE-B OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL UNDER THIS SUBDIVISION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. A DENIAL OF AN OUT-OF-NETWORK REFERRAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBDIVISION SEVEN-F OF THIS SECTION.

S 146. Subdivision 2 of section 4903 of the public health law, as added by chapter 705 of the laws of 1996, is amended to read as follows:

2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. THE NOTIFICATION SHALL IDENTIFY WHETHER THE SERVICES ARE CONSIDERED IN-NETWORK OR OUT-OF-NETWORK.

S 147. Section 4904 of the public health law is amended by adding a new subdivision 1-b to read as follows:

1-B. AN ENROLLEE OR THE ENROLLEE'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE ENROLLEE'S ATTENDING PHYSICIAN, WHO MUST BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT THAT: (A) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE FOR THE HEALTH SERVICE; AND (B) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO

MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 148. Subdivision 2 of section 4910 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D) (I) THE ENROLLEE HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(II) THE ENROLLEE'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 149. Paragraph (d) of subdivision 2 of section 4914 of the public health law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(2) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE ENROLLEE; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 150. The financial services law is amended by adding a new article 7 to read as follows:

ARTICLE 7
EMERGENCY MEDICAL SERVICES

SECTION 701. DEFINITIONS.
702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES.
703. DISPUTE RESOLUTION.
704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES.

S 701. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE:

(A) "EMERGENCY CONDITION" MEANS A MEDICAL OR BEHAVIORAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON, POSSESSING AN AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, COULD REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN (1) PLACING THE HEALTH OF THE PERSON AFFLICTED WITH SUCH CONDITION IN SERIOUS JEOPARDY, OR IN THE CASE OF A BEHAVIORAL CONDITION PLACING THE HEALTH OF SUCH PERSON OR OTHERS IN SERIOUS JEOPARDY; (2) SERIOUS IMPAIRMENT TO SUCH PERSON'S BODILY FUNCTIONS; (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART OF SUCH PERSON; (4) SERIOUS DISFIGUREMENT OF SUCH PERSON; OR (5) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT.

(B) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (1) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION; AND (2) WITHIN THE CAPABILITIES OF THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(C) "EXCESSIVE FEE" MEANS A FEE THAT IS IN EXCESS OF AN AMOUNT DETERMINED IN ACCORDANCE WITH SECTION SEVEN HUNDRED FOUR OF THIS ARTICLE.

(D) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

(E) "INSURED" MEANS A PATIENT COVERED UNDER A POLICY OR CONTRACT WITH A HEALTH CARE PLAN.

(F) "PATIENT" MEANS A PERSON WHO RECEIVES EMERGENCY SERVICES IN THIS STATE.

(G) "USUAL AND CUSTOMARY COST" MEANS THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 702. PROHIBITION OF EXCESSIVE CHARGES FOR EMERGENCY SERVICES. (A) A PHYSICIAN WHO PROVIDES HEALTH CARE SERVICES IN THIS STATE SHALL NOT CHARGE AN EXCESSIVE FEE BASED ON THE CRITERIA FOR PROVIDING EMERGENCY SERVICES IN SECTION SEVEN HUNDRED THREE OF THIS ARTICLE.

(B) THIS ARTICLE SHALL NOT APPLY TO EMERGENCY SERVICES WHERE PROVIDER FEES ARE SUBJECT TO SCHEDULES OR OTHER MONETARY LIMITATIONS UNDER ANY

OTHER LAW, INCLUDING THE WORKERS' COMPENSATION LAW AND ARTICLE FIFTY-ONE OF THE INSURANCE LAW, AND SHALL NOT PREEMPT ANY SUCH LAW.

S 703. DISPUTE RESOLUTION. (A) A HEALTH CARE PLAN OR A PATIENT ALLEGING THAT A PHYSICIAN HAS CHARGED AN EXCESSIVE FEE FOR PROVIDING EMERGENCY SERVICES MAY SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY, IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE SUPERINTENDENT, IF THE PHYSICIAN'S CHARGE EXCEEDS THE USUAL AND CUSTOMARY COST OF THE HEALTH CARE SERVICES.

(B) A PATIENT SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE RESOLUTION ENTITY.

(C) A HEALTH CARE PLAN SHALL NOT SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE RESOLUTION ENTITY UNLESS SUCH PLAN HAS MADE PAYMENT, IN FULL, OF THE PHYSICIAN'S FEE, EXCEPT FOR THE INSURED'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE, FOR THE SERVICES RENDERED. THE HEALTH CARE PLAN MAY ADVISE THE PHYSICIAN THAT THE PAYMENT IS BEING MADE UNDER PROTEST.

S 704. CRITERIA FOR DETERMINING EXCESSIVE CHARGES. (A) (1) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DECIDE WHETHER THE FEE CHARGED BY THE PHYSICIAN FOR THE SERVICES RENDERED IS EXCESSIVE. IN MAKING SUCH A DETERMINATION THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS INCLUDING:

(I) WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE PHYSICIAN FOR SERVICES RENDERED AS COMPARED TO: (A) FEES PAID BY THE HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED PHYSICIANS FOR THE SAME SERVICES IN THE SAME REGION WHO DO NOT PARTICIPATE WITH THE HEALTH CARE PLAN; AND (B) FEES PAID TO THE INVOLVED PHYSICIAN FOR THE SAME SERVICES RENDERED BY THE PHYSICIAN TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN DOES NOT PARTICIPATE;

(II) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE PHYSICIAN;

(III) THE PHYSICIAN'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN DOES NOT PARTICIPATE;

(IV) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING TIME AND PLACE OF THE SERVICE;

(V) INDIVIDUAL PATIENT CHARACTERISTICS; AND

(VI) THE USUAL AND CUSTOMARY COST OF THE SERVICE.

(2) IF THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THAT THE FEE CHARGED IS EXCESSIVE, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES BASED UPON THE SAME CONDITIONS AND FACTORS SET FORTH IN THIS SUBDIVISION, WHICH FEE SHALL NOT BE LESS THAN THE USUAL AND CUSTOMARY COST FOR SUCH SERVICES. THE PHYSICIAN SHALL RETURN TO THE HEALTH CARE PLAN ANY PORTION OF THE FEE PAID BY THE HEALTH CARE PLAN IN EXCESS OF THE AMOUNT DETERMINED TO BE REASONABLE BY THE INDEPENDENT DISPUTE RESOLUTION ENTITY.

(B) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE HEALTH CARE PLAN, PHYSICIAN AND PATIENT, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE PLAN, PHYSICIAN OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE PHYSICIAN.

(C) THE SUPERINTENDENT SHALL PROMULGATE REGULATIONS TO ESTABLISH STANDARDS FOR THE DISPUTE RESOLUTION PROCESS INCLUDING STANDARDS FOR ESTABLISHING WHICH PARTY SHALL BE RESPONSIBLE FOR PAYMENT OF THE DISPUTE RESOLUTION PROCESS.

S 150-a. Paragraph (u) of subdivision 4 of section 364-j of the social services law, as amended by section 40 of part D of chapter 56 of the laws of 2012, is amended 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. FOR THE PURPOSES OF THIS SECTION, "MAIL ORDER PHARMACY" MEANS A PHARMACY WHOSE PRIMARY BUSINESS IS TO RECEIVE PRESCRIPTIONS BY MAIL, TELEFAX OR THROUGH ELECTRONIC SUBMISSIONS, AND TO DISPENSE MEDICATION TO PATIENTS THROUGH THE USE OF THE UNITED STATES MAIL OR OTHER COMMON OR CONTRACT CARRIER SERVICES, AND PROVIDES ANY CONSULTATION WITH PATIENTS ELECTRONICALLY RATHER THAN FACE TO FACE. Every non-mail-order retail pharmacy in the managed care provider's network with respect to any prescription drug shall be deemed to be in the managed care provider's network for every covered prescription drug[; provided, however, that the managed care provider may limit its network of pharmacies for specified drugs, approved by the commissioner, based on clinical, professional or cost criteria. Such limitation shall not be based solely on cost].

S 151. The public health law is amended by adding a new section 4403-g to read as follows:

S 4403-G. HOME AND COMMUNITY-BASED CARE WORK GROUP. 1. THE COMMISSIONER SHALL CONVENE A HOME AND COMMUNITY-BASED CARE WORK GROUP TO EXAMINE ISSUES SURROUNDING CONTINUITY OF CARE, REGULATORY GUIDANCE, QUALITY ASSURANCE, AND CARE DELIVERY AMONG HOME AND COMMUNITY-BASED HEALTH CARE PROVIDERS IN THEIR TRANSITION TO MANAGED CARE. THE COMMISSIONER SHALL CONVENE THE WORKGROUP AS SOON AS PRACTICABLE, HOWEVER NO LATER THAN MAY FIRST, TWO THOUSAND THIRTEEN. IT SHALL INCLUDE, BUT NOT BE LIMITED TO, REPRESENTATIVES OF MANAGED LONG TERM CARE PLANS, CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES AGENCIES, CONSUMER DIRECTED CARE AGENCIES, CONSUMER ORGANIZATIONS AND STATE ASSOCIATIONS REPRESENTATIVES THEREOF ALONG WITH OTHERS WITH DEMONSTRATED EXPERTISE IN QUALITY MEASUREMENTS, REPORTING, AND OTHER AREAS OF CONSIDERATION. THE WORKGROUP SHALL ISSUE RECOMMENDATIONS ON TOPICS INCLUDING, BUT NOT LIMITED TO:

(A) THE WORKGROUP SHALL IDENTIFY AND MAKE RECOMMENDATIONS REGARDING CONSOLIDATION, SIMPLIFICATION, AND WHERE POSSIBLE, MAKE UNIFORM RULES AND REGULATIONS RELATED TO THE INTEGRATION OF EXISTING HOME AND COMMUNITY-BASED CARE WITHIN MANAGED CARE. RECOMMENDATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, CONSIDERATIONS OF:

(I) STREAMLINING OF DUPLICATIVE FUNCTIONS SHARED BETWEEN MANAGED CARE AND HOME AND COMMUNITY-BASED PROVIDERS;

(II) BEST PRACTICES FOR EFFICIENT DELIVERY AND MANAGEMENT OF SERVICES;

(III) ASSESSMENT AND REASSESSMENT REQUIREMENTS OF THE PATIENT, INCLUDING BUT NOT LIMITED TO THE USE OF A SINGLE FORM FOR ASSESSMENTS AND REASSESSMENTS AND FREQUENCY;

(IV) THE DETERMINATION OF ELIGIBILITY;

(V) THE DEVELOPMENT OF THE WRITTEN PLAN OF CARE AND PROCUREMENT AND DOCUMENTATION OF VERBAL AND WRITTEN PHYSICIAN ORDERS;

(VI) CARE COORDINATION INCLUDING COMMUNICATIONS BETWEEN HEALTH CARE PROVIDERS AND PHYSICIANS;

(VII) DOCUMENTATION AND MAINTENANCE OF PATIENT RECORDS; AND

(VIII) REQUIREMENTS FOR DIRECT CARE STAFF SUPERVISION.

(B) THE WORKGROUP SHALL IDENTIFY AND MAKE RECOMMENDATIONS REGARDING QUALITY IMPROVEMENT MEASURES, HEALTH OUTCOMES DATA, INTERNAL QUALITY ASSESSMENT PROCESSES, AND REPORTING MECHANISMS TO ENSURE AND PROMOTE HIGH QUALITY, INTEGRATED AND COST EFFECTIVE CARE AS INDIVIDUALS TRANSITION TO MANAGED CARE.

(C) THE WORKGROUP SHALL MAKE RECOMMENDATIONS REGARDING THE CONTINUITY AND TRANSITION OF TELEHEALTH INTO MANAGED CARE SYSTEMS. RECOMMENDATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, CONSIDERATIONS OF:

(I) THE DETERMINATION OF ELIGIBILITY;

(II) STREAMLINING DUPLICATIVE FUNCTIONS SHARED BETWEEN MANAGED CARE AND HOME AND COMMUNITY-BASED PROVIDERS;

(III) CURRENT ADMINISTRATIVE, REGULATORY, AND INDUSTRY GUIDELINES;

(IV) BEST PRACTICES FOR EFFICIENT DELIVERY AND MANAGEMENT OF SERVICES;

(V) SPECIFIC DELINEATIONS OF RESPECTIVE RESPONSIBILITIES AMONG THE PROVIDERS WHERE APPROPRIATE;

(VI) INFRASTRUCTURE READINESS;

(VII) CONTINUITY OF CARE;

(VIII) CARE COORDINATION;

(IX) CONSISTENT RATING AND REIMBURSEMENT METHODOLOGIES; AND

(X) PROJECTED IMPACTS TO COUNTY POPULATIONS DISPROPORTIONATELY RELIANT ON TELEHEALTH, SPECIFICALLY POPULATIONS OF TWO HUNDRED THOUSAND OR LESS.

2. THE WORKGROUP SHALL REPORT ITS RECOMMENDATIONS AS SOON AS PRACTICABLE BUT NO LATER THAN OCTOBER FIRST, TWO THOUSAND THIRTEEN, TO THE COMMISSIONER, TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, AND CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES. EVERY EFFORT SHALL BE MADE BY THE COMMISSIONER TO INCORPORATE AND IMPLEMENT THE RECOMMENDATIONS OF THE WORKGROUP.

S 152. Notwithstanding any contrary provision of law or regulation, retroactive to January first, two thousand ten, rates of payment made by state governmental agencies for general hospital inpatient total hip joint replacement and total knee joint replacement cases shall utilize the diagnosis-related groups and service intensity weights in effect on December thirty-first, two thousand seven pursuant to subdivision three of section 2807-c of the public health law. Such rates may only be adjusted for a general hospital if the majority of inpatient surgery cases for the general hospital are orthopedic cases, the general hospital has developed a center of excellence in orthopedic surgery and sports medicine, the general hospital incurred a significant reduction in reimbursement for such cases beginning in two thousand eight as a result of revisions to the service intensity weights for these cases, and such adjustment would not increase reimbursement from state governmental agencies to the general hospital by more than an average of two hundred thousand dollars a year. Such adjustment shall not affect the diagnosis related groups and service intensity weights for any other cases or for any other general hospital.

S 153. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (s) to read as follows:

(S) ISSUE A READINESS REPORT TO THE LEGISLATURE, DETAILING THE STATUS OF THE STATEWIDE HEALTH BENEFIT EXCHANGE ESTABLISHED UNDER EXECUTIVE ORDER 42 OF 2012, ON OR BEFORE AUGUST THIRTIETH, TWO THOUSAND THIRTEEN. THE READINESS REPORT MAY BE PROVIDED IN ELECTRONIC FORMAT AND SHALL BE DISTRIBUTED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. THE READINESS REPORT SHALL OUTLINE THE PROGRESS AND PREPAREDNESS OF THE HEALTH BENEFIT EXCHANGE,

AND DETAIL HOW THE EXCHANGE WILL CARRY OUT ITS FUNCTIONS INCLUDING, BUT NOT BE LIMITED TO:

(1) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE WILL BEGIN ACCEPTING APPLICATIONS ON OCTOBER FIRST, TWO THOUSAND THIRTEEN;

(2) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE WILL CERTIFY QUALIFIED HEALTH PLANS;

(3) THE ANTICIPATED COST OF INDIVIDUAL AND SMALL GROUP PLANS BEING OFFERED IN THE HEALTH BENEFIT EXCHANGE;

(4) THE NUMBER OF NAVIGATORS APPROVED;

(5) THE PLAN FOR FULL OPERATION BY JANUARY FIRST, TWO THOUSAND FOURTEEN; AND

(6) THE PLAN TO BECOME FISCALLY SELF-SUSTAINING BY JANUARY FIRST, TWO THOUSAND FIFTEEN.

S 154. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (t) to read as follows:

(T) MAKE AN ANNUAL REPORT TO THE LEGISLATURE ON OR BEFORE THE FIRST DAY OF DECEMBER. THIS REPORT MAY BE PROVIDED IN ELECTRONIC FORMAT AND SHALL BE DISTRIBUTED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. THE REPORT SHALL ALSO BE POSTED ON THE DEPARTMENT'S WEBSITE. THIS REPORT SHALL INCLUDE, BUT NOT LIMITED TO:

(1) A DETAILED DESCRIPTION OF THE DEPARTMENT'S MISSION, PRIORITIES AND GOALS FOR THE UPCOMING YEAR;

(2) ANY AND ALL RELEVANT DATA AND STATISTICS;

(3) A SUMMARY OF THE ACHIEVEMENTS AND INITIATIVES OF THE DEPARTMENT IN THE PAST YEAR;

(4) INFORMATION CONCERNING EACH DIVISION, BUREAU, OFFICE OR INSTITUTION WITHIN THE DEPARTMENT, AND THEIR ACTIVITIES, AFFAIRS AND RECOMMENDATIONS;

(5) ANY MATTERS EXPRESSLY REQUIRED BY LAW TO BE INCLUDED IN THE REPORT; AND

(6) ANY OTHER MATTERS DEEMED NECESSARY BY THE COMMISSIONER.

S 155. Section 23 of part A of chapter 56 of the laws of 2012, amending the public health law relating to evaluations or services under the early intervention program for infants and toddlers with disabilities and their families, is amended to read as follows:

S 23. This act shall take effect January 1, 2013; provided, however, that sections two-a, four, five, seven, eight, nine-a, ten, eighteen and nineteen of this act shall take effect April 1, 2013, AND THE PROVISIONS OF SUBPARAGRAPH (III) OF PARAGRAPH (A) OF SUBDIVISION 3 OF SECTION 2559 OF THE PUBLIC HEALTH LAW, AS ADDED BY SECTION ELEVEN OF THIS ACT, SHALL TAKE EFFECT AUGUST 1, 2013; AND PROVIDED, FURTHER, THAT THE DEPARTMENT OF HEALTH SHALL NOT PROMULGATE REGULATIONS OR TAKE ANY ADMINISTRATIVE ACTION PURSUANT TO THIS ACT AFFECTING PROVIDER RELATIONSHIPS OR AGREEMENTS PRIOR TO APRIL 1, 2014.

S 156. Article 29-A of the public health law is amended by adding a new title 3 to read as follows:

TITLE 3

BROADSCALE SYSTEMS INTEGRATION DEMONSTRATION PROGRAM

SECTION 2959-1. BROADSCALE SYSTEMS INTEGRATION DEMONSTRATION PROGRAM.

S 2959-1. BROADSCALE SYSTEMS INTEGRATION DEMONSTRATION PROGRAM. 1. FEDERAL HEALTH CARE REFORM AND THE CURRENT PROPOSALS TO TRANSITION NEW YORK STATE MEDICAID PROVIDERS TO A MANAGED CARE MODEL, HAVE INITIATED SIGNIFICANT CHANGES TO HEALTH CARE DELIVERY WITHIN THE STATE. THE

LEGISLATURE RECOGNIZES THESE CHANGES, AS WELL AS THE NEED FOR GUIDANCE ON HOW PROVIDERS CAN COMPLY IN AN EFFECTIVE AND COST-EFFICIENT MANNER. GIVEN THE UNIQUE CHARACTERISTICS AND NEEDS OF RURAL COUNTIES WITHIN THE STATE, INCLUDING DISPARITIES IN SUPPLY AND ACCESS TO HEALTH CARE, AS WELL AS PROVIDER SHORTAGES AND HIGHER RATES OF UNDERINSURED AND UNINSURED, IT IS IMPERATIVE THAT THE STATE ADDRESS THE UNIQUE NEEDS OF ITS RURAL POPULATION AND PROVIDE INFORMATION ON THE KEY VARIABLES THAT PROVIDERS MUST UTILIZE FOR A RESPONSIBLE TRANSITION TO MANAGED CARE.

2.(A) THE COMMISSIONER SHALL, WITHIN MONIES APPROPRIATED THEREFOR, ESTABLISH A BROADSCALE SYSTEMS INTEGRATION DEMONSTRATION PROGRAM IN COUNTIES HAVING A POPULATION OF NOT LESS THAN ONE HUNDRED THIRTY THOUSAND AND NOT MORE THAN ONE HUNDRED FORTY THOUSAND, ACCORDING TO THE TWO THOUSAND TEN DECENNIAL FEDERAL CENSUS. THE COMMISSIONER AND THE COMMISSIONER OF MENTAL HEALTH SHALL, IN COORDINATION WITH A NON-PROFIT ORGANIZATION ACTING AS A SAFETY NET PROVIDER SERVING IN SUCH COUNTY TO STUDY COST SAVINGS ACHIEVED THROUGH THE PROVISION OF SERVICES, INCLUDING BUT NOT LIMITED TO, DENTAL, HEALTH, BEHAVIORAL HEALTH, EMPLOYMENT, AND SOCIAL SERVICES INTERVENTION WITHIN A MANAGED CARE MODEL IN A RURAL SETTING. SUCH A STUDY SHALL DETERMINE:

(I) THE QUALITY OF CARE PROVIDED THROUGH AN INTEGRATED MODEL VERSUS CURRENT DELIVERY SYSTEMS;

(II) COST SAVINGS ACHIEVED BY IMPLEMENTING AN INTEGRATED MANAGED CARE DELIVERY SYSTEM;

(III) COROLLARIES BETWEEN AN INTEGRATED SYSTEM AND IMPROVED PATIENT OUTCOMES;

(IV) CARE COORDINATION/CASE MANAGEMENT AMONG DELIVERY SYSTEMS;

(V) IMPLEMENTATION AND TRANSITION COSTS;

(VI) DATA ON ACCESS TO CARE AND THE UNINSURED IN RURAL AREAS;

(VII) SOCIOECONOMIC BENCHMARKS AND IMPROVEMENTS INCLUDING BUT NOT LIMITED TO DATA OF UNEMPLOYMENT, POVERTY, AND UNDERINSURED AND UNINSURED;

(VIII) STAFFING SHORTAGES AND/OR STAFFING MODIFICATIONS IN THE TRANSITION TO A MANAGED CARE MODEL;

(IX) RECOMMENDATIONS FOR REPLICATION/IMPROVEMENT IN OTHER RURAL AREAS; AND

(X) SUCH OTHER ACTIVITIES AS THE COMMISSIONER MAY DEEM NECESSARY AND APPROPRIATE TO THIS SECTION.

(B) THE ORGANIZATION, IN CONSULTATION WITH THE DEPARTMENT AND THE OFFICE OF MENTAL HEALTH, SHALL EVALUATE THE FINDINGS OF THE STUDY AND REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE COMMISSIONER AND THE CHAIR OF THE LEGISLATIVE COMMISSION ON RURAL RESOURCES ON ITS FINDINGS, SO AS TO PROVIDE THE COST BENCHMARKS WITH AND WITHOUT THE BROADSCALE SYSTEMS INTEGRATION, AS WELL AS PROVIDING COST BENEFIT MEASUREMENTS IN TERMS OF THE QUALITY BENEFIT OUTCOMES FOR EACH OF THE BENCHMARKS.

(C) ADDITIONALLY, TO THE EXTENT OF FUNDS APPROPRIATED THEREFOR, MEDICAL ASSISTANCE FUNDS, INCLUDING ANY FUNDING OR SHARED SAVINGS AS MAY BECOME AVAILABLE THROUGH FEDERAL WAIVERS OR OTHERWISE UNDER TITLES 18 AND 19 OF THE FEDERAL SOCIAL SECURITY ACT, MAY BE USED FOR EXPENDITURES IN SUPPORT OF THE DEMONSTRATION PROGRAM.

S 157. Sections one hundred fifty-seven and one hundred fifty-eight this act shall be known and may be cited as "Aidan's Law".

S 158. Subdivision (a) of section 2500-a of the public health law, as amended by chapter 863 of the laws of 1986, is amended to read as follows:

(a) It shall be the duty of the administrative officer or other person in charge of each institution caring for infants twenty-eight days or less of age and the person required in pursuance of the provisions of section forty-one hundred thirty of this chapter to register the birth of a child, to cause to have administered to every such infant or child in its or his care a test for phenylketonuria, homozygous sickle cell disease, hypothyroidism, branched-chain ketonuria, galactosemia, homocystinuria, ADRENOLEUKODYSTROPHY and such other diseases and conditions as may from time to time be designated by the commissioner in accordance with rules or regulations prescribed by the commissioner. Testing, the recording of the results of such tests, tracking, follow-up reviews and educational activities shall be performed at such times and in such manner as may be prescribed by the commissioner. The commissioner shall promulgate regulations setting forth the manner in which information describing the purposes of the requirements of this section shall be disseminated to parents or a guardian of the infant tested.

S 159. Subdivision 2-a of section 2807 of the public health law is amended by adding a new paragraph (j) to read as follows:

(J) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBDIVISION OR ANY OTHER PROVISION OF LAW TO THE CONTRARY AND, SUBJECT TO AN APPROPRIATION THEREFOR, ON AND AFTER APRIL FIRST, TWO THOUSAND THIRTEEN, RATES OF PAYMENT FOR DIAGNOSTIC AND TREATMENT CENTER SERVICES, EMERGENCY SERVICES, GENERAL HOSPITAL OUTPATIENT SERVICES, AMBULATORY SURGICAL SERVICES AND REFERRED AMBULATORY SERVICES, PROVIDED BY A RURAL HOSPITAL DESIGNATED AS A CRITICAL ACCESS HOSPITAL IN ACCORDANCE WITH TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE EQUAL TO ONE HUNDRED ONE PERCENT OF THE REASONABLE COSTS OF A FACILITY IN PROVIDING SUCH SERVICES TO PATIENTS ELIGIBLE FOR PAYMENTS MADE IN ACCORDANCE WITH THIS SUBDIVISION. REASONABLE COSTS SHALL BE DETERMINED IN A MANNER CONSISTENT WITH THAT USED TO DETERMINE PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES PROVIDED TO BENEFICIARIES OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT. FOR FACILITIES WITHOUT ADEQUATE COST EXPERIENCE, SUCH RATES SHALL BE BASED ON BUDGETED COSTS SUBSEQUENTLY ADJUSTED TO ONE HUNDRED ONE PERCENT OF REASONABLE ACTUAL COSTS.

S 160. Subdivision 2 of section 99-f of the state finance law, as amended by chapter 612 of the laws of 1999, is amended to read as follows:

2. The fund shall consist of all monies appropriated for its purpose, all monies required by this section or any other provision of law to be paid into or credited to such fund, and FIVE AND SIX-TENTHS PER CENTUM OF monies COLLECTED BY THE MANDATORY SURCHARGES IMPOSED PURSUANT TO SUBDIVISION ONE OF SECTION EIGHTEEN HUNDRED NINE OF THE VEHICLE AND TRAFFIC LAW in an amount not to exceed eight million five hundred thousand dollars [collected by the mandatory surcharges imposed pursuant to subdivision one of section eighteen hundred nine of the vehicle and traffic law]. Nothing contained herein shall prevent the department of health from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law.

S 161. Section 365-d of the social services law is REPEALED and a new section 365-d is added to read as follows:

S 365-D. HEALTH TECHNOLOGY ASSESSMENT COMMITTEE. 1. THE DEPARTMENT SHALL CONVENE A HEALTH TECHNOLOGY ASSESSMENT COMMITTEE. THE COMMITTEE SHALL, AT THE REQUEST OF THE COMMISSIONER, PROVIDE ADVICE AND MAKE RECOMMENDATIONS REGARDING COVERAGE OF HEALTH TECHNOLOGY FOR PURPOSES OF THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER SHALL CONSULT SUCH

COMMITTEE PRIOR TO ANY DETERMINATION TO EXCLUDE FROM COVERAGE ANY HEALTH TECHNOLOGY FROM THE MEDICAL ASSISTANCE PROGRAM. FOR PURPOSES OF THIS SECTION, "HEALTH TECHNOLOGY" MEANS MEDICAL DEVICES AND SURGICAL PROCEDURES USED IN THE PREVENTION, DIAGNOSIS AND TREATMENT OF DISEASE AND OTHER MEDICAL CONDITIONS.

2. (A) THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL CONSIST OF THIRTEEN 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, FIVE MEMBERS SHALL SERVE TWO YEAR TERMS, AND THREE MEMBERS SHALL SERVE THREE YEAR TERMS. COMMITTEE MEMBERS MAY BE REAPPOINTED UPON THE COMPLETION OF THEIR TERMS. WITH THE EXCEPTION OF THE CHAIRPERSON, NO MEMBER OF THE COMMITTEE SHALL BE AN EMPLOYEE OF THE STATE OR ANY POLITICAL 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.

(B) THE MEMBERSHIP OF SUCH COMMITTEE SHALL BE AS FOLLOWS:

(I) SIX PERSONS LICENSED AND ACTIVELY ENGAGED IN THE PRACTICE OF MEDICINE IN THIS STATE;

(II) ONE PERSON LICENSED AND ACTIVELY ENGAGED IN THE PRACTICE OF NURSING AS A NURSE PRACTITIONER, OR IN THE PRACTICE OF MIDWIFERY IN THIS STATE;

(III) ONE PERSON WHO IS A REPRESENTATIVE OF A HEALTH TECHNOLOGY OR MEDICAL DEVICE ORGANIZATION WITH A REGIONAL, STATEWIDE OR NATIONAL CONSTITUENCY AND WHO IS A HEALTH CARE PROFESSIONAL LICENSED UNDER TITLE EIGHT OF THE EDUCATION LAW;

(IV) ONE PERSON WITH EXPERTISE IN HEALTH TECHNOLOGY ASSESSMENT WHO IS A HEALTH CARE PROFESSIONAL LICENSED UNDER TITLE EIGHT OF THE EDUCATION LAW;

(V) 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; AND

(VI) A MEMBER OF THE DEPARTMENT WHO SHALL ACT AS CHAIRPERSON AS DESIGNATED BY THE COMMISSIONER.

3. THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL BE A PUBLIC BODY UNDER ARTICLE SEVEN OF THE PUBLIC OFFICERS LAW AND SUBJECT TO ARTICLE SIX OF THE PUBLIC OFFICERS LAW. THE DEPARTMENT SHALL PROVIDE INTERNET ACCESS TO ALL MEETINGS OF SUCH COMMITTEE THROUGH THE DEPARTMENT'S WEBSITE.

4. THE MEMBERS OF THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES BUT SHALL BE REIMBURSED FOR EXPENSES ACTUALLY AND NECESSARILY INCURRED IN THE PERFORMANCE OF THEIR DUTIES. COMMITTEE MEMBERS SHALL BE DEEMED TO BE EMPLOYEES OF THE DEPARTMENT FOR PURPOSES OF SECTION SEVENTEEN OF THE PUBLIC OFFICERS LAW, AND SHALL NOT PARTICIPATE IN ANY MATTER FOR WHICH A CONFLICT OF INTEREST EXISTS.

5. THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL, AT THE REQUEST OF THE COMMISSIONER, CONSIDER ANY MATTER RELATING TO HEALTH TECHNOLOGY ASSESSMENT. THE COMMISSIONER SHALL PROVIDE THIRTY DAYS PUBLIC NOTICE ON THE DEPARTMENT'S WEBSITE PRIOR TO ANY MEETING OF THE COMMITTEE TO DEVELOP RECOMMENDATIONS CONCERNING HEALTH TECHNOLOGY COVERAGE DETERMINATIONS. SUCH NOTICE SHALL INCLUDE A DESCRIPTION OF THE PROPOSED HEALTH TECHNOLOGY TO BE REVIEWED, THE CONDITIONS OR DISEASES IMPACTED BY THE HEALTH TECHNOLOGY, AND THE PROPOSALS TO BE CONSIDERED BY THE COMMITTEE. THE COMMITTEE SHALL ALLOW INTERESTED PARTIES A REASONABLE OPPORTUNITY TO

MAKE AN ORAL PRESENTATION TO THE COMMITTEE RELATED TO THE HEALTH TECHNOLOGY TO BE REVIEWED AND TO SUBMIT WRITTEN INFORMATION. THE COMMITTEE SHALL CONSIDER ANY INFORMATION PROVIDED BY ANY INTERESTED PARTY, INCLUDING, BUT NOT LIMITED TO, HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, PATIENTS, CONSUMERS AND MANUFACTURERS.

6. THE COMMISSIONER SHALL PROVIDE NOTICE OF ANY COVERAGE RECOMMENDATIONS DEVELOPED BY THE COMMITTEE BY MAKING SUCH INFORMATION AVAILABLE ON THE DEPARTMENT'S WEBSITE. SUCH PUBLIC NOTICE SHALL INCLUDE: A SUMMARY OF THE DELIBERATIONS OF THE COMMITTEE; A SUMMARY OF THE POSITIONS OF THOSE MAKING PUBLIC COMMENTS AT MEETINGS OF THE COMMITTEE; THE RESPONSE OF THE COMMITTEE TO THOSE COMMENTS, IF ANY; THE CLINICAL EVIDENCE UPON WHICH THE COMMITTEE BASES ITS RECOMMENDATION; AND THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE.

7. THE COMMISSIONER SHALL PROVIDE PUBLIC NOTICE ON THE DEPARTMENT'S WEBSITE OF HIS OR HER FINAL DETERMINATION, INCLUDING: THE NATURE OF THE DETERMINATION; AN ANALYSIS OF THE IMPACT OF THE COMMISSIONER'S DETERMINATION ON STATE PUBLIC HEALTH PLAN POPULATIONS AND PROVIDERS; AND THE PROJECTED FISCAL IMPACT TO THE STATE PUBLIC HEALTH PLAN PROGRAMS OF THE COMMISSIONER'S DETERMINATION. THE COMMISSIONER'S FINAL DETERMINATION SHALL NOT OCCUR PRIOR TO THE THIRTIETH DAY FROM THE POSTING OF THE COMMITTEE'S RECOMMENDATIONS AND FINDINGS ON THE DEPARTMENT'S WEBSITE.

8. THE RECOMMENDATIONS OF THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE, MADE PURSUANT TO THIS SECTION, SHALL BE BASED ON CLINICAL EFFECTIVENESS AND SAFETY. THE COMMITTEE SHALL TRIENNIALLY REVIEW PREVIOUS RECOMMENDATIONS OF THE COMMITTEE AND PERMIT ORAL PRESENTATIONS AND THE SUBMISSION OF NEW EVIDENCE AT SUCH TRIENNIAL REVIEW. SUCH REVIEW SHALL OCCUR PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISIONS FIVE AND SIX OF THIS SECTION. THE COMMISSIONER MAY ALTER OR REVOKE HIS OR HER FINAL DETERMINATION AFTER SUCH TRIENNIAL REVIEW PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISION SEVEN OF THIS SECTION.

9. THE DEPARTMENT SHALL PROVIDE ADMINISTRATIVE SUPPORT TO THE COMMITTEE.

S 162. Section 33 of the public health law, as added by chapter 442 of the laws of 2006, subdivision 1 as amended by section 45 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 33. Cooperation of agency officials and employees. 1. In addition to the authority otherwise provided by this title, the inspector, in carrying out the provisions of this title, is authorized to request such information, assistance and cooperation from any federal, state or local governmental department, board, bureau, commission, or other agency or unit thereof as may be necessary for carrying out the duties and responsibilities enjoined upon the inspector by this section. State and local agencies or units thereof are hereby authorized and directed to provide to the inspector, or, at the request of the inspector, to state agencies or their contractors, such information, assistance and cooperation. Notwithstanding any other provision of law to the contrary, requests for information, assistance and cooperation may include, but not be limited to, all state and local government birth, death and vital statistics which may be contained in files, databases or registries, and for all information shall, upon request, include, where possible, making electronic copies or record exchanges available. Executive agencies shall coordinate and facilitate the transfer of appropriate functions and positions to the office as necessary and in accordance with applicable law.

2. NOTWITHSTANDING ANY PROVISIONS OF THIS ARTICLE A LOCAL SOCIAL SERVICES DISTRICT IS DEEMED TO HAVE THE AUTHORITY TO CONDUCT MEDICAID

PROVIDER INVESTIGATIONS, AND UPON A FINDING OF FRAUD AND ABUSE, TO REFER THE SUSPECTED FRAUD OR CRIMINALITY TO ITS DISTRICT ATTORNEY'S OFFICE.

3. Upon request of a local social services district or a prosecutor of competent jurisdiction, the office, department, any other state or local government entity and the Medicaid fraud control unit shall provide such information and assistance [as such entity or unit shall deem necessary,] appropriate and available to aid and facilitate the investigation of fraud and abuse within the medical assistance program and the recoupment of improperly expended funds.

S 163. The public health law is amended by adding a new section 37 to read as follows:

S 37. OVERSIGHT AUDIT, REVIEW AND EVALUATION. THE DEPARTMENT SHALL CONTRACT WITH AN INDEPENDENT AGENCY FOR THE PURPOSE OF CONDUCTING AN ANNUAL AUDIT, REVIEW AND EVALUATION OF THE STATE MEDICAID PROGRAM AND THE OFFICE OF THE MEDICAID INSPECTOR GENERAL. THE AUDIT, REVIEW AND EVALUATION SHALL ENSURE MEDICAID FUNDS ARE BEING EFFECTIVELY AND EFFICIENTLY SPENT, AND THAT CASES OF FRAUD AND ABUSE ARE BEING APPROPRIATELY INVESTIGATED AND PURSUED. THE REVIEW SHALL INCLUDE RECOMMENDATIONS FOR INCREASING COST EFFECTIVENESS AND FRAUD AND ABUSE RECOVERIES. THE REVIEW SHALL ALSO PROVIDE AN EVALUATION OF PATIENT CARE, HEALTH OUTCOMES AND THE COMPARATIVE COSTS IN EACH SECTOR OF HEALTH CARE FUNDED BY MEDICAID, ALONG WITH RECOMMENDATIONS FOR SYSTEMIC IMPROVEMENTS TO EACH SECTOR. THE AUDIT, REVIEW AND EVALUATION SHALL BE DISTRIBUTED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE BY THE FIRST OF JANUARY EACH YEAR.

S 164. The social services law is amended by adding a new article 5-A to read as follows:

ARTICLE 5-A

MEDICAID FRAUD REIMBURSEMENT

SECTION 370-BB. DISPOSITION OF MONEYS RECEIVED AS THE RESULT OF THE PROSECUTION OF MEDICAID FRAUD.

S 370-BB. DISPOSITION OF MONEYS RECEIVED AS THE RESULT OF THE PROSECUTION OF MEDICAID FRAUD. 1. FOR THE PURPOSES OF THIS SECTION, "MEDICAID FRAUD" SHALL MEAN THE KNOWING COMMISSION OF ANY CRIME WITH INTENT TO ILLEGALLY RECEIVE BENEFITS, OR REIMBURSEMENT FROM THE MEDICAL ASSISTANCE FOR NEEDY PERSONS PROGRAM ESTABLISHED AND ADMINISTERED PURSUANT TO THIS CHAPTER, THE PUBLIC HEALTH LAW AND FEDERAL LAW.

2. SHOULD ANY COUNTY OR THE CITY OF NEW YORK SUCCESSFULLY PROSECUTE ANY CASE FOR MEDICAID FRAUD AND A COURT AWARDS RESTITUTION OR CIVIL FORFEITURE, THE FOLLOWING PORTION OF THE NON-FEDERAL SHARE OF THE PROCEEDS OF SUCH RESTITUTION OR CIVIL FORFEITURE SHALL BE ALLOCATED AS FOLLOWS:

(I) THE COUNTY OR THE CITY OF NEW YORK SHALL RECEIVE ONE HUNDRED PERCENT OF THE LOCAL SHARE OF SUCH FUNDS, IN EFFECT IMMEDIATELY PRIOR TO SUCH DATE AS CERTIFIED BY THE DIVISION OF BUDGET OR TEN PERCENT OF THE TOTAL RECOVERY WHICHEVER NUMBER IS GREATER;

(II) THE REMAINDER THEREOF SHALL BE DEPOSITED INTO THE GENERAL FUND OF THE STATE.

3. NOTHING IN THIS ARTICLE SHALL IMPAIR ANY COUNTY OR THE CITY OF NEW YORK'S ABILITY TO SEEK DAMAGES UNDER SECTION ONE HUNDRED FORTY-FIVE-B OF THIS CHAPTER.

S 165. Paragraph (a) of subdivision 2 of section 145-b of the social services law, as amended by chapter 109 of the laws of 2007, is amended to read as follows:

(a) For civil damages collected by a local social services district, relating to the medical assistance program, pursuant to a judgment OR A SETTLEMENT under this subdivision, such amounts shall be apportioned between the local social services district and the state. [If the violation occurred: (i) prior to January first, two thousand six, the] THE amount apportioned to the local social services district shall be ONE HUNDRED PERCENT OF the local share [percentage] OF SUCH FUNDS, in effect immediately prior to such date as certified by the division of budget[, or (ii) after January first, two thousand six, the amount apportioned to the local social services district shall be based on a reimbursement schedule, created by the office of Medicaid inspector general, in effect at the time the violation occurred; provided that, if there is no schedule in effect at the time the violation occurred, the schedule to be used shall be the first schedule adopted pursuant to this subdivision. Such schedule shall provide for reimbursement to a local social services district in an amount between ten and fifteen percent of the gross amount collected. Such schedule shall be set on a county by county basis and shall be periodically reviewed and updated as necessary; provided, however, that any such updated schedule shall not be less than ten percent nor greater than fifteen percent of the gross amount collected] OR TEN PERCENT OF THE TOTAL RECOVERY WHICHEVER NUMBER IS GREATER; and

S 166. The public health law is amended by adding a new article 2-B to read as follows:

ARTICLE 2-B

MEDICAID IDENTIFICATION AND ANTI-FRAUD BIOMETRIC TECHNOLOGY PILOT PROGRAM

SECTION 290. MEDICAID IDENTIFICATION AND ANTI-FRAUD BIOMETRIC TECHNOLOGY PILOT PROGRAM.

291. DEFINITIONS.

292. BIOMETRIC TECHNOLOGY USE.

293. RULES AND REGULATIONS.

S 290. MEDICAID IDENTIFICATION AND ANTI-FRAUD BIOMETRIC TECHNOLOGY PILOT PROGRAM. THERE IS HEREBY ESTABLISHED IN THE DEPARTMENT THE MEDICAID IDENTIFICATION AND ANTI-FRAUD BIOMETRIC TECHNOLOGY PILOT PROGRAM. THE DEPARTMENT, IN CONSULTATION WITH THE OFFICE OF THE MEDICAID INSPECTOR GENERAL AND THE OFFICE OF THE ATTORNEY GENERAL, SHALL IMPLEMENT SUCH PILOT PROGRAM AT TWO GENERAL HOSPITALS, AS DEFINED BY SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED ONE OF THIS CHAPTER, AS AN ANTI-FRAUD APPLICATION IN THE MEDICAID PROGRAM.

S 291. DEFINITIONS. AS USED IN THIS ARTICLE:

1. "BIOMETRIC TECHNOLOGY" MEANS TECHNOLOGY THAT MEASURES AND ANALYZES BIOLOGICAL DATA, INCLUDING BUT NOT LIMITED TO DNA, FINGER IMAGING, VASCULAR PATTERNS, EYE RETINAS AND IRISES, VOICE PATTERNS, FACIAL PATTERNS AND HAND MEASUREMENTS, FOR AUTHENTICATION PURPOSES.

2. "BIOMETRIC VERIFICATION DEVICE" MEANS A DEVICE CAPABLE OF USING BIOMETRIC VERIFICATION TECHNOLOGY TO VERIFY THE IDENTITY OF A MEDICAID RECIPIENT OR PROVIDER.

S 292. BIOMETRIC TECHNOLOGY USE. 1. THE DEPARTMENT, IN CONSULTATION WITH THE OFFICE OF THE MEDICAID INSPECTOR GENERAL AND THE OFFICE OF THE ATTORNEY GENERAL, SHALL DEVELOP A REQUEST FOR PROPOSALS TO IMPLEMENT A PROGRAM UTILIZING BIOMETRIC TECHNOLOGY BY HOSPITALS FOR THE PURPOSES OF PATIENT AND PROVIDER IDENTIFICATION AND FOR USE AS AN ANTI-FRAUD APPLICATION IN THE MEDICAID PROGRAM.

2. SUCH REQUEST FOR PROPOSALS SHALL INCLUDE AT A MINIMUM THAT (A) MEDICAID RECIPIENTS AND PROVIDERS SHALL PROVIDE BIOMETRIC PROOF OF THEIR

IDENTITY ALONG WITH OTHER INFORMATION DEEMED NECESSARY BY THE COMMISSIONER.

(B) SUCH PROGRAM WILL BE CAPABLE OF STORING BIOMETRIC MARKERS AND A LOG OF GENERAL HOSPITAL AND PHARMACY VISITS FOR EACH SERVICE BILLED TO THE MEDICAID PROGRAM.

(C) MEDICAID IDENTIFICATION SHALL BE ISSUED TO AND ACCEPTED BY THE ADMITTING STAFF OF HEALTH CARE FACILITIES, MEDICAL STAFF PROVIDING SERVICE TO MEDICAID RECIPIENTS AND PHARMACY STAFF.

(D) MEDICAID RECIPIENTS SHALL BE REQUIRED TO PROVIDE BIOMETRIC PROOF OF IDENTIFY AT THE TIME OF EACH VISIT TO A GENERAL HOSPITAL AT THE POINT OF ACTUALLY BEING SEEN BY THE DOCTOR OR CLINICAL STAFF, AND SHALL AGAIN PROVIDE PROOF OF IDENTITY UPON COMPLETION OF CARE OR SERVICES.

(E) PROVISIONS MAY BE INCLUDED FOR EMERGENCY SERVICES OR PRESCRIPTIONS AND ALTERNATE IDENTIFICATION METHODS FOR MEDICAID RECIPIENTS PHYSICALLY OR MENTALLY UNABLE TO PROVIDE BIOMETRIC IDENTIFICATION.

(F) FRAUD PREVENTION MARKERS INCORPORATED INTO SOFTWARE WHICH MAY BE USED TO OPERATE THE HARDWARE COMPONENT OF THE BIOMETRIC TECHNOLOGY SHALL PREVENT AND/OR REJECT THE PAYMENT BY THE MEDICAID PROGRAM AND ALERT THE SERVICE PROVIDER AT POINT OF SERVICE IF FRAUD OR POTENTIAL FRAUD IS IDENTIFIED BY THE BIOMETRIC TECHNOLOGY SYSTEM.

(G) PROVISIONS SHALL BE INCLUDED TO ENSURE THAT MEDICAID RECIPIENTS HAVE ACCESS TO EMERGENCY HEALTH SERVICES IN THE CASE OF A BIOMETRIC TECHNOLOGY SYSTEM MALFUNCTION OR FRAUD DETECTION ALARM.

(H) EVALUATION AND SELECTION OF PROPOSALS THAT ADDRESS THE REQUIREMENTS OF MEDICAID BENEFICIARIES AND PROVIDERS SHALL BE BASED ON THE FOLLOWING CRITERIA: SECURITY, PRIVACY, USABILITY, PERFORMANCE, HYGIENE, BIOMETRIC CAPTURE AND STORAGE REQUIREMENTS, AND INTEROPERABILITY.

3. SUCH REQUEST FOR PROPOSALS SHALL SET FORTH REQUIREMENTS AS TO THE RESULTS AND GOALS TO BE ACHIEVED, RATHER THAN SPECIFIC TECHNICAL METHODS OR SYSTEMS, TO ALLOW CONSIDERATION OF THE WIDEST POSSIBLE CHOICE OF AVAILABLE TECHNOLOGY.

4. SUCH REQUEST FOR PROPOSALS SHALL REQUIRE: (A) THAT THE PROGRAM SHALL BE REVENUE NEUTRAL ON AN ANNUAL BASIS, WHEREBY ANY PROGRAM COSTS ARE AT LEAST OFFSET BY STATE MEDICAID SAVINGS, AND SHALL HAVE AS A PRIMARY GOAL REDUCTION OF MEDICAID EXPENDITURES THROUGH ELIMINATION OF FRAUD AND ABUSE; AND (B) THAT THE PROGRAM SHALL BE COST NEUTRAL TO PROVIDERS FROM INCEPTION, WHEREBY ANY PROVIDER COSTS ARE AT LEAST OFFSET BY PROVIDER SAVINGS, AND SHALL HAVE AS A PRIMARY GOAL PROVIDER SAVINGS THROUGH INCREASED EFFICIENCIES.

5. THE COMMISSIONER SHALL ACCEPT TWO PROPOSALS FOR PILOT PROGRAM PARTICIPATION, PROVIDED, HOWEVER, THAT AT LEAST ONE PROPOSAL SHALL BE FROM THE UPSTATE REGION. FOR THE PURPOSES OF THIS ARTICLE, "UPSTATE REGION" SHALL INCLUDE THE FOLLOWING COUNTIES: ALBANY, ALLEGANY, BROOME, CATTARAUGUS, CAYUGA, CHAUTAUQUA, CHEMUNG, CHENANGO, CLINTON, COLUMBIA, CORTLAND, DELAWARE, ERIE, ESSEX, FRANKLIN, FULTON, GENESEE, GREENE, HAMILTON, HERKIMER, JEFFERSON, LEWIS, LIVINGSTON, MADISON, MONROE, MONTGOMERY, NIAGARA, ONEIDA, ONONDAGA, ONTARIO, ORLEANS, OSWEGO, OTSEGO, RENSSELAER, SARATOGA, SCHENECTADY, SCHOHARIE, SCHUYLER, SENECA, ST. LAWRENCE, STEUBEN, SULLIVAN, TIOGA, TOMKINS, WARREN, WASHINGTON, WAYNE, WYOMING AND YATES.

6. (A) SUCH REQUEST FOR PROPOSALS FOR THE IMPLEMENTATION OF A PROGRAM FOR BIOMETRIC TECHNOLOGY USE SHALL BE PUBLISHED ON OR BEFORE JANUARY FIFTEENTH, TWO THOUSAND FOURTEEN, AND SHALL PROVIDE THAT PROPOSALS SHALL BE OPENED ON OR BEFORE MARCH FIRST, TWO THOUSAND FOURTEEN.

(B) THE COMMISSIONER SHALL REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ONE YEAR AFTER THE

EFFECTIVE DATE OF THIS ARTICLE WITH REGARD TO THE PROGRESS MADE IN THE DEVELOPMENT OF CRITERIA FOR A PILOT PROGRAM OF BIOMETRIC IDENTIFICATION AND OF THE IMPLEMENTATION OF SUCH PILOT PROGRAM.

S 293. RULES AND REGULATIONS. THE COMMISSIONER IS AUTHORIZED AND DIRECTED TO PROMULGATE SUCH RULES AND REGULATIONS AS HE OR SHE MAY DEEM NECESSARY OR APPROPRIATE TO EFFECTUATE THE PURPOSES OF THIS ARTICLE.

S 167. Subdivision 1 of section 367-b of the social services law, as added by chapter 639 of the laws of 1976, is amended to read as follows:

1. The department, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, shall design and implement a statewide medical assistance information and payments system for the purpose of providing individual and aggregate data to social services districts to assist them in making basic management decisions, to the department and other state agencies to assist in the administration of the medical assistance program, and to the governor and the legislature as may be necessary to assist in making major administrative and policy decisions affecting such program. Such system shall be designed so as to be capable of the following:

a. receiving and processing information relating to the eligibility of each person applying for medical assistance and of issuing a medical assistance identification card, AND WHEN AVAILABLE UTILIZING THE BIOMETRIC IDENTIFICATION ISSUED BY THE DEPARTMENT OF HEALTH, CONFORMING TO THE REQUIREMENTS SET FORTH IN THE MEDICAID IDENTIFICATION AND ANTI-FRAUD BIOMETRIC TECHNOLOGY PROGRAM ESTABLISHED PURSUANT TO ARTICLE TWO-B OF THE PUBLIC HEALTH LAW to persons determined by a social services official to be eligible for such assistance;

b. ACTIVATING MEDICAL ASSISTANCE IDENTIFICATION BY REQUIRING AN APPLICANT RECEIVING SUCH IDENTIFICATION FROM THE DEPARTMENT TO HAVE IT VERIFIED AT A SOCIAL SERVICES DISTRICT OFFICE IN THE SOCIAL SERVICES DISTRICT IN WHICH THE APPLICANT RESIDES;

C. receiving and processing information relating to each qualified provider of medical assistance furnishing care, services or supplies for which claims for payment are made pursuant to this title;

[c.] D. receiving and processing, in a form and manner prescribed by the department, all claims for medical care, services and supplies, and making payments for valid claims to providers of medical care, services and supplies on behalf of social services districts; AND

[d.] E. maintaining information necessary to allow the department, consistent with the powers and duties of the department of health, to review the appropriateness, scope and duration of medical care, services and supplies provided to any eligible person pursuant to this chapter[; and

e. initiating implementation of such a system for the district comprising the city of New York, in a manner compatible with expansion of such system to districts other than the district comprising the city of New York].

S 168. Section 2818 of the public health law is REPEALED.

S 169. The state finance law is amended by adding a new section 99-u to read as follows:

S 99-U. HEALTH CARE EFFICIENCY AND AFFORDABILITY LAW OF NEW YORKERS (HEAL NY) ACCOUNT. 1. THERE IS HEREBY ESTABLISHED IN THE JOINT CUSTODY OF THE STATE COMPTROLLER AND THE COMMISSIONER OF TAXATION AND FINANCE THE "HEALTH CARE EFFICIENCY AND AFFORDABILITY LAW OF NEW YORKERS (HEAL NY) ACCOUNT".

2. THE ACCOUNT SHALL CONSIST OF ALL MONIES RECEIVED AND/OR APPROPRIATED FOR THE HEALTH CARE EFFICIENCY AND AFFORDABILITY LAW OF NEW YORKERS (HEAL NY) CAPITAL GRANT PROGRAM.

3. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, ALL MONIES SHALL REMAIN IN SUCH ACCOUNT UNLESS OTHERWISE DISBURSED PURSUANT TO APPROPRIATION BY THE LEGISLATURE.

S 170. Severability. 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 the 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 171. This act shall take effect immediately; provided that sections one through one hundred twenty of this act shall be deemed to have been in full force and effect on and after April 1, 2013; provided, however, that the provisions of sections one through one hundred twenty of this act shall apply only to actions and proceedings commenced on or after such effective date; provided, further, that:

(a) sections fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-four, twenty-six, twenty-seven, twenty-eight, and thirty of this act shall take effect January 1, 2014;

(b) sections forty-three, forty-four, forty-six and one hundred one of this act shall take effect on the one hundred eightieth day after it shall have become a law;

(c) sections ninety, ninety-one, ninety-three and ninety-four of this act shall take effect April 1, 2014, provided that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of such sections on the effective date of this act are authorized and directed to be made and completed on or before such effective date;

(d) section ninety-six of this act shall take effect on the ninetieth day after it shall have become a law;

(e) 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;

(f) 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;

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

(h) 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 financial services 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;

(i) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act;

(j) section 3621 of the public health law, as added by section one hundred twenty-five of this act shall expire and be deemed repealed March 31, 2015;

(k) sections one hundred twenty-six-a through one hundred fifty of this act shall take effect September 1, 2013, provided, however, that for policies renewed on and after such date, such sections shall take effect on the renewal date;

(l) sections one hundred thirty-seven, one hundred forty-one, one hundred forty-six and one hundred fifty of this act shall apply to health care services provided on and after such date and section one hundred fifty of this act shall expire and be deemed repealed January 1, 2016;

(m) sections one hundred thirty-six, one hundred thirty-eight, one hundred thirty-nine, one hundred forty, one hundred forty-five, one hundred forty-seven, one hundred forty-eight and one hundred forty-nine of this act shall apply to denials issued on and after such date;

(n) the amendments to section 364-j of the social services law, made by section one hundred fifty-a of this act shall not affect the expiration and repeal of such section and shall expire and be deemed repealed therewith;

(o) sections one hundred fifty-seven and one hundred fifty-eight of this act shall take effect on the one hundred eightieth day after it shall have become a law; provided, however, 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;

(p) the implementation of the provisions of section one hundred fifty-nine of this act shall be subject to the appropriation of moneys specifically for the purposes thereof;

(q) the amendments to section 33 of the public health law, made by section one hundred sixty-two of this act shall expire and be deemed repealed one year after the effective date of this act; and

(r) sections one hundred sixty-four and one hundred sixty-five of this act shall expire and be deemed repealed three years after the effective date of this act.

PART F

Section 1. Section 19.16 of the mental hygiene law, as added by chapter 223 of the laws of 1992, is amended to read as follows:

S 19.16 Methadone Registry.

The office shall establish and maintain, either directly or through contract, a central registry for purposes of preventing multiple enrollment, ENSURING ACCURATE DOSAGE DELIVERY AND FACILITATING DISASTER MANAGEMENT in methadone programs. The office shall require all methadone programs to utilize such registry and shall have the power to assess methadone programs such fees as are necessary and appropriate; PROVIDED, HOWEVER, THAT PROVISIONS RELATING TO ENSURING ACCURATE DOSAGE DELIVERY AND FACILITATING DISASTER MANAGEMENT SHALL NOT RESULT IN UNREIMBURSED COSTS TO, OR EXPENDITURES BY, METHADONE PROGRAMS.

S 2. This act shall take effect April 1, 2013.

PART G

Section 1. Article 26 of the mental hygiene law is REPEALED.

S 2. The article heading of article 25 of the mental hygiene law, as added by chapter 471 of the laws of 1980, is amended to read as follows:

[FUNDING FOR SUBSTANCE ABUSE SERVICES]

FUNDING FOR SERVICES OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

S 3. Paragraphs 1, 2, 3 and 4 of subdivision (a) of section 25.01 of the mental hygiene law, paragraph 1 as added by chapter 471 of the laws of 1980, and paragraphs 2, 3 and 4 as amended by chapter 223 of the laws of 1992, are amended, and four new paragraphs 5, 6, 7 and 8 are added to read as follows:

1. ["Local agency" shall mean a county governmental unit for a county not wholly within a city, and a city governmental unit for a city having a population of one million or more, designated by such county or city as responsible for substance abuse services in such county or city.] "LOCAL GOVERNMENTAL UNIT" SHALL HAVE THE SAME MEANING AS THAT CONTAINED IN ARTICLE FORTY-ONE OF THIS CHAPTER.

2. "Operating [costs] EXPENSES" shall mean expenditures[, excluding capital costs and debt service, subject to the approval of the office,] APPROVED BY THE OFFICE AND incurred for the maintenance and operation of substance [abuse] USE DISORDER programs, including but not limited to expenditures for treatment, administration, personnel, AND contractual services[, rental, depreciation and interest expenses incurred, in connection with the design, construction, acquisition, reconstruction, rehabilitation or improvement of a substance abuse program facility, and payments made to the facilities development corporation for substance abuse program facilities; provided that where the]. OPERATING EXPENSES DO NOT INCLUDE CAPITAL COSTS AND DEBT SERVICE UNLESS SUCH EXPENSES ARE RELATED TO THE rent, financing or refinancing of the design, construction, acquisition, reconstruction, rehabilitation or improvement of a substance [abuse] USE DISORDER program facility [is through the facilities development corporation, operating costs shall include the debt service to be paid to amortize obligations, including principal and interest, issued by the New York State medical care facilities finance agency to finance or refinance the capital costs of such facilities] PURSUANT TO THE MENTAL HYGIENE FACILITIES FINANCE PROGRAM THROUGH THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK (DASNY; SUCCESSOR TO THE FACILITIES DEVELOPMENT CORPORATION), OR OTHERWISE APPROVED BY THE OFFICE.

3. "Debt service" shall mean amounts, subject to the approval of the office, [as shall be] required to be paid to amortize obligations including principal and interest [issued by the New York state housing finance agency, the New York State medical care facilities finance agency or], ASSUMED by or on behalf of a [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency to finance capital costs for substance abuse program facilities] GOVERNMENTAL UNIT.

4. "Capital costs" shall mean [expenditures, subject to the approval of the office, as shall be obligated to acquire, construct, reconstruct, rehabilitate or improve a substance abuse program facility.] THE COSTS OF A PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR A VOLUNTARY AGENCY WITH RESPECT TO THE ACQUISITION OF REAL PROPERTY ESTATES, INTERESTS, AND COOPERATIVE INTERESTS IN REALTY, THEIR DESIGN, CONSTRUCTION, RECONSTRUCTION, REHABILITATION AND IMPROVEMENT, ORIGINAL FURNISHINGS AND EQUIPMENT, SITE DEVELOPMENT, AND APPURTENANCES OF A FACILITY.

5. "STATE AID" SHALL MEAN FINANCIAL SUPPORT PROVIDED THROUGH APPROPRIATIONS OF THE OFFICE TO SUPPORT THE PROVISION OF SUBSTANCE USE DISORDER TREATMENT, COMPULSIVE GAMBLING, PREVENTION OR OTHER AUTHORIZED SERVICES,

WITH THE EXCLUSION OF APPROPRIATIONS FOR THE PURPOSE OF MEDICAL ASSISTANCE.

6. "VOLUNTARY AGENCY CONTRIBUTIONS" SHALL MEAN REVENUE SOURCES OF VOLUNTARY AGENCIES EXCLUSIVE OF STATE AID AND LOCAL TAX LEVY.

7. "APPROVED NET OPERATING COST" SHALL MEAN THE REMAINDER OF TOTAL OPERATING EXPENSES APPROVED BY THE OFFICE, LESS ALL SOURCES OF REVENUE, INCLUDING VOLUNTARY AGENCY CONTRIBUTIONS AND LOCAL TAX LEVY.

8. "VOLUNTARY AGENCY" SHALL MEAN A CORPORATION ORGANIZED OR EXISTING PURSUANT TO THE NOT-FOR-PROFIT CORPORATION LAW FOR THE PURPOSE OF PROVIDING SUBSTANCE USE DISORDER, TREATMENT, COMPULSIVE GAMBLING, PREVENTION OR OTHER AUTHORIZED SERVICES.

S 4. Subdivisions (a) and (b) of section 25.03 of the mental hygiene law, subdivision (a) as amended by chapter 558 of the laws of 1999 and subdivision (b) as amended by chapter 223 of the laws of 1992, are amended and a new subdivision (d) is added to read as follows:

(a) In accordance with the provisions of this article, AND WITHIN APPROPRIATIONS MADE AVAILABLE, the office may provide [financial support] STATE AID to a [substance abuse program or a] PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT OR VOLUNTARY AGENCY up to one hundred per centum of the APPROVED NET operating costs of such [program] PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT or VOLUNTARY agency, and [either fifty per centum of the capital cost or fifty per centum of the debt service,] STATE AID MAY ALSO BE GRANTED TO A PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR A VOLUNTARY AGENCY FOR CAPITAL COSTS ASSOCIATED WITH THE PROVISION OF SERVICES AT A RATE OF UP TO ONE HUNDRED PERCENT OF APPROVED CAPITAL COSTS. SUCH STATE AID SHALL NOT BE GRANTED UNLESS AND UNTIL SUCH PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY IS IN COMPLIANCE WITH ALL REGULATIONS PROMULGATED BY THE COMMISSIONER REGARDING THE FINANCING OF CAPITAL PROJECTS. SUCH STATE AID for approved [services] NET OPERATING COSTS SHALL BE MADE AVAILABLE by way of advance or reimbursement, through EITHER contracts entered into between the office and such [program or] VOLUNTARY agency[, upon such terms and conditions as the office shall deem appropriate, except as provided in section 25.07 of this article, provided, however, that, upon issuance of an operating certificate in accordance with article thirty-two of this chapter, if required, the office shall provide financial support for approved chemical dependence services in accordance with article twenty-six of this title.] OR BY DISTRIBUTION OF SUCH STATE AID TO LOCAL GOVERNMENTS THROUGH A GRANT PROCESS PURSUANT TO SECTION 25.11 OF THIS ARTICLE.

(b) Financial support by the office shall be subject to the approval of the director of the budget AND WITHIN AVAILABLE APPROPRIATIONS.

(D) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO REQUIRE THE STATE TO INCREASE SUCH STATE AID SHOULD A LOCAL GOVERNMENTAL UNIT CHOOSE TO REMOVE ANY PORTION OF ITS LOCAL TAX LEVY SUPPORT OF VOLUNTARY AGENCIES, ALTHOUGH THE STATE MAY CHOOSE TO DO SO TO ADDRESS AN URGENT PUBLIC NEED, OR CONVERSELY, MAY CHOOSE TO REDUCE ITS STATE AID.

S 5. Section 25.05 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.05 Reimbursement from other sources.

The office shall not provide a [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT with financial support for obligations incurred by or on behalf of such program or agency for substance [abuse] USE DISORDER services for which reimbursement is or may be claimed under any provision of law other than this article.

S 6. The section heading and subdivisions (a) and (c) of section 25.06 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, are amended to read as follows:

Disclosures by closely allied entities of [substance abuse programs] A VOLUNTARY AGENCY.

(a) A closely allied entity of a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office shall provide the office with the following information:

1. A schedule of the dates, nature and amounts of all fiscal transactions between the closely allied entity and the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office.

2. A copy of the closely allied entity's certified annual financial statements.

3. With respect to any lease agreement between the closely allied entity, as lessor, and the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office, as lessee, of real or personal property:

(i) A certified statement by an independent outside entity providing a fair market appraisal of the real property space to be rented, as well as of any rental of personal property.

(ii) A statement of projected operating costs of the allied entity relative to any such leased property for the budget period. The closely allied entity must furnish the office with a certified statement of its actual operating costs relative to the leased property.

4. A statement of the funds received by the closely allied entity in connection with its fund raising activities conducted on behalf of the substance [abuse] USE DISORDER program that is funded or has applied for funding from the office which clearly identifies how such funds were and will be distributed or applied to such program.

5. Any other data or information which the office may deem necessary for purposes of making a funding decision.

(c) For purposes of this section, a "closely allied entity" shall mean, but not be limited to, a corporation, partnership or unincorporated association or other body that has been formed or is organized to provide financial assistance and aid for the benefit of a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office AND which FINANCIAL ASSISTANCE AND AID shall include, but not be limited to, engaging in fund raising activities, administering funds, holding title to real property, having an interest in personal property of any nature whatsoever, and engaging in any other activities for the benefit of any such program. Moreover, an entity shall be deemed closely allied to a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office to the extent that such entity and applicable fiscal transactions are required to be disclosed within the annual financial statements of the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office, under the category of related party transactions, as defined by and in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards (GAAS), as promulgated by the American institute of certified public accountants (AICPA).

S 7. Section 25.07 of the mental hygiene law, as added by chapter 471 of the laws of 1980, is amended to read as follows:

S 25.07 Non-substitution.

A [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT shall not substitute state monies for cash contributions, federal aid otherwise committed to or intended for use in such program or by such agency, revenues derived from the operation of such program or agency, or the other resources available for use in the operation of the program or agency.

S 8. Section 25.09 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.09 Administrative costs.

Subject to the approval of the director of the budget, the office shall establish a limit on the amount of financial support which may be advanced or reimbursed to a [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT for the administration of a [substance abuse] program.

S 9. Section 25.11 of the mental hygiene law, as added by chapter 471 of the laws of 1980, subdivision (a) as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.11 [Comprehensive plan] DISTRIBUTION OF STATE AID TO A LOCAL GOVERNMENTAL UNIT.

[(a) A local agency intending to seek financial support from the office shall no later than July first of each year submit to the office a comprehensive substance abuse services plan, which shall describe the programs and activities planned for its ensuing fiscal year. Such plan shall indicate to the extent possible, the nature of the services to be provided, whether such services are to be provided directly, through subcontract, or through the utilization of existing public resources, the area or areas to be served, and an estimate of the cost of such services, including amounts to be provided other than by office financial support, specifically identifying the amount of local governmental funds committed to substance abuse programs during its current fiscal year, and a commitment that no less than such an amount will be used from such funds for the operation of such programs during the next fiscal year. Such plan shall make provisions for all needed substance abuse services and for the evaluation of the effectiveness of such services.

(b) When a comprehensive plan includes a local school district based substance abuse program such plan shall include the details of an adequate distribution of in-school and community-wide preventive education services, including, but not limited to, services to be provided by local drug abuse prevention councils, and shall emphasize the use of other volunteer agency services as may be available. The description of the program and activities thereunder shall be separately stated, and the data and information required to be provided shall conform to the provisions of subdivision (a) of this section except that the period to be covered may, notwithstanding the fiscal year of the local agency, conform to the school year.] NOTWITHSTANDING SECTION ONE HUNDRED TWELVE OF THE STATE FINANCE LAW, THE OFFICE IS AUTHORIZED TO GRANT STATE AID ANNUALLY TO LOCAL GOVERNMENTAL UNITS IN THE FOLLOWING MANNER:

(A) LOCAL GOVERNMENTAL UNITS SHALL BE GRANTED STATE AID BY A STATE AID FUNDING AUTHORIZATION LETTER ISSUED BY THE OFFICE FOR APPROVED NET OPERATING COSTS FOR VOLUNTARY AGENCIES TO SUPPORT THE BASE AMOUNT OF STATE AID PROVIDED TO SUCH VOLUNTARY AGENCIES FOR THE PRIOR YEAR PROVIDED THAT THE LOCAL GOVERNMENTAL UNIT HAS APPROVED AND SUBMITTED BUDGETS FOR THE VOLUNTARY AGENCIES TO THE OFFICE. THE VOLUNTARY AGENCY BUDGETS SHALL IDENTIFY THE NATURE OF THE SERVICES TO BE PROVIDED WHICH MUST BE CONSISTENT WITH THE LOCAL SERVICES PLAN SUBMITTED BY THE LOCAL GOVERN-

MENTAL UNIT PURSUANT TO ARTICLE FORTY-ONE OF THIS CHAPTER, THE AREAS TO BE SERVED AND INCLUDE A DESCRIPTION OF THE VOLUNTARY AGENCY CONTRIBUTIONS AND LOCAL GOVERNMENTAL UNIT FUNDING PROVIDED. THE LOCAL GOVERNMENTAL UNIT SHALL ENTER INTO CONTRACTS WITH THE VOLUNTARY AGENCIES RECEIVING SUCH STATE AID. SUCH CONTRACTS SHALL INCLUDE FUNDING REQUIREMENTS SET BY THE OFFICE INCLUDING BUT NOT LIMITED TO RESPONSIBILITIES OF VOLUNTARY AGENCIES RELATING TO WORK SCOPES, PROGRAM PERFORMANCE AND OPERATIONS, APPLICATION OF PROGRAM INCOME, PROHIBITED USE OF FUNDS, RECORDKEEPING AND AUDIT OBLIGATIONS. UPON DESIGNATION BY THE OFFICE, LOCAL GOVERNMENTAL UNITS SHALL NOTIFY VOLUNTARY AGENCIES AS TO THE SOURCE OF FUNDING RECEIVED BY SUCH VOLUNTARY AGENCIES.

(B) STATE AID MADE AVAILABLE TO A LOCAL GOVERNMENTAL UNIT FOR APPROVED NET OPERATING COSTS FOR A VOLUNTARY AGENCY MAY BE REDUCED WHERE A REVIEW OF SUCH VOLUNTARY AGENCY'S PRIOR YEAR'S BUDGET AND/OR PERFORMANCE INDICATES:

(1) THAT THE PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY HAS FAILED TO MEET MINIMUM PERFORMANCE STANDARDS AND REQUIREMENTS OF THE OFFICE INCLUDING, BUT NOT LIMITED TO, MAINTAINING SERVICE UTILIZATION RATES AND PRODUCTIVITY STANDARDS AS SET BY THE OFFICE;

(2) THAT THE VOLUNTARY AGENCY HAS HAD AN INCREASE IN VOLUNTARY AGENCY CONTRIBUTIONS THAT REDUCES THE APPROVED NET OPERATING COSTS NECESSARY;

(3) THAT THE OFFICE, UPON CONSULTATION WITH THE LOCAL GOVERNMENTAL UNIT, OTHERWISE DETERMINES THERE IS A NEED TO REDUCE THE AMOUNT OF STATE AID AVAILABLE.

S 10. Section 25.13 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.13 Office is authorized state agency.

(a) The office when designated by the governor is the agency of the state to administer and/or supervise the state plan or plans concerning substance [abuse] USE DISORDER services specified in the federal drug abuse office and treatment act of nineteen hundred seventy-two and to cooperate with the duly designated federal authorities charged with the administration thereof.

(b) The office and all entities to which it provides financial support shall do all that is required and shall render necessary cooperation to ensure optimum use of federal aid for substance [abuse] USE DISORDER services.

(c) The commissioner is authorized and empowered to take such steps, not inconsistent with law, as may be necessary for the purpose of procuring for the people of this state all of the benefits and assistance, financial and otherwise, provided, or to be provided for, by or pursuant to any act of congress relating to substance [abuse] USE DISORDER services.

S 11. Section 25.15 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.15 Optimizing federal aid.

(a) A PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT or [substance abuse program] VOLUNTARY AGENCY shall, unless a specific written waiver of this requirement is made by the office, cause applications to be completed on such forms and in such manner as directed by the office and submit the same to the office for the purpose of causing a determination to be made whether the cost of the services provided individuals and groups qualify for federal aid which may be available for services provided pursuant to titles IV, XVI, XIX and XX of the federal social security act, or any other federal law. A PROGRAM OPER-

ATED BY A local [agency] GOVERNMENTAL UNIT or a [substance abuse program] VOLUNTARY AGENCY shall furnish to the office such other data as may be required and shall render such cooperation as may be necessary to maximize such potential federal aid. All information concerning the identity of individuals obtained and provided pursuant to this subdivision shall be kept confidential.

(b) To the extent that federal aid may be available for any substance [abuse] USE DISORDER services, the office, notwithstanding any other inconsistent provision of law, and with the approval of the director of the budget, is hereby authorized to seek such federal aid on behalf of [substance abuse programs] VOLUNTARY AGENCIES and A PROGRAM OPERATED BY A local [agencies] GOVERNMENTAL UNIT either directly or through the submission of claims to another state agency authorized to submit the same to an appropriate federal agency. The office is further authorized to certify for payment to [substance abuse programs] VOLUNTARY AGENCIES and A PROGRAM OPERATED BY A local [agencies] GOVERNMENTAL UNIT any federal aid received by the state which is attributable to the activities financed by such programs and agencies.

S 12. Section 25.17 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.17 Fees for services.

[Local agencies GOVERNMENTS and substance abuse treatment programs] VOLUNTARY AGENCIES AND PROGRAMS OPERATED BY LOCAL GOVERNMENTAL UNITS funded in whole or in part by the office shall establish, subject to the approval of the office, fee schedules for substance [abuse] USE DISORDER services, not specifically covered by the rates established pursuant to article twenty-eight of the public health law or title two of article five of the social services law. Such fees shall be charged for substance [abuse] USE DISORDER services furnished to persons who are financially able to pay the same, provided, that such services shall not be refused to any person because of his inability to pay therefor.

S 13. Subdivision (d) of section 41.18 of the mental hygiene law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(d) The liability of the state in any state fiscal year for state aid pursuant to this section shall exclude chemical dependence services, which are subject to article [twenty-six] TWENTY-FIVE of this chapter, and shall be limited to the amounts appropriated for such state aid by the legislature for such state fiscal year.

S 14. This act shall take effect April 1, 2013; provided, however, that effective immediately, any rule or regulation necessary for the implementation of this act on its effective date is authorized and directed to be made and completed on or before such effective date.

PART H

Section 1. Section 7.17 of the mental hygiene law is amended by adding a new subdivision (a-1) to read as follows:

(A-1) NOTWITHSTANDING ANY LAW TO THE CONTRARY, INPATIENT FACILITIES IN THE OFFICE SHALL ONLY BE ESTABLISHED PURSUANT TO EXPLICIT STATUTORY AUTHORITY.

S 2. The commissioner of mental health shall provide a report regarding the proposed restructuring of state-operated facilities that provide inpatient care to individuals with mental illness to the legislature no later than September 1, 2013, and shall provide an update of such report

every six months thereafter. Such report shall address topics including, but not limited to:

(a) the size and location of, and type of services to be provided by, facilities;

(b) the relative quality of the care and treatment provided by any hospital subject to a proposed closure, as may be informed by internal or external quality or accreditation reviews;

(c) the current and anticipated long-term need for the types of services provided by existing and proposed facilities;

(d) the availability of staff sufficient to address current and anticipated long term service needs;

(e) the long term capital investment required to ensure that the facilities meets relevant state and federal regulatory and capital construction requirements, and national accreditation standards;

(f) anticipated savings based upon economics of scale or other factors;

(g) community mental health services available in the catchment area of proposed facilities and hospitals subject to proposed closure, and the ability of such community mental health services to meet the behavioral health needs of the impacted consumers;

(h) how restructuring would address the obligations of the state to place persons with mental disabilities in community settings rather than in institutions, when appropriate;

(i) the anticipated impact of a proposed closure on access to mental health services;

(j) the impact on the state workforce, and strategies for the development of necessary retraining and redeployment programs;

(k) the impact on the local and regional economies; and

(l) proposed alternative uses for land and buildings to be vacated by the office of mental health.

S 3. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 2 of part C of chapter 111 of the laws of 2010, is amended to read as follows:

S 7. This act shall take effect immediately and shall expire March 31, [2013] 2014 when upon such date the provisions of this act shall be deemed repealed.

S 4. 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 5. This act shall take effect April 1, 2013; provided, however that if this act shall become a law after April 1, 2013, this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013.

Section 1. Subdivisions (d), (e), (f) and (g) of section 41.44 of the mental hygiene law are relettered subdivisions (e), (f), (g), and (h) and a new subdivision (d) is added to read as follows:

(D) THE COMMISSIONER IS AUTHORIZED TO RECOVER FUNDING FROM PROVIDERS OF COMMUNITY RESIDENCES LICENSED BY THE OFFICE OF MENTAL HEALTH, CONSISTENT WITH CONTRACTUAL OBLIGATIONS OF SUCH PROVIDERS, AND NOTWITHSTANDING ANY OTHER INCONSISTENT PROVISION OF LAW TO THE CONTRARY, SUCH RECOVERY AMOUNT SHALL EQUAL FIFTY PERCENT OF THE MEDICAID REVENUE RECEIVED BY SUCH PROVIDERS WHICH EXCEEDS THE FIXED AMOUNT OF ANNUAL MEDICAID REVENUE LIMITATIONS, AS ESTABLISHED BY THE COMMISSIONER.

S 2. This act shall take effect immediately, shall be deemed to have been in full force and effect on and after April 1, 2013, and shall expire and be deemed repealed March 31, 2014.

PART J

Intentionally Omitted

PART K

Section 1. Subdivisions (a), (b) and (c) of section 10.09 of the mental hygiene law, subdivisions (a) and (c) as added by chapter 7 of the laws of 2007 and subdivision (b) as amended by section 3 of part P of chapter 56 of the laws of 2012, are amended to read as follows:

(a) The commissioner shall provide the respondent and counsel for respondent with [an annual] A written notice of the right to petition the court for discharge, WHICH SHALL BE PROVIDED NO LATER THAN ELEVEN MONTHS AFTER THE DATE ON WHICH THE SUPREME OR COUNTY COURT JUDGE LAST ORDERED OR CONFIRMED THE NEED FOR CONTINUED CONFINEMENT PURSUANT TO THIS ARTICLE. The notice shall contain a form for the waiver of the right to petition for discharge.

(b) The commissioner shall also assure that each respondent committed under this article shall have an examination for evaluation of his or her mental condition made [at least once every] NO LATER THAN ONE year [(calculated from] AFTER the date on which the supreme or county court judge last ordered or confirmed the need for continued confinement pursuant to this article [or the date on which the respondent waived the right to petition for discharge pursuant to this section, whichever is later, as applicable)]. SUCH EXAMINATION SHALL BE conducted by a psychiatric examiner who shall report to the commissioner his or her written findings as to whether the respondent is currently a dangerous sex offender requiring confinement. At such time, the respondent also shall have the right to be evaluated by an independent psychiatric examiner. If the respondent is financially unable to obtain an examiner, the court shall appoint an examiner of the respondent's choice to be paid within the limits prescribed by law. Following such evaluation, each psychiatric examiner shall report his or her findings in writing to the commissioner and to counsel for respondent. The commissioner shall review relevant records and reports, along with the findings of the psychiatric examiners, and shall make a determination in writing as to whether the respondent is currently a dangerous sex offender requiring confinement.

(c) The commissioner shall [annually] forward the notice and waiver form, along with a report including the commissioner's written determination and the findings of the psychiatric examination, to the supreme or county court where the respondent is located, WHICH SHALL BE PROVIDED NO LATER THAN ONE YEAR AFTER THE DATE ON WHICH THE SUPREME OR COUNTY

COURT JUDGE LAST ORDERED OR CONFIRMED THE NEED FOR CONTINUED CONFINEMENT PURSUANT TO THIS ARTICLE.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013.

PART L

Section 1. The mental hygiene law is amended by adding a new section 31.37 to read as follows:

S 31.37 MENTAL HEALTH INCIDENT REVIEW PANELS.

(A) THE COMMISSIONER IS AUTHORIZED TO, ON HIS OR HER OWN ACCORD OR PURSUANT TO A REQUEST BY A LOCAL GOVERNMENT UNIT, ESTABLISH A MENTAL HEALTH INCIDENT REVIEW PANEL FOR THE PURPOSES OF REVIEWING IN CONJUNCTION WITH LOCAL REPRESENTATION, THE CIRCUMSTANCES AND EVENTS RELATED TO A SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL ILLNESS. FOR PURPOSES OF THIS SECTION, A "SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL ILLNESS" MEANS AN INCIDENT OCCURRING IN THE COMMUNITY IN WHICH A PERSON WITH A SERIOUS MENTAL ILLNESS IS PHYSICALLY INJURED OR CAUSES PHYSICAL INJURY TO ANOTHER PERSON, OR SUFFERS A SERIOUS AND PREVENTABLE MEDICAL COMPLICATION OR BECOMES INVOLVED IN A CRIMINAL INCIDENT INVOLVING VIOLENCE. A PANEL SHALL CONDUCT A REVIEW OF SUCH SERIOUS INCIDENT IN AN ATTEMPT TO IDENTIFY PROBLEMS OR GAPS IN MENTAL HEALTH DELIVERY SYSTEMS AND TO MAKE RECOMMENDATIONS FOR CORRECTIVE ACTIONS TO IMPROVE THE PROVISION OF MENTAL HEALTH OR RELATED SERVICES, TO IMPROVE THE COORDINATION, INTEGRATION AND ACCOUNTABILITY OF CARE IN THE MENTAL HEALTH SERVICE SYSTEM, AND TO ENHANCE INDIVIDUAL AND PUBLIC SAFETY.

(B) A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, REPRESENTATIVES FROM THE OFFICE OF MENTAL HEALTH AND THE LOCAL GOVERNMENTAL UNIT WHERE THE SERIOUS INCIDENT INVOLVING A PERSON WITH A MENTAL ILLNESS OCCURRED. A MENTAL HEALTH INCIDENT REVIEW PANEL MAY ALSO INCLUDE, IF DEEMED APPROPRIATE BY THE COMMISSIONER BASED ON THE NATURE OF THE SERIOUS INCIDENT BEING REVIEWED, ONE OR MORE REPRESENTATIVES FROM MENTAL HEALTH PROVIDERS, LOCAL DEPARTMENTS OF SOCIAL SERVICES, HUMAN SERVICES PROGRAMS, HOSPITALS, LOCAL SCHOOLS, EMERGENCY MEDICAL OR MENTAL HEALTH SERVICES, THE OFFICE OF THE COUNTY ATTORNEY, A COUNTY PROSECUTOR'S OFFICE, STATE OR LOCAL LAW ENFORCEMENT AGENCIES, THE OFFICE OF THE MEDICAL EXAMINER OR THE OFFICE OF THE CORONER, THE JUDICIARY, OR OTHER APPROPRIATE STATE OR LOCAL OFFICIALS.

(C) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY AND TO THE EXTENT CONSISTENT WITH FEDERAL LAW, A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL HAVE ACCESS TO THOSE CLIENT-IDENTIFIABLE MENTAL HEALTH RECORDS, AS WELL AS ALL RECORDS, DOCUMENTATION AND REPORTS RELATING TO THE INVESTIGATION OF AN INCIDENT BY A FACILITY IN ACCORDANCE WITH REGULATIONS OF THE COMMISSIONER, WHICH ARE NECESSARY FOR THE INVESTIGATION OF THE INCIDENT AND THE PREPARATION OF A REPORT OF THE INCIDENT, AS PROVIDED IN SUBDIVISION (E) OF THIS SECTION. A MENTAL HEALTH INCIDENT REVIEW PANEL ESTABLISHED PURSUANT TO THIS SECTION SHALL BE PROVIDED WITH ACCESS TO ALL OTHER RECORDS IN THE POSSESSION OF STATE OR LOCAL OFFICIALS OR AGENCIES, WITHIN TWENTY-ONE DAYS OF RECEIPT OF A REQUEST, EXCEPT: (1) THOSE RECORDS PROTECTED BY SECTION 190.25 OF THE CRIMINAL PROCEDURE LAW; AND (2) WHERE PROVISION OF LAW ENFORCEMENT RECORDS WOULD INTERFERE WITH AN ONGOING LAW ENFORCEMENT INVESTIGATION OR JUDICIAL PROCEEDING, IDENTIFY A CONFIDENTIAL SOURCE OR DISCLOSE CONFIDENTIAL INFORMATION RELATING TO AN ONGOING CRIMINAL INVESTIGATION, HIGHLY SENSITIVE CRIMINAL INVESTIGATIVE TECHNIQUES OR PROCEDURES, OR ENDANGER THE SAFETY OR WELFARE OF AN INDIVIDUAL.

(D) MENTAL HEALTH INCIDENT REVIEW PANELS, MEMBERS OF THE REVIEW PANELS AND PERSONS WHO PRESENT INFORMATION TO A REVIEW PANEL SHALL HAVE IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR ALL REASONABLE AND GOOD FAITH ACTIONS TAKEN PURSUANT TO THIS SECTION, AND SHALL NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING ANY OPINIONS FORMED AS A RESULT OF A MEETING OF SUCH REVIEW PANEL. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PREVENT A PERSON FROM TESTIFYING AS TO INFORMATION OBTAINED INDEPENDENTLY OF A MENTAL HEALTH INCIDENT REVIEW PANEL, OR INFORMATION WHICH IS PUBLIC.

(E) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ALL MEETINGS CONDUCTED, ALL REPORTS AND RECORDS MADE AND MAINTAINED AND ALL BOOKS AND PAPERS OBTAINED BY A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL BE CONFIDENTIAL, AND SHALL NOT BE OPEN OR MADE AVAILABLE, EXCEPT BY COURT ORDER OR AS SET FORTH IN SUBDIVISION (G) OF THIS SECTION. EACH MENTAL HEALTH INCIDENT REVIEW PANEL SHALL DEVELOP A REPORT OF THE INCIDENT INVESTIGATED. SUCH REPORT SHALL NOT CONTAIN ANY INDIVIDUALLY IDENTIFIABLE INFORMATION AND SHALL BE PROVIDED TO THE OFFICE OF MENTAL HEALTH UPON COMPLETION. SUCH REPORTS MUST BE APPROVED BY THE OFFICE OF MENTAL HEALTH PRIOR TO BECOMING FINAL.

(F) IF QUALITY PROBLEMS OF PARTICULAR MENTAL HEALTH PROGRAMS ARE IDENTIFIED BASED ON SUCH REVIEWS, THE COMMISSIONER IS AUTHORIZED, PURSUANT TO THE RELEVANT PROVISIONS OF THIS CHAPTER, TO TAKE APPROPRIATE ACTIONS REGARDING THE LICENSURE OF PARTICULAR PROVIDERS, TO REFER THE ISSUE TO OTHER RESPONSIBLE PARTIES FOR INVESTIGATION, OR TO TAKE OTHER APPROPRIATE ACTION WITHIN THE SCOPE OF HIS OR HER AUTHORITY.

(G) IN HIS OR HER DISCRETION, THE COMMISSIONER SHALL BE AUTHORIZED TO PROVIDE THE FINAL REPORT OF A REVIEW PANEL OR PORTIONS THEREOF TO ANY INDIVIDUAL OR ENTITY FOR WHOM THE REPORT MAKES RECOMMENDATIONS FOR CORRECTIVE OR OTHER APPROPRIATE ACTIONS THAT SHOULD BE TAKEN. ANY FINAL REPORT OR PORTION THEREOF SHALL NOT BE FURTHER DISSEMINATED BY THE INDIVIDUAL OR ENTITY RECEIVING SUCH REPORT. FURTHER, THE COMMISSIONER SHALL SUBMIT THE FINAL REPORT OF A REVIEW PANEL, WITHIN FIFTEEN DAYS OF THE CONCLUSION OF A PANEL, TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY.

(H) THE COMMISSIONER SHALL SUBMIT AN ANNUAL CUMULATIVE REPORT TO THE GOVERNOR AND THE LEGISLATURE INCORPORATING THE DATA IN THE MENTAL HEALTH INCIDENT REVIEW PANEL REPORTS AND INCLUDING A SUMMARY OF THE FINDINGS AND RECOMMENDATIONS MADE BY SUCH REVIEW PANELS, WHICH MEASURES THAT HAVE BEEN IMPLEMENTED, AND A DESCRIPTION OF THE IMPACT OF SUCH IMPLEMENTATIONS. THE ANNUAL CUMULATIVE REPORTS MAY THEREAFTER BE MADE AVAILABLE TO THE PUBLIC.

S 2. Subdivision (c) of section 33.13 of the mental hygiene law is amended by adding a new paragraph 16 to read as follows:

16. TO A MENTAL HEALTH INCIDENT REVIEW PANEL, OR MEMBERS THEREOF, ESTABLISHED BY THE COMMISSIONER PURSUANT TO SECTION 31.37 OF THIS TITLE, IN CONNECTION WITH INCIDENT REVIEWS CONDUCTED BY SUCH PANEL.

S 3. Subdivision 3 of section 6527 of the education law, as amended by chapter 257 of the laws of 1987, is amended to read as follows:

3. No individual who serves as a member of (a) a committee established to administer a utilization review plan of a hospital, including a hospital as defined in article twenty-eight of the public health law or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, or (b) a committee having the responsibility of the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law or the evaluation and improvement of the quality of care rendered in a hospital as defined in article twenty-eight of the public

health law or a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law, or (c) any medical review committee or subcommittee thereof of a local, county or state medical, dental, podiatry or optometrical society, any such society itself, a professional standards review organization or an individual when such committee, subcommittee, society, organization or individual is performing any medical or quality assurance review function including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law, either described in clauses (a) and (b) of this subdivision, required by law, or involving any controversy or dispute between (i) a physician, dentist, podiatrist or optometrist or hospital administrator and a patient concerning the diagnosis, treatment or care of such patient or the fees or charges therefor or (ii) a physician, dentist, podiatrist or optometrist or hospital administrator and a provider of medical, dental, podiatric or optometrical services concerning any medical or health charges or fees of such physician, dentist, podiatrist or optometrist, or (d) a committee appointed pursuant to section twenty-eight hundred five-j of the public health law to participate in the medical and dental malpractice prevention program, or (e) any individual who participated in the preparation of incident reports required by the department of health pursuant to section twenty-eight hundred five-l of the public health law, or (f) a committee established to administer a utilization review plan, or a committee having the responsibility of evaluation and improvement of the quality of care rendered, in a health maintenance organization organized under article forty-four of the public health law or article forty-three of the insurance law, including a committee of an individual practice association or medical group acting pursuant to a contract with such a health maintenance organization, OR (G) A MENTAL HEALTH INCIDENT REVIEW PANEL CONVENED PURSUANT TO SECTION 31.37 OF THE MENTAL HYGIENE LAW, shall be liable in damages to any person for any action taken or recommendations made, by him OR HER within the scope of his OR HER function in such capacity provided that (a) such individual has taken action or made recommendations within the scope of his OR HER function and without malice, and (b) in the reasonable belief after reasonable investigation that the act or recommendation was warranted, based upon the facts disclosed.

Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health pursuant to section twenty-eight hundred five-l of the public health law described herein, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law OR REVIEWED PURSUANT TO SECTION 31.37 OF THE MENTAL HYGIENE LAW, shall be subject to disclosure under article thirty-one of the civil practice law and rules except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting when a medical or a quality assurance review or a medical and dental malpractice prevention program or an incident reporting function described herein was performed, including the investigation of an incident reported pursuant to section 29.29 of the mental hygiene law OR AN INCIDENT REVIEWED PURSUANT TO SECTION 31.37 OF THE MENTAL HYGIENE LAW, shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.

S 4. This act shall take effect on the sixtieth day after it shall have become a law.

PART M

Section 1. Section 20 of chapter 723 of the laws of 1989, amending the mental hygiene law and other laws relating to the establishment of comprehensive psychiatric emergency programs, is REPEALED.

S 2. Subdivision (c) of section 7.15 of the mental hygiene law is REPEALED.

S 3. Subdivision (c) of section 13.15 of the mental hygiene law is REPEALED.

S 4. Paragraph 3 of subdivision (d) of section 16.19 of the mental hygiene law is REPEALED.

S 5. Subparagraph e of paragraph 2 of subdivision (b) of section 5.07 of the mental hygiene law, as added by chapter 322 of the laws of 1992, is amended as follows:

e. a description of the available community-based acute inpatient, out-patient, [emergency, and community support] COMMUNITY SUPPORT AND EMERGENCY services, WHICH SHALL INCLUDE COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS LICENSED PURSUANT TO SECTION 31.27 OF THIS CHAPTER. Such description should include the extent to which these services are currently utilized by persons with mental illness and, as available, compare estimates of utilization with estimates of the prevalence of mental illness among persons residing in the service area to determine unmet need;

S 6. This act shall take effect April 1, 2013.

PART N

Section 1. Subdivisions 3-b and 3-c of section 1 and 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 1 of part H of chapter 56 of the laws of 2012, is amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [2013] 2014, 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, [2013] 2014 and ending March 31, [2016] 2017, 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 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, [2016] 2017; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013; 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 O

Section 1. Legislative findings and purpose. Recent actions by the United States Center for Medicare and Medicaid Services impact the stability of New York state's mental hygiene system. While the state must embark on a deliberate path to replace the existing, long-standing financing system for developmental disability services, replacement of the sudden loss of $1.1 billion in federal revenue is too significant to be solved solely by actions within the mental hygiene system. A partnership with the entire health care community is needed to manage this loss over time. Accordingly, this part authorizes the actions necessary and creates the Mental Hygiene Stabilization Fund that will be supported by department of health medicaid resources under the Global Cap in annual amounts not to exceed $730,000,000 in state fiscal year 2013-14, $445,000,000 in 2014-15, $267,000,000 in 2015-16, and $267,000,000 in 2016-17.

S 2. Notwithstanding any contrary provision of law, the commissioner of health shall annul implementation of the reimbursement reductions authorized by section one of part A of this act commencing February 15, 2014.

S 3. Notwithstanding any contrary provision of law, implementation of the provisions of sections twenty-two, twenty-three, and/or twenty-four of part A of this act shall be delayed to the state fiscal year beginning April 1, 2014.

S 4. 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 5. 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, as amended, 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 6. 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 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013.

PART P

Section 1. Legislative intent. The legislature hereby finds that the goals of the state include providing individuals with mental illnesses

the tools necessary to: (a) make informed choices and decisions; and (b) achieve equality of opportunity, full inclusion and integration in society, employment, independent living, and economic and social self-sufficiency. The legislature further finds that such goals are best achieved by providing individuals with mental illnesses a variety of residential options that are both integrated and appropriate to the needs of each person. Therefore, the legislature finds it appropriate and prudent to continue overseeing the regulation of adult homes as the state develops community based settings sufficient to meet the desires and needs of individuals with mental illnesses.

S 2. Definitions. For the purposes of this act, the following terms shall have the following meanings:

(a) "Administrative action" means any decision or action by an executive agency, including but not limited to, the promulgation, implementation or enforcement of regulations.

(b) "Adult home" means an adult care facility established and operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care and supervision to five or more adults who are unrelated to the operator.

(c) "Mental health census" means the number or percentage of residents in a facility who are persons with serious mental illness, as defined in subdivision (d) of this section.

(d) "Persons with serious mental illness" means persons who are in psychiatric crisis; or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, and whose severity and duration of mental illness results in substantial functional disability.

S 3. Notwithstanding any law, rule or regulation to the contrary, absent explicit statutory authority, no executive agency shall undertake any administrative action designed to limit or reduce the mental health census of an adult home.

(a) Prior to provision of such statutory authority:

(1) The commissioner of health and the commissioner of mental health shall, in consultation with stakeholders, including representation from the legislature, mental health advocacy organizations, and the adult home industry, jointly develop a report and recommendations regarding the provision of integrated housing that is appropriate to the needs of individuals with serious mental illnesses. Such report and recommendations shall include a plan and timeline for developing community settings and community services in all regions of the state; guidance as to how adult homes impacted by such plan can support, and continue to serve, residents; details as to which adult homes and residents would be impacted by such plan, as well as any foreseeable effects on local economies; proposals for evaluating persons with serious mental illnesses residing in adult homes, and providing the support necessary to aid them in making informed decisions regarding future treatment; and details with regard to the progress of the department of health and the office of mental health in facilitating such informed decisions.

(2) The commissioner of health and the commissioner of mental health shall certify that sufficient alternative housing options exist to accommodate those persons with serious mental illnesses residing in adult homes who chose to transition to an appropriate community setting, within a reasonable distance from individuals' current housing.

(b) Such report and recommendations shall be provided to the temporary president of the senate and the speaker of the assembly no later than

December 31, 2013, and shall be updated no less frequently than once per year.

S 4. This act shall take effect immediately.

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 P of this act shall be as specifically set forth in the last section of such Parts.