

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

S. 2606--D

A. 3006--D

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

January 22, 2013

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

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

AN ACT to amend 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; in relation to the determination of rates of payments by certain state governmental agencies; to amend the social services law, in relation to the medical assistance information and payment system; to amend the social services law, in relation to managed care programs; to amend the public health law, in relation to managed long term care plans; to amend the public health law, in relation to participation in the state health insurance exchange; 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 part C of chapter 58 of the laws of 2005, amending the public health law and other laws authorizing reimbursements for expenditures made by social services districts for medical assistance, in relation to delay of certain administrative costs; 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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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 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 the social services law, in relation to the funding of health home infrastructure development; 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 rates of payment for residential health care facilities and in relation to rates of reimbursement for inpatient detoxification and withdrawal services; 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 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 payment of claims; to amend the insurance law, in relation to health care providers; in relation to establishing the home and community-based care work group; in relation to critical access hospitals; to amend the public health law, in relation to eliminating the bed hold requirement; to amend the social services law, in relation to eligibility for Medicaid; 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 the mental hygiene law, in relation to people first waiver program; to amend 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, in relation to the effectiveness thereof; to amend subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state funds Medicaid expenditures, in relation to the effectiveness thereof; in relation to elimi-

nating 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; and to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness 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; to amend the social services law, in relation to permitting online and telephone Medicaid applications; to amend the social services law, in relation to allowing

administrative renewals and self-attestation of residency; to amend the social services law, in relation to ending applications for family health plus; to amend the social services law, in relation to modified adjusted gross income and Medicaid eligibility groups; to amend the public health law, in relation to establishing methodology for modified adjusted gross income; to amend the public health law, in relation to centralizing child health plus eligibility determinations; to amend the public health law, in relation to requiring audit standards for eligibility; to amend the public health law, in relation to residency and income attestation and verification for child health plus; to amend the public health law, in relation to eliminating temporary enrollment in child health plus; to amend the public health law, in relation to expanding the child health plus social security number requirement to lawfully residing children; to amend the public health law, in relation to modified adjusted gross income under child health plus; to amend the public health law, in relation to personal interviews under child health plus; to amend the social services law, in relation to amendment of contracts awarded by the commissioner of health; to amend the public health law, in relation to requiring a status report on the health benefit exchange; to amend the insurance law, in relation to health benefit exchange navigators and in relation to clarifying the identity of persons to whom insurance licensing requirements apply; to amend the insurance law, in relation to coverage limitations requirements and student accident and health insurance; to amend the insurance law, in relation to standardization of individual enrollee direct payment contracts; to amend the public health law, in relation to HMOs; to amend the insurance law, in relation to ensuring that group and individual insurance policy provisions conform to applicable requirements of federal law and to make conforming changes; 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; 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 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 use of Medicaid recovery savings; to repeal sections 602, 610 and 612 and subdivisions 5 and 7 of section 613 of the public health law relating to state aid; to repeal sections 2300, 2301, 2302, 2303, 2309 and 2310 of the public health law relating to the control of sexually transmitted diseases; 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 and chapter 56 of the laws of 2012, amending the mental hygiene law relating to the closure and the reduction in size of certain facilities serving persons with mental illness, in relation to references to certain former children's psychiatric centers in the city of New York, and in relation to the expiration and repeal of certain provisions thereof; 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 chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part I); to amend the mental hygiene law, in relation to vesting all authority to appoint and remove officers and employees of the office of mental health (Part J); intentionally omitted (Part K); to amend the mental hygiene law, in relation to creating mental health incident review panels (Part L); to amend the mental hygiene law, in relation to psychiatric emergency programs; 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); to provide medical assistance to certain retirees of the New York city off-track betting corporation (Part P); and to amend the education law and the public health law, in relation to funding to SUNY Downstate Medical Center and directing the restructuring of hospital (Part Q)

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

1 Section 1. This act enacts into law major components of legislation
2 which are necessary to implement the state fiscal plan for the 2013-2014
3 state fiscal year. Each component is wholly contained within a Part
4 identified as Parts A through Q. The effective date for each particular
5 provision contained within such Part is set forth in the last section of
6 such Part. Any provision in any section contained within a Part, including
7 the effective date of the Part, which makes a reference to a section
8 "of this act", when used in connection with that particular component,
9 shall be deemed to mean and refer to the corresponding section of the
10 Part in which it is found. Section three of this act sets forth the
11 general effective date of this act.

12 PART A

1 Section 1. Subdivision (a) of section 90 of part H of chapter 59 of
2 the laws of 2011, amending the public health law and other laws, relat-
3 ing to general hospital inpatient reimbursement for annual rates, is
4 amended to read as follows:

5 (a) Notwithstanding any other provision of law to the contrary, for
6 the state fiscal years beginning April 1, 2011 and ending on March 31,
7 [2013] 2015, all Medicaid payments made for services provided on and
8 after April 1, 2011, shall, except as hereinafter provided, be subject
9 to a uniform two percent reduction and such reduction shall be applied,
10 to the extent practicable, in equal amounts during the fiscal year,
11 provided, however, that an alternative method may be considered at the
12 discretion of the commissioner of health and the director of the budget
13 based upon consultation with the health care industry including but not
14 limited to, a uniform reduction in Medicaid rates of payments or other
15 reductions provided that any method selected achieves up to \$345,000,000
16 in Medicaid state share savings in state fiscal year 2011-12 and up to
17 \$357,000,000 ANNUALLY in state fiscal [year] YEARS 2012-13, 2013-14 AND
18 2014-15 except as hereinafter provided, for services provided on and
19 after April 1, 2011 through March 31, [2013] 2015. Any alternative
20 methods to achieve the reduction must be provided in writing and shall
21 be filed with the senate finance committee and the assembly ways and
22 means committee not less than thirty days before the date on which
23 implementation is expected to begin. Nothing in this section shall be
24 deemed to prevent all or part of such alternative reduction plan from
25 taking effect retroactively, to the extent permitted by the federal
26 centers for medicare and medicaid services.

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

32 1. Notwithstanding any inconsistent provision of state law, rule or
33 regulation to the contrary, subject to federal approval, the year to
34 year rate of growth of department of health state funds Medicaid spend-
35 ing shall not exceed the ten year rolling average of the medical compo-
36 nent of the consumer price index as published by the United States
37 department of labor, bureau of labor statistics, for the preceding ten
38 years[.]; PROVIDED, HOWEVER, THAT FOR STATE FISCAL YEAR 2013-14 AND FOR
39 EACH FISCAL YEAR THEREAFTER, THE MAXIMUM ALLOWABLE ANNUAL INCREASE IN
40 THE AMOUNT OF DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING SHALL
41 BE CALCULATED BY MULTIPLYING THE DEPARTMENT OF HEALTH STATE FUNDS MEDI-
42 CAID SPENDING FOR THE PREVIOUS YEAR, MINUS THE AMOUNT OF ANY DEPARTMENT
43 OF HEALTH STATE OPERATIONS SPENDING INCLUDED THEREIN, BY SUCH TEN YEAR
44 ROLLING AVERAGE.

45 S 3. Subdivisions 1 and 5 of section 92 of part H of chapter 59 of
46 the laws of 2011, amending the public health law and other laws relating
47 to known and projected department of health state fund medicaid expendi-
48 tures, subdivision 1 as amended by section 57 of part D of chapter 56 of
49 the laws of 2012, are amended to read as follows:

50 1. For state fiscal years 2011-12 through [2013-14] 2014-15, the
51 director of the budget, in consultation with the commissioner of health
52 referenced as "commissioner" for purposes of this section, shall assess
53 on a monthly basis, as reflected in monthly reports pursuant to subdivi-
54 sion five of this section known and projected department of health state
55 funds medicaid expenditures by category of service and by geographic
56 regions, as defined by the commissioner, and if the director of the

1 budget determines that such expenditures are expected to cause medicaid
2 disbursements for such period to exceed the projected department of
3 health medicaid state funds disbursements in the enacted budget finan-
4 cial plan pursuant to subdivision 3 of section 23 of the state finance
5 law, the commissioner of health, in consultation with the director of
6 the budget, shall develop a medicaid savings allocation plan to limit
7 such spending to the aggregate limit level specified in the enacted
8 budget financial plan, provided, however, such projections may be
9 adjusted by the director of the budget to account for any changes in the
10 New York state federal medical assistance percentage amount established
11 pursuant to the federal social security act, changes in provider reven-
12 ues, reductions to local social services district medical assistance
13 administration, and beginning April 1, 2012 the operational costs of the
14 New York state medical indemnity fund. SUCH PROJECTIONS MAY BE ADJUSTED
15 BY THE DIRECTOR OF THE BUDGET TO ACCOUNT FOR INCREASED OR EXPEDITED
16 DEPARTMENT OF HEALTH STATE FUNDS MEDICAID EXPENDITURES AS A RESULT OF A
17 NATURAL OR OTHER TYPE OF DISASTER, INCLUDING A GOVERNMENTAL DECLARATION
18 OF EMERGENCY.

19 5. The department of health shall prepare a monthly report that sets
20 forth: (a) known and projected department of health medicaid expendi-
21 tures as described in subdivision one of this section, AND FACTORS THAT
22 COULD RESULT IN MEDICAID DISBURSEMENTS FOR THE RELEVANT STATE FISCAL
23 YEAR TO EXCEED THE PROJECTED DEPARTMENT OF HEALTH STATE FUNDS DISBURSE-
24 MENTS IN THE ENACTED BUDGET FINANCIAL PLAN PURSUANT TO SUBDIVISION 3 OF
25 SECTION 23 OF THE STATE FINANCE LAW, INCLUDING SPENDING INCREASES OR
26 DECREASES DUE TO: ENROLLMENT FLUCTUATIONS, RATE CHANGES, UTILIZATION
27 CHANGES, MRT INVESTMENTS, AND SHIFT OF BENEFICIARIES TO MANAGED CARE;
28 AND VARIATIONS IN OFFLINE MEDICAID PAYMENTS; and (b) the actions taken
29 to implement any medicaid savings allocation plan implemented pursuant
30 to subdivision four of this section, including information concerning
31 the impact of such actions on each category of service and each
32 geographic region of the state. Each such monthly report shall be
33 provided to the chairs of the senate finance and the assembly ways and
34 means committees and shall be posted on the department of health's
35 website in a timely manner.

36 S 4. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c
37 of the public health law, section 21 of chapter 1 of the laws of 1999,
38 or any other contrary provision of law, in determining rates of payments
39 by state governmental agencies effective for services provided on and
40 after April 1, 2013, for inpatient and outpatient services provided by
41 general hospitals, for inpatient services and adult day health care
42 outpatient services provided by residential health care facilities
43 pursuant to article 28 of the public health law, except for residential
44 health care facilities or units of such facilities providing inpatient
45 services primarily to children under twenty-one years of age, for home
46 health care services provided pursuant to article 36 of the public
47 health law by certified home health agencies, long term home health care
48 programs and AIDS home care programs, and for personal care services
49 provided pursuant to section 365-a of the social services law, the
50 commissioner of health shall apply no greater than zero trend factors
51 attributable to the 2013 and 2014 calendar years in accordance with
52 paragraph (c) of subdivision 10 of section 2807-c of the public health
53 law, provided, however, that such no greater than zero trend factors
54 attributable to such 2013 and 2014 calendar years shall also be applied
55 to rates of payment for rate periods on and after April 1, 2013 for
56 personal care services provided in those local social services

1 districts, including New York city, whose rates of payment for such
2 services are established by such local social services districts pursu-
3 ant to a rate-setting exemption issued by the commissioner of health to
4 such local social services districts in accordance with applicable regu-
5 lations, and provided further, however, that for rates of payment for
6 assisted living program services provided on and after April 1, 2013,
7 such trend factors attributable to the 2013 and 2014 calendar years
8 shall be established at no greater than zero percent.

9 S 4-a. Notwithstanding paragraph (c) of subdivision 10 of section
10 2807-c of the public health law, section 21 of chapter 1 of the laws of
11 1999, or any other contrary provision of law, in determining rates of
12 payments by state governmental agencies effective for services provided
13 on and after January 1, 2015 through March 31, 2015, for inpatient and
14 outpatient services provided by general hospitals, for inpatient
15 services and adult day health care outpatient services provided by resi-
16 dential health care facilities pursuant to article 28 of the public
17 health law, except for residential health care facilities or units of
18 such facilities providing services primarily to children under twenty-
19 one years of age, for home health care services provided pursuant to
20 article 36 of the public health law by certified home health agencies,
21 long term home health care programs and AIDS home care programs, and for
22 personal care services provided pursuant to section 365-a of the social
23 services law, the commissioner of health shall apply no greater than
24 zero trend factors attributable to the 2015 calendar year in accordance
25 with paragraph (c) of subdivision 10 of section 2807-c of the public
26 health law, provided, however, that such no greater than zero trend
27 factors attributable to such 2015 calendar year shall also be applied to
28 rates of payment provided on and after January 1, 2015 through March 31,
29 2015 for personal care services provided in those local social services
30 districts, including New York city, whose rates of payment for such
31 services are established by such local social services districts pursu-
32 ant to a rate-setting exemption issued by the commissioner of health to
33 such local social services districts in accordance with applicable regu-
34 lations, and provided further, however, that for rates of payment for
35 assisted living program services provided on and after January 1, 2015
36 through March 31, 2015, such trend factors attributable to the 2015
37 calendar year shall be established at no greater than zero percent.

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

41 (a) For the purpose of orderly and timely implementation of the
42 medical assistance information and payment system, the department is
43 hereby authorized to enter into agreements with fiscal intermediaries or
44 fiscal agents for the design, development, implementation, operation,
45 processing, auditing and making of payments, subject to audits being
46 conducted by the state in accordance with the terms of such agreements,
47 for medical assistance claims under the system described by this section
48 in any social services district. Such agreements shall specifically
49 provide that the state shall have complete oversight responsibility for
50 the fiscal intermediaries' or fiscal agents' performance and shall be
51 solely responsible for establishing eligibility requirements for recipi-
52 ents, provider qualifications, rates of payment, investigation of
53 suspected fraud and abuse, issuance of identification cards, establish-
54 ing and maintaining recipient eligibility files, provider profiles, and
55 conducting state audits of the fiscal intermediaries' or agents' at
56 least once annually. The system described in this subdivision shall be

1 operated by [a] ONE OR MORE fiscal [intermediary] INTERMEDIARIES or
2 fiscal [agent] AGENTS in accordance with this subdivision unless the
3 department is otherwise authorized by a law enacted subsequent to the
4 effective date of this subdivision to operate the system in another
5 manner. In no event shall such intermediary or agent be a political
6 subdivision of the state or any other governmental agency or entity.
7 NOTWITHSTANDING THE FOREGOING, THE DEPARTMENT MAY MAKE PAYMENTS TO A
8 PROVIDER UPON THE COMMISSIONER'S DETERMINATION THAT THE PROVIDER IS
9 TEMPORARILY UNABLE TO COMPLY WITH BILLING REQUIREMENTS. The department
10 shall consult with the office of Medicaid inspector general regarding
11 any activities undertaken by the fiscal intermediaries or fiscal agents
12 regarding investigation of suspected fraud and abuse.

13 S 6. Section 365-l of the social services law is amended by adding a
14 new subdivision 9 to read as follows:

15 9. ANY CONTRACT OR CONTRACTS ENTERED INTO BY THE COMMISSIONER OF
16 HEALTH PRIOR TO JANUARY FIRST, TWO THOUSAND THIRTEEN PURSUANT TO SUBDI-
17 VISION EIGHT OF THIS SECTION MAY BE AMENDED OR MODIFIED WITHOUT THE NEED
18 FOR A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, AND WITHOUT
19 REGARD TO THE PROVISIONS OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED
20 SIXTY-THREE OF THE STATE FINANCE LAW, SECTION ONE HUNDRED FORTY-TWO OF
21 THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER PROVISION OF LAW, TO ALLOW
22 THE PURCHASE OF ADDITIONAL PERSONNEL AND SERVICES, SUBJECT TO AVAILABLE
23 FUNDING, FOR THE LIMITED PURPOSE OF ASSISTING THE DEPARTMENT OF HEALTH
24 WITH IMPLEMENTING THE BALANCING INCENTIVE PROGRAM, THE FULLY INTEGRATED
25 DUALS ADVANTAGE PROGRAM, THE VITAL ACCESS PROVIDER PROGRAM, THE MEDICAID
26 WAIVER AMENDMENT ASSOCIATED WITH THE PUBLIC HOSPITAL TRANSFORMATION, THE
27 ADDITION OF BEHAVIORAL HEALTH SERVICES AS A MANAGED CARE PLAN BENEFIT,
28 AND/OR ANY WORKGROUPS REQUIRED TO BE ESTABLISHED BY THE CHAPTER OF THE
29 LAWS OF TWO THOUSAND THIRTEEN THAT ADDED THIS SUBDIVISION.

30 S 7. Section 364-j of the social services law is amended by adding a
31 new subdivision 27 to read as follows:

32 27. THE COMMISSIONER OF THE DEPARTMENT OF HEALTH MAY MAKE ANY NECES-
33 SARY AMENDMENTS TO A CONTRACT PURSUANT TO THIS SECTION WITH A MANAGED
34 CARE PROVIDER, AS DEFINED IN PARAGRAPH (B) OF SUBDIVISION ONE OF THIS
35 SECTION, TO ALLOW SUCH MANAGED CARE PROVIDER TO PARTICIPATE AS A QUALI-
36 FIED HEALTH PLAN IN A STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT
37 TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L.
38 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCIL-
39 IATION ACT OF 2010 (P.L. 111-152).

40 S 7-a. Section 4403-f of the public health law is amended by adding a
41 new subdivision 12 to read as follows:

42 12. THE COMMISSIONER MAY MAKE ANY NECESSARY AMENDMENTS TO A CONTRACT
43 PURSUANT TO THIS SECTION WITH A MANAGED LONG TERM CARE PLAN, AS DEFINED
44 IN PARAGRAPH (A) OF SUBDIVISION ONE OF THIS SECTION, TO ALLOW SUCH
45 MANAGED LONG TERM CARE PLAN TO PARTICIPATE AS A QUALIFIED HEALTH PLAN IN
46 A STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL
47 PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY
48 THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L.
49 111-152).

50 S 7-b. Section 2511 of the public health law is amended by adding a
51 new subdivision 21 to read as follows:

52 21. THE COMMISSIONER MAY MAKE ANY NECESSARY AMENDMENTS TO A CONTRACT
53 PURSUANT TO THIS SECTION WITH AN APPROVED ORGANIZATION, AS DEFINED IN
54 SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED TEN OF THIS TITLE, TO
55 ALLOW SUCH APPROVED ORGANIZATION TO PARTICIPATE AS A QUALIFIED HEALTH
56 PLAN IN A STATE HEALTH BENEFIT 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).

S 8. Subdivisions 1 and 4 of section 189 of the state finance law, as amended by chapter 379 of the laws of 2010, are amended to read as follows:

1. Subject to the provisions of subdivision two of this section, any person who:

(a) knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval;

(b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(c) conspires to commit a violation of paragraph (a), (b), (d), (e), (f) or (g) of this subdivision;

(d) has possession, custody, or control of property or money used, or to be used, by the state or a local government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(f) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee violates a provision of law when selling or pledging such property; [or]

(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

(H) 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, OR CONSPIRES TO DO THE SAME; 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.

4. (a) This section shall apply to claims, records, or statements made under the tax law only if (i) the net income or sales of the person against whom the action is brought equals or exceeds one million dollars for any taxable year subject to any action brought pursuant to this article; [and] (ii) the damages pleaded in such action exceed three hundred and fifty thousand dollars; AND (III) THE PERSON IS ALLEGED TO HAVE VIOLATED PARAGRAPH (A), (B), (C), (D), (E), (F) OR (G) OF SUBDIVISION ONE OF THIS SECTION; PROVIDED, HOWEVER, THAT NOTHING IN THIS SUBPARAGRAPH SHALL BE DEEMED TO MODIFY OR RESTRICT THE APPLICATION OF SUCH PARAGRAPHS TO ANY ACT ALLEGED THAT RELATES TO A VIOLATION OF THE TAX LAW.

(b) The attorney general shall consult with the commissioner of the department of taxation and finance prior to filing or intervening in any action under this article that is based on the filing of false claims, records or statements made under the tax law. If the state declines to participate or to authorize participation by a local government in such an action pursuant to subdivision two of section one hundred ninety of this article, the qui tam plaintiff must obtain approval from the attor-

1 ney general before making any motion to compel the department of taxa-
2 tion and finance to disclose tax records.

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

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

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

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

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

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

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

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

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

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

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

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

48 S 10. Paragraph (a) of section 4-a of part C of chapter 58 of the laws
49 of 2005, amending the public health law and other laws authorizing
50 reimbursements for expenditures made by social services districts for
51 medical assistance, as added by section 4 of part F of chapter 56 of the
52 laws of 2012, is amended to read as follows:

53 (a) For state fiscal year 2012-13, and for each state fiscal year
54 thereafter, a social services district will be reimbursed by the state
55 for the full non-federal share of expenditures by the district for the
56 administration of the medical assistance program, not to exceed the

1 administrative cap amount determined in accordance with subdivision (b)
2 of this section. Any portion of the non-federal share of such expendi-
3 tures in excess of the administrative cap amount shall be the responsi-
4 bility of the social services district and shall be in addition to the
5 medical assistance expenditure amount calculated in accordance with
6 subdivisions (b), (c), (c-1), and (d) of section one of this act. Begin-
7 ning in state fiscal year 2013-14, no reimbursement will be made for
8 administrative expenditures in excess of such cap, WITH THE EXCEPTION OF
9 ADMINISTRATIVE COSTS FROM A PRIOR FISCAL YEAR IF REIMBURSEMENT FOR SUCH
10 EXPENDITURES WAS DELAYED DUE TO A DEFERRAL OF THE FEDERAL SHARE OF THE
11 EXPENDITURES.

12 S 11. Part C of chapter 58 of the laws of 2005, amending the public
13 health law and other laws relating to authorizing reimbursements for
14 expenditures made by social services districts for medical assistance,
15 is amended by adding a new section 7-a to read as follows:

16 S 7-A. (A) THE COMMISSIONER OF HEALTH, WITH THE APPROVAL OF THE DIREC-
17 TOR OF THE DIVISION OF BUDGET, SHALL REDUCE THE WEEKLY AMOUNTS REQUIRED
18 BY PARAGRAPH (F) OF SECTION ONE OF THIS ACT TO REFLECT INCREASED FEDERAL
19 REIMBURSEMENT THAT IS EXPECTED TO BE RECEIVED IN THE FIRST CALENDAR
20 QUARTER OF 2014 AS THE RESULT OF AN INCREASE IN THE STATE'S FEDERAL
21 MEDICAL ASSISTANCE PERCENTAGE FOR CARE, SERVICES, AND SUPPLIES PROVIDED
22 TO CERTAIN RECIPIENTS PURSUANT TO 42 U.S.C. S 1396D(Z), AND THAT MUST BE
23 SHARED WITH SOCIAL SERVICES DISTRICTS IN ACCORDANCE WITH THE PROVISIONS
24 OF 42 U.S.C. S 1396(CC). THE WEEKLY REDUCTIONS DESCRIBED IN THIS PARA-
25 GRAPH WILL BEGIN APRIL 1, 2013 AND CONTINUE THROUGH MARCH 31, 2014.

26 (B) AMOUNTS ADVANCED TO SOCIAL SERVICES DISTRICTS THROUGH THE WEEKLY
27 REDUCTIONS DESCRIBED IN PARAGRAPH (A) OF THIS SECTION SHALL BE RECON-
28 CILED AGAINST THE AMOUNT OF INCREASED FEDERAL ASSISTANCE ACTUALLY
29 RECEIVED PURSUANT TO 42 U.S.C. S 1396D(Z) FOR THE FIRST CALENDAR QUARTER
30 OF 2014, AND ANY EXCESS AMOUNTS ADVANCED TO DISTRICTS SHALL BE RECOVERED
31 BY THE COMMISSIONER OF HEALTH THROUGH AN ADJUSTMENT TO THE WEEKLY
32 AMOUNTS REQUIRED FROM SUCH DISTRICTS BY PARAGRAPH (F) OF SECTION ONE OF
33 THIS ACT FOR THE PERIOD FROM APRIL 1, 2014 THROUGH MARCH 31, 2015.

34 S 12. Paragraph (u) of subdivision 4 of section 364-j of the social
35 services law, as amended by section 40 of part D of chapter 56 of the
36 laws of 2012, is amended to read as follows:

37 (u) A managed care provider that provides coverage for prescription
38 drugs shall permit each participant to fill any mail order covered
39 prescription, at his or her option, at any mail order pharmacy or non-
40 mail-order retail pharmacy in the managed care provider network. IF THE
41 MANAGED CARE PROVIDER HAS DESIGNATED ONE OR MORE PHARMACIES FOR FILLING
42 PRESCRIPTIONS FOR A PARTICULAR DRUG OR DRUGS, THEN SUCH PRESCRIPTIONS
43 MAY BE FILLED, AT THE PARTICIPANT'S OPTION, AT ANY OTHER PHARMACY IN THE
44 NETWORK, if the [non-mail-order retail pharmacy] NETWORK PHARMACY CHOSEN
45 BY THE PARTICIPANT offers to accept a price that is comparable to that
46 of the [mail order] pharmacy DESIGNATED BY THE MANAGED CARE PROVIDER.
47 FOR THE PURPOSES OF THIS SECTION, "MAIL ORDER PHARMACY" MEANS A PHARMACY
48 WHOSE PRIMARY BUSINESS IS TO RECEIVE PRESCRIPTIONS BY MAIL, TELEFAX OR
49 THROUGH ELECTRONIC SUBMISSIONS, AND TO DISPENSE MEDICATION TO PATIENTS
50 THROUGH THE USE OF THE UNITED STATES MAIL OR OTHER COMMON OR CONTRACT
51 CARRIER SERVICES, AND PROVIDES ANY CONSULTATION WITH PATIENTS ELECTRON-
52 ICALLY RATHER THAN FACE TO FACE. Every non-mail-order retail pharmacy in
53 the managed care provider's network with respect to any prescription
54 drug shall be deemed to be in the managed care provider's network for
55 every covered prescription drug[; provided, however, that the managed
56 care provider may limit its network of pharmacies for specified drugs,

1 approved by the commissioner, based on clinical, professional or cost
2 criteria. Such limitation shall not be based solely on cost].

3 S 13. Section 364-j of the social services law is amended by adding a
4 new subdivision 25-a to read as follows:

5 25-A. EFFECTIVE JULY FIRST, TWO THOUSAND THIRTEEN, NOTWITHSTANDING ANY
6 PROVISION OF LAW TO THE CONTRARY, MANAGED CARE PROVIDERS SHALL COVER
7 MEDICALLY NECESSARY PRESCRIPTION DRUGS IN THE ANTI-DEPRESSANT, ANTI-RE-
8 TROVIRAL, ANTI-REJECTION, SEIZURE, EPILEPSY, ENDOCRINE, HEMATOLOGIC AND
9 IMMUNOLOGIC THERAPEUTIC CLASSES, INCLUDING NON-FORMULARY DRUGS, UPON
10 DEMONSTRATION BY THE PRESCRIBER, AFTER CONSULTING WITH THE MANAGED CARE
11 PROVIDER, THAT SUCH DRUGS, IN THE PRESCRIBER'S REASONABLE PROFESSIONAL
12 JUDGMENT, ARE MEDICALLY NECESSARY AND WARRANTED.

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

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

17 2. "BOARD" SHALL MEAN THE DRUG UTILIZATION REVIEW BOARD.

18 S 15-a. Subdivision 12 of section 270 of the public health law, as
19 added by section 10 of part C of chapter 58 of the laws of 2005, is
20 amended to read as follows:

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

23 S 16. Section 272 of the public health law, as added by section 10 of
24 part C of chapter 58 of the laws of 2005, subdivision 4 as amended by
25 section 30 of part A of chapter 58 of the laws of 2008, subdivision 8 as
26 amended by section 5 of part B of chapter 109 of the laws of 2010, para-
27 graph (d) of subdivision 10 as added by section 17 of part H of chapter
28 59 of the laws of 2011, subdivision 11 as amended by section 36 of part
29 C of chapter 58 of the laws of 2009, paragraph (b) of subdivision 11 as
30 amended by section 9 of part H of chapter 59 of the laws of 2011, is
31 amended to read as follows:

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

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

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

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

51 5. The [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW
52 BOARD shall consider and make recommendations to the commissioner for
53 the adoption of a preferred drug program. (a) In developing the
54 preferred drug program, the [committee] BOARD shall, without limitation:
55 (i) identify therapeutic classes or drugs to be included in the
56 preferred drug program; (ii) identify preferred drugs in each of the

1 chosen therapeutic classes; (iii) evaluate the clinical effectiveness
2 and safety of drugs considering the latest peer-reviewed research and
3 may consider studies submitted to the federal food and drug adminis-
4 tration in connection with its drug approval system; (iv) consider the
5 potential impact on patient care and the potential fiscal impact that
6 may result from making such a therapeutic class subject to prior author-
7 ization; and (v) consider the potential impact of the preferred drug
8 program on the health of special populations such as children, the
9 elderly, the chronically ill, persons with HIV/AIDS and persons with
10 mental health conditions.

11 (b) In developing the preferred drug program, the [committee] BOARD
12 may consider preferred drug programs or evidence based research operated
13 or conducted by or for other state governments, the federal government,
14 or multi-state coalitions. Notwithstanding any inconsistent provision of
15 section one hundred twelve or article eleven of the state finance law or
16 section one hundred forty-two of the economic development law or any
17 other law, the department may enter into contractual agreements with the
18 Oregon Health and Science University Drug Effectiveness Review Project
19 to provide technical and clinical support to the [committee] BOARD and
20 the department in researching and recommending drugs to be placed on the
21 preferred drug list.

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

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

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

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

35 (b) the patient has tried the preferred drug and has experienced unac-
36 ceptable side effects;

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

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

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

1 8. The commissioner shall provide notice of any recommendations devel-
2 oped by the [committee] BOARD regarding the preferred drug program, at
3 least five days before any final determination by the commissioner, by
4 making such information available on the department's website. Such
5 public notice [shall] MAY include: a summary of the deliberations of the
6 [committee] BOARD; a summary of the positions of those making public
7 comments at meetings of the [committee] BOARD; the response of the
8 [committee] BOARD to those comments, if any; and the findings and recom-
9 mendations of the [committee] BOARD.

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

17 10. The commissioner shall adopt a preferred drug program and amend-
18 ments after considering the recommendations from the [committee] BOARD
19 and any comments received from prescribers, dispensers, patients,
20 consumers and manufacturers of the drug.

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

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

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

41 (d) Notwithstanding any provision of this section to the contrary, the
42 commissioner may designate therapeutic classes of drugs, including
43 classes with only one drug, as all preferred prior to any review that
44 may be conducted by the [committee] BOARD pursuant to this section.

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

51 (b) The commissioner may designate a pharmaceutical manufacturer as
52 one with whom the commissioner is negotiating or has negotiated a
53 manufacturer agreement, and all of the drugs it manufactures or markets
54 shall be included in the preferred drug program. The commissioner may
55 negotiate directly with a pharmaceutical manufacturer for rebates relat-
56 ing to any or all of the drugs it manufactures or markets. A manufactur-

1 er agreement shall designate any or all of the drugs manufactured or
2 marketed by the pharmaceutical manufacturer as being preferred or non
3 preferred drugs. When a pharmaceutical manufacturer has been designated
4 by the commissioner under this paragraph but the commissioner has not
5 reached a manufacturer agreement with the pharmaceutical manufacturer,
6 then the commissioner may designate some or all of the drugs manufac-
7 tured or marketed by the pharmaceutical manufacturer as non preferred
8 drugs. However, notwithstanding this paragraph, any drug that is
9 selected to be on the preferred drug list under paragraph (b) of subdi-
10 vision ten of this section on grounds that it is significantly more
11 clinically effective and safer than other drugs in its therapeutic class
12 shall be a preferred drug.

13 (c) Supplemental rebates under this subdivision shall be in addition
14 to those required by applicable federal law and subdivision seven of
15 section three hundred sixty-seven-a of the social services law. In order
16 to be considered in connection with the preferred drug program, such
17 supplemental rebates shall apply to the drug products dispensed under
18 the Medicaid program and the EPIC program. The commissioner is prohibit-
19 ed from approving alternative rebate demonstrations, value added
20 programs or guaranteed savings from other program benefits as a substi-
21 tution for supplemental rebates.

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

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

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

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

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

54 (b) the public notice and interested party provisions of subdivisions
55 seven, eight and nine of section two hundred seventy-two of this arti-
56 cle.

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

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

14 S 18. Section 277 of the public health law, as added by section 10 of
15 part C of chapter 58 of the laws of 2005, is amended to read as follows:

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

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

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

25 (c) complaints received from patients and providers;

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

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

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

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

37 3. The commissioner and the [panel] BOARD shall, beginning with the
38 commencement of the preferred drug program and monthly thereafter,
39 submit a report to the governor and the legislature concerning the
40 amount of supplemental rebates received.

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

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

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

52 (II) EVALUATING AND PROVIDING RECOMMENDATIONS TO THE COMMISSIONER OF
53 HEALTH ON OTHER ISSUES RELATING TO PHARMACY SERVICES UNDER MEDICAID OR
54 EPIC, INCLUDING, BUT NOT LIMITED TO: THERAPEUTIC COMPARISONS; ENHANCED
55 USE OF GENERIC DRUG PRODUCTS; ENHANCED TARGETING OF PHYSICIAN PRESCRIB-
56 ING 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, are amended to read as follows:

1. A [thirteen-member] NINETEEN-MEMBER drug utilization review board is hereby created in the department. 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).] THREE 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.

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

3 S 21. Paragraph (g) of subdivision 2 of section 365-a of the social
4 services law, as amended by section 7 of part D of chapter 56 of the
5 laws of 2012, is amended to read as follows:

6 (g) sickroom supplies, eyeglasses, prosthetic appliances and dental
7 prosthetic appliances furnished in accordance with the regulations of
8 the department; provided further that: (i) the commissioner of health is
9 authorized to implement a preferred diabetic supply program wherein the
10 department of health will receive enhanced rebates from preferred
11 manufacturers of glucometers and test strips, and may subject non-pre-
12 ferred manufacturers' glucometers and test strips to prior authorization
13 under section two hundred seventy-three of the public health law; (ii)
14 enteral formula therapy and nutritional supplements are limited to
15 coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding,
16 for treatment of an inborn metabolic disorder, or to address growth and
17 development problems in children, or, subject to standards established
18 by the commissioner, for persons with a diagnosis of HIV infection, AIDS
19 or HIV-related illness or other diseases and conditions; (iii)
20 prescription footwear and inserts are limited to coverage only when used
21 as an integral part of a lower limb orthotic appliance, as part of a
22 diabetic treatment plan, or to address growth and development problems
23 in children; [and] (iv) compression and support stockings are limited to
24 coverage only for pregnancy or treatment of venous stasis ulcers; AND
25 (V) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO IMPLEMENT AN INCONTI-
26 NENCE SUPPLY UTILIZATION MANAGEMENT PROGRAM TO REDUCE COSTS WITHOUT
27 LIMITING ACCESS THROUGH THE EXISTING PROVIDER NETWORK, INCLUDING BUT NOT
28 LIMITED TO SINGLE OR MULTIPLE SOURCE CONTRACTS OR, A PREFERRED INCONTI-
29 NENCE SUPPLY PROGRAM WHEREIN THE DEPARTMENT OF HEALTH WILL RECEIVE
30 ENHANCED REBATES FROM PREFERRED MANUFACTURERS OF INCONTINENCE SUPPLIES,
31 AND MAY SUBJECT NON-PREFERRED MANUFACTURERS' INCONTINENCE SUPPLIES TO
32 PRIOR APPROVAL PURSUANT TO REGULATIONS OF THE DEPARTMENT, PROVIDED ANY
33 NECESSARY APPROVALS UNDER FEDERAL LAW HAVE BEEN OBTAINED TO RECEIVE
34 FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF INCONTINENCE SUPPLIES
35 PROVIDED PURSUANT TO THIS SUBPARAGRAPH;

36 S 22. Intentionally omitted.

37 S 23. Section 365-1 of the social services law is amended by adding a
38 new subdivision 2-a to read as follows:

39 2-A. UP TO FIFTEEN MILLION DOLLARS IN STATE FUNDING MAY BE USED TO
40 FUND HEALTH HOME INFRASTRUCTURE DEVELOPMENT. SUCH FUNDS SHALL BE USED
41 TO DEVELOP ENHANCED SYSTEMS TO SUPPORT HEALTH HOME OPERATIONS INCLUDING
42 ASSIGNMENTS, WORKFLOW, AND TRANSMISSION OF DATA. FUNDING WILL ALSO BE
43 DISBURSED PURSUANT TO A FORMULA ESTABLISHED BY THE COMMISSIONER TO BE
44 DESIGNATED HEALTH HOMES. SUCH FORMULA MAY CONSIDER PRIOR ACCESS TO SIMI-
45 LAR FUNDING OPPORTUNITIES, GEOGRAPHIC AND DEMOGRAPHIC FACTORS, INCLUDING
46 THE POPULATION SERVED, AND PREVALENCE OF QUALIFYING CONDITIONS, CONNEC-
47 TIVITY TO PROVIDERS, AND OTHER CRITERIA AS ESTABLISHED BY THE COMMIS-
48 SIONER.

49 S 24. Paragraph (c) of subdivision 2 of section 365-a of the social
50 services law, as amended by chapter 778 of the laws of 1977, is amended
51 to read as follows:

52 (c) out-patient hospital or clinic services in facilities operated in
53 compliance with applicable provisions of this chapter, the public health
54 law, the mental hygiene law and other laws, including any provisions
55 thereof requiring an operating certificate or license, INCLUDING FACILI-
56 TIES AUTHORIZED BY THE APPROPRIATE LICENSING AUTHORITY TO PROVIDE INTE-

1 GRATED MENTAL HEALTH SERVICES, AND/OR ALCOHOLISM AND SUBSTANCE ABUSE
2 SERVICES, AND/OR PHYSICAL HEALTH SERVICES, AND/OR SERVICES TO PERSONS
3 WITH DEVELOPMENTAL DISABILITIES, WHEN SUCH SERVICES ARE PROVIDED AT A
4 SINGLE LOCATION OR SERVICE SITE, or where such facilities are not
5 conveniently accessible, in any hospital located without the state and
6 care and services in a day treatment program operated by the department
7 of mental hygiene or by a voluntary agency under an agreement with such
8 department in that part of a public institution operated and approved
9 pursuant to law as an intermediate care facility for [the mentally
10 retarded] PERSONS WITH DEVELOPMENTAL DISABILITIES;

11 S 25. The opening paragraph of paragraph 1 of subdivision 4 of section
12 2807-c of the public health law, as amended by section 11 of part C of
13 chapter 58 of the laws of 2009, is amended to read as follows:

14 Notwithstanding any inconsistent provision of this section and subject
15 to the availability of federal financial participation, rates of payment
16 by governmental agencies for general hospitals which are certified by
17 the office of alcoholism and substance abuse services to provide inpa-
18 tient detoxification and withdrawal services and, with regard to inpa-
19 tient services provided to patients discharged on and after December
20 first, two thousand eight and who are determined to be in diagnosis-re-
21 lated groups [numbered seven hundred forty-three, seven hundred forty-
22 four, seven hundred forty-five, seven hundred forty-six, seven hundred
23 forty-seven, seven hundred forty-eight, seven hundred forty-nine, seven
24 hundred fifty, or seven hundred fifty-one] AS DEFINED BY THE COMMISSION-
25 ER AND PUBLISHED ON THE NEW YORK STATE DEPARTMENT OF HEALTH WEBSITE,
26 shall be made on a per diem basis in accordance with the following:

27 S 26. Paragraph (c) of subdivision 35 of section 2807-c of the public
28 health law, as added by section 2 of part C of chapter 58 of the laws of
29 2009, is amended to read as follows:

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

37 S 27. Intentionally omitted.

38 S 28. Intentionally omitted.

39 S 29. Intentionally omitted.

40 S 30. Subparagraph (iv) of paragraph (e-2) of subdivision 4 of section
41 2807-c of the public health law is amended by adding a new clause (D) to
42 read as follows:

43 (D) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW TO THE CONTRARY AND
44 SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR ALL
45 RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE OPER-
46 ATING COMPONENT OF OUTPATIENT SPECIALTY RATES OF HOSPITALS SUBJECT TO
47 THIS SUBPARAGRAPH SHALL BE DETERMINED BY THE COMMISSIONER PURSUANT TO
48 REGULATIONS, INCLUDING EMERGENCY REGULATIONS, AND IN CONSULTATION WITH
49 SUCH SPECIALTY OUTPATIENT FACILITIES, PROVIDED HOWEVER, THAT FOR THE
50 PERIOD BEGINNING OCTOBER FIRST, TWO THOUSAND THIRTEEN THROUGH SEPTEMBER
51 THIRTIETH, TWO THOUSAND FOURTEEN, SERVICES PROVIDED TO PATIENTS ENROLLED
52 IN MEDICAID MANAGED CARE SHALL BE PAID BY THE MEDICAID MANAGED CARE
53 PLANS AT NO LESS THAN THE OTHERWISE APPLICABLE MEDICAID FEE-FOR-SERVICE
54 RATES, AS COMPUTED IN ACCORDANCE WITH CLAUSE (B) OF THIS SUBPARAGRAPH
55 FOR THE PERIOD BEGINNING OCTOBER FIRST, TWO THOUSAND THIRTEEN THROUGH
56 MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN AND AS COMPUTED IN ACCORDANCE

1 WITH THIS CLAUSE FOR THE PERIOD BEGINNING APRIL FIRST, TWO THOUSAND
2 FOURTEEN THROUGH SEPTEMBER THIRTIETH, TWO THOUSAND FOURTEEN.

3 S 31. Intentionally omitted.

4 S 32. Intentionally omitted.

5 S 33. Intentionally omitted.

6 S 33-a. Subparagraphs (ii) and (x) of paragraph (b) of subdivision 35
7 of section 2807-c of the public health law, as added by section 2 of
8 part C of chapter 58 of the laws of 2009, are amended to read as
9 follows:

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

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

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

29 7. NOTWITHSTANDING SECTION ONE HUNDRED THIRTY-THREE OF THIS CHAPTER,
30 WHERE CARE OR SERVICES ARE RECEIVED PRIOR TO THE DATE THE INDIVIDUAL IS
31 DETERMINED ELIGIBLE FOR ASSISTANCE UNDER THIS TITLE, MEDICAL ASSISTANCE
32 REIMBURSEMENT SHALL BE AVAILABLE FOR SUCH CARE OR SERVICES ONLY (A) IF
33 THE CARE OR SERVICES ARE RECEIVED DURING THE THREE MONTH PERIOD PRECED-
34 ING THE MONTH OF APPLICATION FOR MEDICAL ASSISTANCE AND THE RECIPIENT IS
35 DETERMINED TO HAVE BEEN ELIGIBLE IN THE MONTH IN WHICH THE CARE OR
36 SERVICE WAS RECEIVED, OR (B) AS PROVIDED FOR IN THIS SECTION OR REGU-
37 LATIONS OF THE DEPARTMENT.

38 S 35. Intentionally omitted.

39 S 35-a. Subparagraph (i) of paragraph (b) of subdivision 1 of section
40 364-j of the social services law, as amended by chapter 433 of the laws
41 of 1997, is amended to read as follows:

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

48 S 36. Paragraphs (c), (m) and (p) of subdivision 1 of section 364-j of
49 the social services law, paragraph (c) as amended by section 12 of part
50 C of chapter 58 of the laws of 2004, paragraph (m) as amended by section
51 42-b of part H of chapter 59 of the laws of 2011, and paragraph (p) as
52 amended by chapter 649 of the laws of 1996, are amended and a new para-
53 graph (z) is added to read as follows:

54 (c) "Managed care program". A statewide program in which medical
55 assistance recipients enroll on a voluntary or mandatory basis to
56 receive medical assistance services, including case management, directly

1 and indirectly (including by referral) from a managed care provider,
2 [and] INCLUDING as applicable, a [mental health special needs plan]
3 SPECIAL NEEDS MANAGED CARE PLAN or a comprehensive HIV special needs
4 plan, under this section.

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

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

12 (Z) "CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELOR (CASAC)".
13 AN INDIVIDUAL CREDENTIALED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE
14 ABUSE SERVICES IN ACCORDANCE WITH APPLICABLE REGULATIONS OF THE COMMIS-
15 SIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

16 S 37. Paragraph (c) of subdivision 2 of section 364-j of the social
17 services law, as added by section 42-c of part H of chapter 59 of the
18 laws of 2011, is amended to read as follows:

19 (c) The commissioner of health, jointly with the commissioner of
20 mental health and the commissioner of alcoholism and substance abuse
21 services shall be authorized to establish special needs managed care
22 [and specialized managed care] plans, under the medical assistance
23 program, in accordance with applicable federal law and regulations. The
24 commissioner of health, in cooperation with such commissioners, is
25 authorized, subject to the approval of the director of the division of
26 the budget, to apply for federal waivers when such action would be
27 necessary to assist in promoting the objectives of this section. WITH
28 REGARD TO SUCH SPECIAL NEEDS MANAGED CARE PLANS, IN ADDITION TO THE
29 APPLICABLE REQUIREMENTS ESTABLISHED IN THIS SECTION, SUCH COMMISSIONERS
30 SHALL JOINTLY ESTABLISH STANDARDS AND REQUIREMENTS TO:

31 (I) ENSURE THAT ANY SPECIAL NEEDS MANAGED CARE PLAN SHALL HAVE AN
32 ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH
33 NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF
34 ANY SPECIAL NEEDS MANAGED CARE PLAN, AND UPON CONTRACT RENEWAL OR EXPAN-
35 SION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STAND-
36 ARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED
37 THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE;

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

41 (III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH
42 SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENE-
43 TRATION RATES OF SPECIAL NEEDS MANAGED CARE PLANS; AND

44 (IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS
45 AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENT-
46 LY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES;
47 AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFI-
48 CIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF
49 ENROLLEES.

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

52 S 38. Paragraphs (a), (d) and (e) of subdivision 3 of section 364-j
53 of the social services law, paragraph (a) as amended by section 13 of
54 part C of chapter 58 of the laws of 2004, paragraph (d) as relettered by
55 section 77 and paragraph (e) as amended by section 77-a of part H of
56 chapter 59 of the laws of 2011, and paragraph (d) as amended by chapter

648 of the laws of 1999, are amended and a new paragraph (d-1) is added 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; PROVIDED, HOWEVER, THAT NO MEDICAL ASSISTANCE RECIPIENT SHALL BE REQUIRED TO OBTAIN SERVICES THAT ARE CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES THROUGH A MANAGED CARE PROGRAM UNTIL THE PROGRAM FEATURES APPROVED BY THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, INCLUDE FEATURES FOR HABILITATION SERVICES AS DEFINED IN PARAGRAPH C OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW:

(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)] (IV) 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)] (V) long term services as determined by the commissioner of [mental retardation and] THE OFFICE FOR PEOPLE WITH 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)] (VI) TB directly observed therapy;

[(viii)] (VII) AIDS adult day health care;

[(ix)] (VIII) HIV COBRA case management; and

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

(D-1) SERVICES PROVIDED PURSUANT TO TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW 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.

(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):

(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.]; PROVIDED, HOWEVER, NOTHING HEREIN SHALL: (A) 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; OR (B) MAKE ENROLLMENT IN A MEDICARE MANAGED CARE PLAN A CONDITION OF THE INDIVIDUAL'S PARTICIPATION IN THE MANAGED CARE PROGRAM PURSUANT TO THIS SECTION, OR AFFECT THE INDIVIDUAL'S ENTITLEMENT TO PAYMENT OF APPLICABLE MEDICARE MANAGED CARE OR FEE FOR SERVICE COINSURANCE AND DEDUCTIBLES BY THE INDIVIDUAL'S MANAGED CARE PROVIDER.

(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

1 the federal social security act or who has characteristics and needs
2 similar to such persons;

3 (viii) a person who is eligible for medical assistance pursuant to
4 subparagraph twelve or subparagraph thirteen of paragraph (a) of subdi-
5 vision one of section three hundred sixty-six of this title;

6 (ix) a person receiving services provided by a long term home health
7 care program, or a person receiving inpatient services in a state-oper-
8 ated psychiatric facility or a residential treatment facility for chil-
9 dren and youth;

10 (x) certified blind or disabled children living or expected to be
11 living separate and apart from the parent for thirty days or more;

12 (xi) residents of nursing facilities;

13 (xii) a foster child in the placement of a voluntary agency or in the
14 direct care of the local social services district;

15 (xiii) a person or family that is homeless; [and]

16 (xiv) individuals for whom a managed care provider is not geograph-
17 ically accessible so as to reasonably provide services to the person. A
18 managed care provider is not geographically accessible if the person
19 cannot access the provider's services in a timely fashion due to
20 distance or travel time[.];

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

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

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

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

29 (XIX) INDIVIDUALS RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;
30 PROVIDED, HOWEVER, THAT THIS CLAUSE SHALL NOT BE CONSTRUED TO REQUIRE AN
31 INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN OR ANOTHER CARE
32 COORDINATION MODEL, WHO SUBSEQUENTLY ELECTS HOSPICE, TO DISENROLL FROM
33 SUCH PROGRAM;

34 (XX) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAIL-
35 ABLE FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY
36 PAYMENT, OR PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN
37 PAYMENT OF SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE,
38 AS DETERMINED BY THE LOCAL SOCIAL SERVICES DISTRICT;

39 (XXI) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARA-
40 GRAPH SIX OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED
41 SIXTY-SIX OF THIS TITLE;

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

45 (XXIII) INDIVIDUALS WITH A CHRONIC MEDICAL CONDITION WHO ARE BEING
46 TREATED BY A SPECIALIST PHYSICIAN THAT IS NOT ASSOCIATED WITH A MANAGED
47 CARE PROVIDER IN THE INDIVIDUAL'S SOCIAL SERVICES DISTRICT; AND

48 (XXIV) NATIVE AMERICANS.

49 S 39. Subparagraphs (ii), (iv) and (vii) of paragraph (e), subpara-
50 graphs (i) and (v) of paragraph (f) and paragraphs (g), (h), (i), (o),
51 (p), (q) and (r) of subdivision 4 of section 364-j of the social
52 services law, subparagraphs (ii), (iv) and (vii) of paragraph (e),
53 subparagraph (v) of paragraph (f) and paragraph (g) as amended by
54 section 14 of part C of chapter 58 of the laws of 2004, subparagraph (i)
55 of paragraph (f) as amended by section 79 of part H of chapter 59 of the
56 laws of 2011, paragraph (h) as amended by chapter 433 of the laws of

1 1997, and paragraphs (i), (o), (p), (q) and (r) as amended by chapter
2 649 of the laws of 1996, are amended and a new paragraph (v) is added to
3 read as follows:

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

19 (iv) Local social services districts or enrollment organizations
20 through their enrollment counselors shall provide participants with the
21 opportunity for face to face counseling including individual counseling
22 upon request of the participant. Local social services districts or
23 enrollment organizations through their enrollment counselors shall also
24 provide participants with information in a culturally and linguistically
25 appropriate and understandable manner, in light of the participant's
26 needs, circumstances and language proficiency, sufficient to enable the
27 participant to make an informed selection of a managed care provider.
28 Such information shall include, but shall not be limited to: how to
29 access care within the program; a description of the medical assistance
30 services that can be obtained other than through a managed care provid-
31 er[, mental health special needs plan or comprehensive HIV special needs
32 plan]; the available managed care providers[, mental health special
33 needs plans and comprehensive HIV special needs plans] and the scope of
34 services covered by each; a listing of the medical services providers
35 associated with each managed care provider; the participants' rights
36 within the managed care program; and how to exercise such rights.
37 Enrollment counselors shall inquire into each participant's existing
38 relationships with medical services providers and explain whether and
39 how such relationships may be maintained within the managed care
40 program. For enrollments made during face to face counseling, if the
41 participant has a preference for particular medical services providers,
42 enrollment counselors shall verify with the medical services providers
43 that such medical services providers whom the participant prefers
44 participate in the managed care provider's network and are available to
45 serve the participant.

46 (vii) Any marketing materials developed by a managed care provider[,
47 comprehensive HIV special needs plan or mental health special needs
48 plan] shall be approved by the department of health or the local social
49 services district, and the commissioner of mental health AND THE COMMIS-
50 SIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, where appropriate,
51 within sixty days prior to distribution to recipients of medical assist-
52 ance. All marketing materials shall be reviewed within sixty days of
53 submission.

54 (i) Participants shall choose a managed care provider at the time of
55 application for medical assistance; if the participant does not choose
56 such a provider the commissioner shall assign such participant to a

1 managed care provider in accordance with subparagraphs (ii), (iii), (iv)
2 and (v) of this paragraph. Participants already in receipt of medical
3 assistance shall have no less than thirty days from the date selected by
4 the district to enroll in the managed care program to select a managed
5 care provider[, and as appropriate, a mental health special needs plan,]
6 and shall be provided with information to make an informed choice. Where
7 a participant has not selected such a provider [or mental health special
8 needs plan,] the commissioner of health shall assign such participant to
9 a managed care provider[, and as] WHICH, IF appropriate, [to] MAY BE a
10 [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN,
11 taking into account capacity and geographic accessibility. The commis-
12 sioner may after the period of time established in subparagraph (ii) of
13 this paragraph assign participants to a managed care provider taking
14 into account quality performance criteria and cost. Provided however,
15 cost criteria shall not be of greater value than quality criteria in
16 assigning participants.

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

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

37 (h) If another medical services provider is available, a participant
38 may change his or her provider of medical services (including primary
39 care practitioners) without cause within thirty days of the partic-
40 ipant's first appointment with a medical services provider by making a
41 request of the managed care provider[, mental health special needs plan
42 or comprehensive HIV special needs plan]. However, after that thirty day
43 period, no participant shall be permitted to change his or her provider
44 of medical services other than once every six months except for good
45 cause as determined by the commissioner through regulations.

46 (i) A managed care provider[, mental health special needs plan, and
47 comprehensive HIV special needs plan] requesting a disenrollment shall
48 not disenroll a participant without the prior approval of the local
49 social services district in which the participant resides, provided that
50 disenrollment from a [mental health special needs plan] SPECIAL NEEDS
51 MANAGED CARE PLAN must comply with the standards of the commissioner of
52 health, THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, and
53 the commissioner of mental health. A managed care provider[, mental
54 health special needs plan or comprehensive HIV special needs plan] shall
55 not request disenrollment of a participant based on any diagnosis,
56 condition, or perceived diagnosis or condition, or a participant's

1 efforts to exercise his or her rights under a grievance process,
2 provided however, that a managed care provider may, where medically
3 appropriate, request permission to refer participants to a [mental
4 health special needs plan] MANAGED CARE PROVIDER THAT IS A SPECIAL NEEDS
5 MANAGED CARE PLAN or a comprehensive HIV special needs plan after
6 consulting with such participant and upon obtaining his/her consent to
7 such referral, and[,] provided further that a [mental health special
8 needs plan] SPECIAL NEEDS MANAGED CARE PLAN may, where clinically appro-
9 priate, disenroll individuals who no longer require the level of
10 services provided by a [mental health special needs plan] SPECIAL NEEDS
11 MANAGED CARE PLAN.

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

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

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

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

32 (v) A MANAGED CARE PROVIDER MUST ALLOW ENROLLEES TO ACCESS CHEMICAL
33 DEPENDENCE TREATMENT SERVICES FROM FACILITIES CERTIFIED BY THE OFFICE OF
34 ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, EVEN IF SUCH SERVICES ARE
35 RENDERED BY A PRACTITIONER WHO WOULD NOT OTHERWISE BE SEPARATELY REIM-
36 BURED, INCLUDING BUT NOT LIMITED TO A CREDENTIALED ALCOHOLISM AND
37 SUBSTANCE ABUSE COUNSELOR (CASAC).

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

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

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

4 A managed care provider[, mental health special needs plan or compre-
5 hensive HIV special needs plan provider] shall not engage in the follow-
6 ing practices:

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

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

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

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

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

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

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

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

42 The commissioners of the office of mental health, the office of alco-
43 holism and substance abuse services and the department of health, shall
44 have the responsibility for jointly designating on a regional basis,
45 after consultation with the local social services district and local
46 governmental unit, as such term is defined in the mental hygiene law, of
47 a city with a population of over one million persons, and after consul-
48 tation of other affected counties, a limited number of [specialized
49 managed care plans under section three hundred sixty-four-j of this
50 title,] special [need] NEEDS managed care plans under section three
51 hundred sixty-four-j of this title[, and/or integrated physical and
52 behavioral health provider systems certified under article twenty-nine-E
53 of the public health law] capable of managing the behavioral and phys-
54 ical health needs of medical assistance enrollees with significant
55 behavioral health needs. Initial designations of such plans [or provider
56 systems] should be made no later than April first, two thousand [thir-

1 teen] FOURTEEN, provided, however, such designations shall be contingent
2 upon a determination by such state commissioners that the entities to be
3 designated have the capacity and financial ability to provide services
4 in such plans [or provider systems], and that the region has a suffi-
5 cient population and service base to support such plans [and systems].
6 Once designated, the commissioner of health shall make arrangements to
7 enroll such enrollees in such plans [or integrated provider systems] and
8 to pay such plans [or provider systems] on a capitated or other basis to
9 manage, coordinate, and pay for behavioral and physical health medical
10 assistance services for such enrollees. Notwithstanding any inconsistent
11 provision of section one hundred twelve and one hundred sixty-three of
12 the state finance law, and section one hundred forty-two of the economic
13 development law, or any other law to the contrary, the designations of
14 such plans [and provider systems], and any resulting contracts with such
15 plans[,] OR providers [or provider systems] are authorized to be entered
16 into by such state commissioners without a competitive bid or request
17 for proposal process, provided however that:

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

21 (c) the commissioners of the office of mental health and the office of
22 alcoholism and substance abuse services, in consultation with the
23 commissioner of health and the impacted local governmental units, shall
24 select such contractor or contractors that, in their discretion, have
25 demonstrated the ability to effectively, efficiently, and economically
26 integrate behavioral health and health services; have the requisite
27 expertise and financial resources; have demonstrated that their direc-
28 tors, sponsors, members, managers, partners or operators have the requi-
29 site character, competence and standing in the community, and are best
30 suited to serve the purposes of this section. IN SELECTING SUCH
31 CONTRACTOR OR CONTRACTORS, THE COMMISSIONERS SHALL:

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

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

43 (III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH
44 SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENE-
45 TRATION RATES OF ANY SUCH CONTRACTOR OR CONTRACTORS.

46 (IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS
47 AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENT-
48 LY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES;
49 AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFI-
50 CIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF
51 ENROLLEES.

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

55 (c) the commissioners of the office of mental health and the office of
56 alcoholism and substance abuse services, in consultation with the

1 commissioner of health, shall select such plans or systems that, in
2 their discretion, have demonstrated the ability to effectively, effi-
3 ciently, and economically manage the behavioral and physical health
4 needs of medical assistance enrollees with significant behavioral health
5 needs; have the requisite expertise and financial resources; have demon-
6 strated that their directors, sponsors, members, managers, partners or
7 operators have the requisite character, competence and standing in the
8 community, and are best suited to serve the purposes of this section.
9 Oversight of such contracts with such plans, providers or provider
10 systems shall be the joint responsibility of such state commissioners,
11 and for contracts affecting a city with a population of over one million
12 persons, also with the city's local social services district and local
13 governmental unit, as such term is defined in the mental hygiene law.

14 IN SELECTING SUCH PLANS OR SYSTEMS, THE COMMISSIONERS SHALL:

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

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

25 (III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH
26 SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENE-
27 TRATION RATES OF ANY SUCH PLANS OR SYSTEMS.

28 (IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS
29 AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENT-
30 LY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES;
31 AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFI-
32 CIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF
33 ENROLLEES.

34 S 45-c. The commissioner of health in consultation with the commis-
35 sioners of the office of mental health and the office of alcoholism and
36 substance abuse shall prepare a report on the transition of behavioral
37 health services as a managed care benefit in the medical assistance
38 program. Such report shall examine (i) the adequacy of rates; (ii) the
39 ability of managed care plans to arrange and manage covered services for
40 eligible enrollees; (iii) the ability of managed care plans to provide
41 an adequate network of providers to meet the needs of enrollees; (iv)
42 the use of evidence based tools or guidelines by managed care plans when
43 determining the appropriate level of care or coverage for enrollees; (v)
44 the ability of managed care plans to provide eligible enrollees with
45 both the appropriate amount and type of services; (vi) the quality
46 assurance mechanisms used by managed care plans, including processes to
47 ensure enrollee satisfaction; (vii) the manner in which managed care
48 plans address the cultural and linguistic needs of enrollees; and (viii)
49 any other quality of care criteria deemed appropriate by the commis-
50 sioners to ensure the adequacy of rates, continuity of care and the quality
51 of life, health, and safety of enrollees during the transition of the
52 behavioral health benefit. The report shall be submitted no later than
53 April first, two thousand sixteen to the governor, the temporary presi-
54 dent of the senate, the speaker of the assembly, the minority leader of
55 the senate, and the minority leader of the assembly.

1 S 46. Subdivision 8 of section 4401 of the public health law, as added
2 by section 42 of part H of chapter 59 of the laws of 2011, is amended to
3 read as follows:

4 8. "Special needs managed care plan" [or "specialized managed care
5 plan"] shall mean a combination of persons natural or corporate, or any
6 groups of such persons, or a county or counties, who enter into an
7 arrangement, agreement or plan, or combination of arrangements, agree-
8 ments or plans, to provide health and behavioral health services to
9 enrollees with significant behavioral health needs.

10 S 47. Section 4403-d of the public health law, as added by section
11 42-a of part H of chapter 59 of the laws of 2011, is amended to read as
12 follows:

13 S 4403-d. Special needs managed care plans [and specialized managed
14 care plans]. No person, group of persons, county or counties may operate
15 a special needs managed care plan [or specialized managed care plan]
16 without first obtaining a certificate of authority from the commission-
17 er, issued jointly with the commissioner of the office of mental health
18 and the commissioner of the office of alcoholism and substance abuse
19 services.

20 S 47-a. Subparagraphs (iii) and (iv) of paragraph (b) of subdivision
21 7 of section 4403-f of the public health law are REPEALED.

22 S 48. Subparagraph (v) of paragraph (b) of subdivision 7 of section
23 4403-f of the public health law, as amended by section 41-b of part H of
24 chapter 59 of the laws of 2011, is amended to read as follows:

25 (v) The following medical assistance recipients shall not be eligible
26 to participate in a managed long term care program or other care coordi-
27 nation model established pursuant to this paragraph until program
28 features and reimbursement rates are approved by the commissioner and,
29 as applicable, the commissioner of developmental disabilities:

30 (1) a person enrolled in a managed care plan pursuant to section three
31 hundred sixty-four-j of the social services law;

32 (2) a participant in the traumatic brain injury waiver program;

33 (3) a participant in the nursing home transition and diversion waiver
34 program;

35 (4) a person enrolled in the assisted living program;

36 (5) a person enrolled in home and community based waiver programs
37 administered by the office for people with developmental
38 disabilities[.];

39 (6) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR
40 LESS THAN SIX MONTHS, FOR A REASON OTHER THAN THAT THE PERSON IS ELIGI-
41 BLE FOR MEDICAL ASSISTANCE ONLY THROUGH THE APPLICATION OF EXCESS INCOME
42 TOWARD THE COST OF MEDICAL CARE AND SERVICES;

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

45 (8) A PERSON RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT;
46 PROVIDED, HOWEVER, THAT THIS CLAUSE SHALL NOT BE CONSTRUED TO REQUIRE AN
47 INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN OR ANOTHER CARE
48 COORDINATION MODEL, WHO SUBSEQUENTLY ELECTS HOSPICE, TO DISENROLL FROM
49 SUCH PROGRAM;

50 (9) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAILABLE
51 FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY PAYMENT, OR
52 PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN PAYMENT OF
53 SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE, AS DETER-
54 MINED BY THE SOCIAL SERVICES DISTRICT;

(10) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARAGRAPH SIX OF PARAGRAPH (B) 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 (B) 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, 2016.

S 50. Intentionally omitted.

S 51. Intentionally omitted.

S 52. Intentionally omitted.

S 53. Intentionally omitted.

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

1 after the twentieth day of the month, the enrollment shall commence on
2 the first day of the second month following submission.] Enrollments
3 conducted by a plan or demonstration shall be subject to review and
4 audit by the department or a contractor selected pursuant to paragraph
5 (d) of this subdivision.

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

9 (a) Notwithstanding any inconsistent provision of law, rule or regu-
10 lation and subject to the provisions of paragraph (b) of this subdivi-
11 sion and to the availability of federal financial participation, the
12 commissioner shall adjust medical assistance rates of payment for
13 services provided by certified home health agencies FOR SUCH SERVICES
14 PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES
15 PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE
16 CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING
17 UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term home health
18 care programs and AIDS home care programs in accordance with this para-
19 graph and paragraph (b) of this subdivision for purposes of improving
20 recruitment and retention of non-supervisory home care services workers
21 or any worker with direct patient care responsibility in the following
22 amounts for services provided on and after December first, two thousand
23 two.

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

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

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

39 S 56. The opening paragraph of subdivision 9 of section 3614 of the
40 public health law, as amended by section 5 of part C of chapter 109 of
41 the laws of 2006, is amended to read as follows:

42 Notwithstanding any law to the contrary, the commissioner shall,
43 subject to the availability of federal financial participation, adjust
44 medical assistance rates of payment for certified home health agencies
45 FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND
46 FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX
47 AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA
48 OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term
49 home health care programs, AIDS home care programs established pursuant
50 to this article, hospice programs established under article forty of
51 this chapter and for managed long term care plans and approved managed
52 long term care operating demonstrations as defined in section forty-four
53 hundred three-f of this chapter. Such adjustments shall be for purposes
54 of improving recruitment, training and retention of home health aides or
55 other personnel with direct patient care responsibility in the following
56 aggregate amounts for the following periods:

1 S 57. Paragraph (a) of subdivision 10 of section 3614 of the public
2 health law, as amended by section 24 of part C of chapter 59 of the laws
3 of 2011, is amended to read as follows:

4 (a) Such adjustments to rates of payments shall be allocated propor-
5 tionally based on each certified home health [agency's] AGENCY, long
6 term home health care program, AIDS home care and hospice program's home
7 health aide or other direct care services total annual hours of service
8 provided to medicaid patients, as reported in each such agency's most
9 recently available cost report as submitted to the department or for the
10 purpose of the managed long term care program a suitable proxy developed
11 by the department in consultation with the interested parties. Payments
12 made pursuant to this section shall not be subject to subsequent adjust-
13 ment or reconciliation; PROVIDED THAT SUCH ADJUSTMENTS TO RATES OF
14 PAYMENTS TO CERTIFIED HOME HEALTH AGENCIES SHALL ONLY BE FOR THAT
15 PORTION OF SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND
16 FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX
17 AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA
18 OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT.

19 S 57-a. The public health law is amended by adding a new section 3621
20 to read as follows:

21 S 3621. PAYMENT OF CLAIMS. NOTWITHSTANDING ANY LAW TO THE CONTRARY,
22 THE PROVISIONS OF SECTION THIRTY-TWO HUNDRED TWENTY-FOUR-A OF THE INSUR-
23 ANCE LAW, AND REGULATIONS THEREUNDER, SHALL APPLY TO CLAIMS FOR PAYMENT
24 SUBMITTED BY A LICENSED HOME CARE SERVICES AGENCY, CERTIFIED HOME HEALTH
25 AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR FISCAL INTERMEDIARY OPER-
26 ATING UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES
27 LAW, PURSUANT TO A CONTRACT WITH A PAYOR UNDER SECTION FORTY-FOUR
28 HUNDRED THREE-F OF THIS CHAPTER OR SECTION THREE HUNDRED SIXTY-FOUR-J OF
29 THE SOCIAL SERVICES LAW, AND SUCH CLAIMS SHALL BE SUBJECT TO AND SETTLED
30 IN COMPLIANCE WITH THE STANDARDS SET FORTH IN SUCH SECTION.

31 S 57-b. Paragraph 2 of subsection (d) of section 3224-a of the insur-
32 ance law, as amended by chapter 666 of the laws of 1997, is amended to
33 read as follows:

34 (2) "health care provider" shall mean an entity licensed or certified
35 pursuant to article twenty-eight, thirty-six or forty of the public
36 health law, a facility licensed pursuant to article nineteen[, twenty-
37 three] or thirty-one of the mental hygiene law, A FISCAL INTERMEDIARY
38 OPERATING UNDER SECTION THREE HUNDRED SIXTY FIVE-F OF THE SOCIAL
39 SERVICES LAW, a health care professional licensed, registered or certi-
40 fied pursuant to title eight of the education law, a dispenser or
41 provider of pharmaceutical products, services or durable medical equip-
42 ment, or a representative designated by such entity or person.

43 S 57-c. Home and community based care workgroup. The commissioner of
44 health shall convene a home and community based care workgroup to exam-
45 ine and make recommendations on issues which include, but are not limit-
46 ed to:

47 a. State and federal regulatory requirements and related policy guide-
48 lines (including the applicability of the federal conditions of partic-
49 ipation);

50 b. Efficient home and community based care delivery, including tele-
51 health and hospice services; and

52 c. Alignment of functions between managed care entities and home and
53 community based providers.

54 The workgroup shall be 11 members. The members of the workgroup shall
55 including providers, plans and representatives of consumers and direct
56 caregivers with relevant expertise.

1 The commissioner of health, or his or her designee shall chair the
2 workgroup and department of health and other executive agencies and
3 offices shall provide relevant data and other information as is neces-
4 sary for the group to perform its duties.

5 The commissioner of health shall convene this workgroup by May 15,
6 2013 and the group shall issue a report with recommendations by March 1,
7 2014.

8 S 58. Paragraph (h) of subdivision 21 of section 2808 of the public
9 health law, as amended by section 8 of part D of chapter 58 of the laws
10 of 2009, is amended to read as follows:

11 (h) The total amount of funds to be allocated and distributed as
12 medical assistance for financially disadvantaged residential health care
13 facility rate adjustments to eligible facilities for a rate period in
14 accordance with this subdivision shall be thirty million dollars for the
15 period October first, two thousand four through December thirty-first,
16 two thousand four and thirty million dollars on an annualized basis for
17 rate periods on and after January first, two thousand five through
18 December thirty-first, two thousand eight and thirty million dollars on
19 an annualized basis on and after January first, two thousand nine,
20 PROVIDED THAT, SUBJECT TO ALL NECESSARY FEDERAL APPROVALS, ON AND AFTER
21 JANUARY FIRST, TWO THOUSAND THIRTEEN FUNDS ALLOCATED UNDER THIS PARA-
22 GRAPH SHALL BE DISTRIBUTED PURSUANT TO 10 NYCRR 86-2.39. The nonfederal
23 share of such rate adjustments shall be paid by the state, with no local
24 share, from allocations made pursuant to paragraph (hh) of subdivision
25 one of section twenty-eight hundred seven-v of this article. In the
26 event the statewide total of the annual rate adjustments determined
27 pursuant to paragraph (g) of this subdivision varies from the amounts
28 set forth in this paragraph, each qualifying facility's rate adjustment
29 shall be proportionately increased or decreased such that the total of
30 the annual rate adjustments made pursuant to this subdivision is equal
31 to the amounts set forth in this paragraph on a statewide basis.

32 S 58-a. Notwithstanding any law to the contrary, and subject to the
33 availability of federal financial participation, general hospitals
34 defined as critical access hospitals pursuant to title XVIII of the
35 federal social security act shall be allocated no less than five million
36 dollars in accordance with the provisions of 10 NYCRR 86-1.31. In addi-
37 tion, the department of health shall analyze the adequacy of rates for
38 critical access hospitals and develop recommendations for consideration
39 in preparing the 2014-15 Executive Budget.

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

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

52 S 60. Subparagraph (ii) of paragraph (a) of subdivision 2-b of section
53 2808 of the public health law, as added by section 47 of part C of chap-
54 ter 109 of the laws of 2006, is amended to read as follows:

55 (ii) Rates for the periods two thousand seven and two thousand eight
56 shall be further adjusted by a per diem add-on amount, as determined by

1 the commissioner, reflecting the proportional amount of each facility's
2 projected Medicaid benefit to the total projected Medicaid benefit for
3 all facilities of the imputed use of the rate-setting methodology set
4 forth in paragraph (b) of this subdivision, provided, however, that for
5 those facilities that do not receive a per diem add-on adjustment pursu-
6 ant to this subparagraph, rates shall be further adjusted to include the
7 proportionate benefit, as determined by the commissioner, of the expira-
8 tion of the opening paragraph and paragraph (a) of subdivision sixteen
9 of this section and of paragraph (a) of subdivision fourteen of this
10 section, provided, further, however, that the aggregate total of the
11 rate adjustments made pursuant to this subparagraph shall not exceed one
12 hundred thirty-seven million five hundred thousand dollars for the two
13 thousand seven rate period and one hundred sixty-seven million five
14 hundred thousand dollars for the two thousand eight rate period AND
15 PROVIDED FURTHER, HOWEVER, THAT SUCH RATE ADJUSTMENTS AS MADE PURSUANT
16 TO THIS SUBPARAGRAPH PRIOR TO TWO THOUSAND TWELVE SHALL NOT BE SUBJECT
17 TO SUBSEQUENT ADJUSTMENT OR RECONCILIATION.

18 S 61. Subparagraph (i) of paragraph (b) of subdivision 2-b of section
19 2808 of the public health law, as amended by section 94 of part H of
20 chapter 59 of the laws of 2011, is amended to read as follows:

21 (i) (A) Subject to the provisions of subparagraphs (ii) through (xiv)
22 of this paragraph, for periods on and after April first, two thousand
23 nine the operating cost component of rates of payment shall reflect
24 allowable operating costs as reported in each facility's cost report for
25 the two thousand two calendar year, as adjusted for inflation on an
26 annual basis in accordance with the methodology set forth in paragraph
27 (c) of subdivision ten of section twenty-eight hundred seven-c of this
28 article, provided, however, that for those facilities which [do not
29 receive a per diem add-on adjustment pursuant to subparagraph (ii) of
30 paragraph (a) of this subdivision] ARE DETERMINED BY THE COMMISSIONER TO
31 BE QUALIFYING FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B)
32 OF THIS SUBPARAGRAPH, rates shall be further adjusted to include the
33 proportionate benefit, as determined by the commissioner, of the expira-
34 tion of the opening paragraph and paragraph (a) of subdivision sixteen
35 of this section and of paragraph (a) of subdivision fourteen of this
36 section, and provided further that the operating cost component of rates
37 of payment for those facilities which [did not receive a per diem
38 adjustment in accordance with subparagraph (ii) of paragraph (a) of this
39 subdivision] ARE DETERMINED BY THE COMMISSIONER TO BE QUALIFYING FACILI-
40 TIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B) OF THIS SUBPARA-
41 GRAPH shall not be less than the operating component such facilities
42 received in the two thousand eight rate period, as adjusted for
43 inflation on an annual basis in accordance with the methodology set
44 forth in paragraph (c) of subdivision ten of section twenty-eight
45 hundred seven-c of this article and further provided, however, that
46 rates for facilities whose operating cost component reflects base year
47 costs subsequent to January first, two thousand two shall have rates
48 computed in accordance with this paragraph, utilizing allowable operat-
49 ing costs as reported in such subsequent base year period, and trended
50 forward to the rate year in accordance with applicable inflation
51 factors.

52 (B) FOR THE PURPOSES OF THIS SUBPARAGRAPH QUALIFYING FACILITIES ARE
53 THOSE FACILITIES FOR WHICH THE COMMISSIONER DETERMINES THAT THEIR
54 REPORTED TWO THOUSAND TWO BASE YEAR OPERATING COST COMPONENT, AS DEFINED
55 IN ACCORDANCE WITH THE REGULATIONS OF THE DEPARTMENT AS SET FORTH IN 10
56 NYCRR 86-2.10(A)(7); IS LESS THAN THE OPERATING COMPONENT SUCH FACILI-

1 TIES RECEIVED IN THE TWO THOUSAND EIGHT RATE PERIOD, AS ADJUSTED BY
2 APPLICABLE TREND FACTORS.

3 S 62. Intentionally omitted.

4 S 63. Paragraph (e-1) of subdivision 12 of section 2808 of the public
5 health law, as amended by section 1 of part D of chapter 59 of the laws
6 of 2011, is amended to read as follows:

7 (e-1) Notwithstanding any inconsistent provision of law or regulation,
8 the commissioner shall provide, in addition to payments established
9 pursuant to this article prior to application of this section, addi-
10 tional payments under the medical assistance program pursuant to title
11 eleven of article five of the social services law for non-state operated
12 public residential health care facilities, including public residential
13 health care facilities located in the county of Nassau, the county of
14 Westchester and the county of Erie, but excluding public residential
15 health care facilities operated by a town or city within a county, in
16 aggregate annual amounts of up to one hundred fifty million dollars in
17 additional payments for the state fiscal year beginning April first, two
18 thousand six and for the state fiscal year beginning April first, two
19 thousand seven and for the state fiscal year beginning April first, two
20 thousand eight and of up to three hundred million dollars in such aggre-
21 gate annual additional payments for the state fiscal year beginning
22 April first, two thousand nine, and for the state fiscal year beginning
23 April first, two thousand ten and for the state fiscal year beginning
24 April first, two thousand eleven, and for the state fiscal years begin-
25 ning April first, two thousand twelve and April first, two thousand
26 thirteen. The amount allocated to each eligible public residential
27 health care facility for this period shall be computed in accordance
28 with the provisions of paragraph (f) of this subdivision, provided,
29 however, that patient days shall be utilized for such computation
30 reflecting actual reported data for two thousand three and each repre-
31 sentative succeeding year as applicable, AND PROVIDED FURTHER, HOWEVER,
32 THAT, IN CONSULTATION WITH IMPACTED PROVIDERS, OF THE FUNDS ALLOCATED
33 FOR DISTRIBUTION IN THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO
34 THOUSAND THIRTEEN, UP TO THIRTY-TWO MILLION DOLLARS MAY BE ALLOCATED IN
35 ACCORDANCE WITH PARAGRAPH (F-1) OF THIS SUBDIVISION.

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

38 (F-1) FUNDS ALLOCATED BY THE PROVISIONS OF PARAGRAPH (E-1) OF THIS
39 SUBDIVISION FOR DISTRIBUTION PURSUANT TO THIS PARAGRAPH, SHALL BE ALLO-
40 CATED PROPORTIONALLY TO THOSE PUBLIC RESIDENTIAL HEALTH CARE FACILITIES
41 WHICH WERE SUBJECT TO RETROACTIVE REDUCTIONS IN PAYMENTS MADE PURSUANT
42 TO THIS SUBDIVISION FOR STATE FISCAL YEAR PERIODS BEGINNING APRIL FIRST,
43 TWO THOUSAND SIX.

44 S 65. Intentionally omitted.

45 S 66. Intentionally omitted.

46 S 67. Intentionally omitted.

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

50 (a) For purposes of this section an "institutionalized spouse" is a
51 person (I) WHO IS in a medical institution or nursing facility [(i) who
52 is] AND expected to remain in such facility or institution for at least
53 thirty consecutive days[,]; or (II) WHO is receiving care, services and
54 supplies pursuant to a waiver pursuant to subsection (c) of section
55 nineteen hundred fifteen of the federal social security act OR IS
56 RECEIVING CARE, SERVICES AND SUPPLIES IN A MANAGED LONG-TERM CARE PLAN

1 PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE SOCIAL SECURITY ACT;
2 and ~~[(ii)]~~ (III) who is married to a person who is not in a medical
3 institution or nursing facility or is not receiving WAIVER services
4 [pursuant to a waiver pursuant to subsection (c) of section nineteen
5 hundred fifteen of the federal social security act] DESCRIBED IN SUBPAR-
6 AGRAPH (II) OF THIS PARAGRAPH; PROVIDED, HOWEVER, THAT MEDICAL ASSIST-
7 ANCE SHALL BE FURNISHED PURSUANT TO THIS PARAGRAPH ONLY IF, FOR SO LONG
8 AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE
9 THEREFOR. THE COMMISSIONER OF HEALTH SHALL MAKE ANY AMENDMENTS TO THE
10 STATE PLAN FOR MEDICAL ASSISTANCE, OR APPLY FOR ANY WAIVER OR APPROVAL
11 UNDER THE FEDERAL SOCIAL SECURITY ACT THAT ARE NECESSARY TO CARRY OUT
12 THE PROVISIONS OF THIS PARAGRAPH.

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

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

35 S 70. Subdivision 3 of section 461-1 of the social services law is
36 amended by adding a new paragraph (j) to read as follows:

37 (J) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ADD UP TO FOUR THOU-
38 SAND FIVE HUNDRED ASSISTED LIVING PROGRAM BEDS TO THE GROSS NUMBER OF
39 ASSISTED LIVING PROGRAM BEDS HAVING BEEN DETERMINED TO BE AVAILABLE AS
40 OF APRIL FIRST, TWO THOUSAND TWELVE. APPLICANTS ELIGIBLE TO SUBMIT AN
41 APPLICATION UNDER THIS PARAGRAPH SHALL BE LIMITED TO ADULT HOMES ESTAB-
42 LISHED PURSUANT TO SECTION FOUR HUNDRED SIXTY-ONE-B OF THIS ARTICLE
43 WITH, AS OF SEPTEMBER FIRST, TWO THOUSAND TWELVE, A CERTIFIED CAPACITY
44 OF EIGHTY BEDS OR MORE IN WHICH TWENTY-FIVE PERCENT OR MORE OF THE RESI-
45 DENT POPULATION ARE PERSONS WITH SERIOUS MENTAL ILLNESS AS DEFINED IN
46 REGULATIONS PROMULGATED BY THE COMMISSIONER OF HEALTH. THE COMMISSIONER
47 OF HEALTH SHALL NOT BE REQUIRED TO REVIEW ON A COMPARATIVE BASIS APPLI-
48 CATIONS SUBMITTED FOR ASSISTED LIVING PROGRAM BEDS MADE AVAILABLE UNDER
49 THIS PARAGRAPH.

50 S 71. Subdivision 14 of section 366 of the social services law, as
51 added by section 74 of part H of chapter 59 of the laws of 2011, is
52 amended to read as follows:

53 14. The commissioner of health may make any available amendments to
54 the state plan for medical assistance submitted pursuant to section
55 three hundred sixty-three-a of this title, or, if an amendment is not
56 possible, develop and submit an application for any waiver or approval

1 under the federal social security act that may be necessary to disregard
2 or exempt an amount of income, for the purpose of assisting with housing
3 costs, for individuals receiving coverage of nursing facility services
4 under this title, OTHER THAN SHORT-TERM REHABILITATION SERVICES, AND FOR
5 INDIVIDUALS IN RECEIPT OF MEDICAL ASSISTANCE WHILE IN AN ADULT HOME, AS
6 DEFINED IN SUBDIVISION TWENTY-FIVE OF SECTION TWO OF THIS CHAPTER, who
7 [are]: ARE (i) discharged [from the nursing facility] to the community;
8 AND (ii) IF ELIGIBLE, enrolled in a plan certified pursuant to section
9 forty-four hundred three-f of the public health law; and (iii) [while so
10 enrolled, not] DO NOT MEET THE CRITERIA TO BE considered an "institu-
11 tionalized spouse" for purposes of section three hundred sixty-six-c of
12 this title.

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

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

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

32 (C) UNDER THE FIDA PROGRAM ESTABLISHED PURSUANT TO THIS SUBDIVISION,
33 UP TO THREE MANAGED LONG TERM CARE PLANS MAY BE AUTHORIZED TO EXCLUSIVE-
34 LY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS
35 DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW. THE COMMISSIONER OF
36 HEALTH MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS SUCH COMMISSION-
37 ER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH
38 DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG
39 TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICE FOR INDIVIDUALS WITH
40 DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE
41 NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.
42 THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
43 TIES MAY WAIVE ANY OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
44 TIES' REGULATIONS AS SUCH COMMISSIONER, IN CONSULTATION WITH THE COMMIS-
45 SIONER OF HEALTH, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE
46 PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR INDIVIDUALS WITH DEVELOP-
47 MENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS
48 OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.

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

53 (E) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO SUBMIT AMENDMENTS TO
54 THE STATE PLAN FOR MEDICAL ASSISTANCE AND/OR SUBMIT ONE OR MORE APPLICA-
55 TIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT AS MAY BE NECESSARY
56 TO OBTAIN THE FEDERAL APPROVALS NECESSARY TO IMPLEMENT THIS SUBDIVISION.

(F) NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SECTION AND SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE COMMISSIONER OF HEALTH AND, IN THE CASE OF FIDAS AUTHORIZED EXCLUSIVELY TO ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, MAY CONTRACT WITH FIDAS APPROVED UNDER THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, ARE AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER THIS SECTION, PROVIDED, HOWEVER, THAT:

(I) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(A) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(B) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(C) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(D) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(II) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN A TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH OR COMMISSIONERS, AS APPLICABLE; AND

(III) THE COMMISSIONER OR, IN THE CASE OF FIDAS AUTHORIZED EXCLUSIVELY TO ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, MAY SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY AND ECONOMICALLY INTEGRATE HEALTH AND LONG TERM CARE SERVICES, AND MEET THE STANDARDS FOR A CERTIFICATE OF AUTHORITY UNDER THE PUBLIC HEALTH LAW FOR THE PROVISION OF SERVICES APPLICABLE TO THE TYPE OF MANAGED LONG TERM CARE PLAN THAT SUCH CONTRACTOR PROPOSES TO OPERATE.

(G) NOTHING IN THIS SECTION SHALL BE CONSTRUED AS REQUIRING AN INDIVIDUAL WITH A DEVELOPMENTAL DISABILITY TO ENROLL IN A FIDA THAT IS AUTHORIZED TO EXCLUSIVELY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

(H) NOTHING IN THIS SECTION SHALL MAKE ENROLLMENT IN A MEDICARE MANAGED CARE PLAN A CONDITION OF AN INDIVIDUAL'S PARTICIPATION IN THE FIDA PROGRAM, OR AFFECT THE INDIVIDUAL'S ENTITLEMENT TO PAYMENT OF APPLICABLE MEDICARE MANAGED CARE OR FEE-FOR-SERVICE COINSURANCE DEDUCTIBLES BY THE INDIVIDUAL'S FIDA PLAN.

S 72-a. Legislative intent of the people first waiver act. The legislature finds that persons receiving services operated, certified, funded, authorized or approved by the office for people with developmental disabilities can benefit from care coordination and integrated care that incorporates both long-term habilitation supports and health care. The legislature also finds that services provided to individuals with developmental disabilities should be designed to achieve person-centered outcomes and to enable the person 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 in social, workplace and other community settings, consistent with the person's needs and wishes, to the extent such wishes are known. As such, the legislature hereby enacts sections 72-b, 73, 74, 75, 76, 77, 78, 79, 80 and 80-a of this act, herein referred to as the people first waiver act. This program shall include the use of developmental disability individ-

1 ual support and care coordination organizations pursuant to section
2 4403-g of the public health law, health maintenance organizations as
3 provided for in subdivision 8 of section 4403 of the public health law,
4 and managed long term care plans providing services under subdivisions
5 12, 13 and 14 of section 4403-f of the public health law. It is the
6 intent of the legislature that, to the greatest extent possible and
7 consistent with a person's needs and known wishes, all services provided
8 should be in the most-integrated setting appropriate for such individual
9 persons receiving services through this act, and that such individuals
10 should be able to make informed choices, either individually or through
11 an authorized decision maker, regarding the development of a person-cen-
12 tered plan of care.

13 S 72-b. The mental hygiene law is amended by adding a new section
14 13.40 to read as follows:

15 S 13.40 PEOPLE FIRST WAIVER PROGRAM.

16 (A) THE COMMISSIONER AND THE COMMISSIONER OF HEALTH SHALL JOINTLY
17 ESTABLISH A PEOPLE FIRST WAIVER PROGRAM FOR PURPOSES OF DEVELOPING A
18 CARE COORDINATION MODEL THAT INTEGRATES VARIOUS LONG-TERM HABILITATION
19 SUPPORTS AND/OR HEALTH CARE. THE PEOPLE FIRST WAIVER PROGRAM SHALL
20 INCLUDE THE USE OF DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE
21 COORDINATION ORGANIZATIONS, HEREIN REFERRED TO AS DISCOS, PURSUANT TO
22 SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, HEALTH
23 MAINTENANCE ORGANIZATIONS, HEREIN REFERRED TO AS HMOS, PROVIDING
24 SERVICES UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF
25 THE PUBLIC HEALTH LAW, AND MANAGED LONG TERM CARE PLANS, HEREIN REFERRED
26 TO AS MLTCS, PROVIDING SERVICES UNDER SUBDIVISIONS TWELVE, THIRTEEN AND
27 FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW.
28 SERVICES SHALL BE PROVIDED AS DESCRIBED IN SECTION FORTY-FOUR HUNDRED
29 THREE-G OF THE PUBLIC HEALTH LAW, SUBDIVISION EIGHT OF SECTION
30 FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND SUBDIVISIONS
31 TWELVE, THIRTEEN AND FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF
32 THE PUBLIC HEALTH LAW.

33 (B) ENTITIES PROVIDING SERVICES PURSUANT TO THIS SECTION SHALL PROVIDE
34 HEALTH AND LONG TERM CARE SERVICES AS THE TERM IS DEFINED IN SECTION
35 FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

36 (C) NO PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS RECEIVING OR
37 APPLYING FOR MEDICAL ASSISTANCE AND WHO IS RECEIVING, OR ELIGIBLE TO
38 RECEIVE, SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY
39 THE OFFICE, SHALL BE REQUIRED TO ENROLL IN A DISCO, HMO OR MLTC IN ORDER
40 TO RECEIVE SUCH SERVICES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES
41 ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF HEALTH, AND
42 UNTIL SUCH COMMISSIONERS DETERMINE THAT A SUFFICIENT NUMBER OF PLANS
43 THAT ARE AUTHORIZED TO COORDINATE CARE FOR INDIVIDUALS PURSUANT TO THIS
44 SECTION OR THAT ARE AUTHORIZED TO OPERATE AND TO EXCLUSIVELY ENROLL
45 PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO SUBDIVISION TWENTY-
46 SEVEN OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW
47 ARE OPERATING IN SUCH PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF
48 PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH ENTITIES MEET THE
49 STANDARDS OF THIS SECTION. NO PERSON SHALL BE REQUIRED TO ENROLL IN A
50 DISCO, HMO OR MLTC IN ORDER TO RECEIVE SERVICES OPERATED, FUNDED, CERTI-
51 FIED, AUTHORIZED OR APPROVED BY THE OFFICE UNTIL THERE ARE AT LEAST TWO
52 ENTITIES OPERATING UNDER THIS SECTION IN SUCH PERSON'S COUNTY OF RESI-
53 DENCE, UNLESS FEDERAL APPROVAL IS SECURED TO REQUIRE ENROLLMENT WHEN
54 THERE ARE LESS THAN TWO SUCH ENTITIES OPERATING IN SUCH COUNTY.

55 (D) DISCOS, HMOS AND MLTCS OPERATING UNDER THIS SECTION SHALL ENSURE,
56 TO THE GREATEST EXTENT PRACTICABLE, THAT THEIR ASSESSMENT, SERVICES, AND

1 THE GRIEVANCE AND APPEALS PROCESSES ARE CULTURALLY AND LINGUISTICALLY
2 COMPETENT.

3 (E) 1. THE COMMISSIONER AND THE COMMISSIONER OF HEALTH SHALL IDENTIFY
4 ONE OR MORE VALID AND RELIABLE QUALITY ASSURANCE INSTRUMENTS THAT
5 INCLUDE ASSESSMENTS OF INDIVIDUAL AND FAMILY SATISFACTION, PROVISION OF
6 SERVICES, AND PERSONAL OUTCOMES. THE INSTRUMENTS SHALL:

7 (1) PROVIDE NATIONALLY VALIDATED, BENCHMARKED, CONSISTENT, RELIABLE
8 AND MEASURABLE DATA FOR A COMPREHENSIVE QUALITY IMPROVEMENT AND REVIEW
9 PROCESS, AND

10 (2) INCLUDE OUTCOME-BASED MEASURES SUCH AS HEALTH, SAFETY, WELL-BEING,
11 RELATIONSHIPS, INTERACTIONS WITH PEOPLE WHO DO NOT HAVE A DISABILITY,
12 EMPLOYMENT, QUALITY OF LIFE, INTEGRATION, CHOICE, SERVICE AND CONSUMER
13 SATISFACTION.

14 2. WITHIN AVAILABLE APPROPRIATIONS, THE INSTRUMENTS IDENTIFIED IN THIS
15 SUBDIVISION MAY BE EXPANDED TO COLLECT ADDITIONAL DATA REQUESTED BY
16 OTHER OFFICES, DEPARTMENTS OR AGENCIES OF THE STATE, LOCAL OR FEDERAL
17 GOVERNMENT.

18 3. THE COMMISSIONER MAY CONTRACT WITH AN INDEPENDENT AGENCY OR ORGAN-
19 IZATION FOR THE DEVELOPMENT OF THE QUALITY ASSURANCE INSTRUMENTS
20 DESCRIBED IN THIS SUBDIVISION.

21 4. THE COMMISSIONER SHALL ESTABLISH THE METHODOLOGY BY WHICH THE QUAL-
22 ITY ASSURANCE INSTRUMENTS SHALL BE ADMINISTERED.

23 5. THE COMMISSIONER, IN CONSULTATION WITH STAKEHOLDERS, SHALL ANNUALLY
24 REVIEW THE DATA COLLECTED FROM THE QUALITY ASSURANCE INSTRUMENTS
25 DESCRIBED IN THIS SUBDIVISION AND SHALL REVIEW RECOMMENDATIONS REGARDING
26 ADDITIONAL OR DIFFERENT CRITERIA FOR THE QUALITY ASSURANCE INSTRUMENTS
27 IN ORDER TO ASSESS THE PERFORMANCE OF THE STATE'S DEVELOPMENTAL DISABIL-
28 ITIES SERVICES SYSTEM AND IMPROVE SERVICES FOR CONSUMERS.

29 (F) THERE SHALL BE A JOINT ADVISORY COUNCIL CHAIRED BY THE COMMISSION-
30 ER AND THE COMMISSIONER OF HEALTH THAT SHALL BE CHARGED WITH ADVISING
31 BOTH COMMISSIONERS IN REGARD TO THE OVERSIGHT OF DISCOS, HMOS PROVIDING
32 SERVICES UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF
33 THE PUBLIC HEALTH LAW, AND MLTCS PROVIDING SERVICES UNDER SUBDIVISIONS
34 TWELVE, THIRTEEN AND FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF
35 THE PUBLIC HEALTH LAW. THE JOINT ADVISORY COUNCIL MAY BE COMPRISED OF
36 THE MEMBERS OF EXISTING ADVISORY COUNCILS OR SIMILAR ENTITIES SERVING
37 THE OFFICE, PROVIDED THAT IT SHALL BE COMPRISED OF TWELVE MEMBERS,
38 INCLUDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, FAMILY MEMBERS
39 OF, ADVOCATES FOR, AND PROVIDERS OF SERVICES TO PEOPLE WITH DEVELOP-
40 MENTAL DISABILITIES. THREE MEMBERS OF THE JOINT ADVISORY COUNCIL SHALL
41 ALSO BE MEMBERS OF THE SPECIAL ADVISORY REVIEW PANEL ON MEDICAID MANAGED
42 CARE ESTABLISHED UNDER SECTION THREE HUNDRED SIXTY-FOUR-JJ OF THE SOCIAL
43 SERVICES LAW. THE JOINT ADVISORY COUNCIL SHALL REVIEW ALL MANAGED CARE
44 OPTIONS PROVIDED TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, INCLUD-
45 ING: THE ADEQUACY OF HABILITATION SERVICES; THE RECORD OF COMPLIANCE
46 WITH PERSON-CENTERED PLANNING, PERSON-CENTERED SERVICES AND COMMUNITY
47 INTEGRATION; THE ADEQUACY OF RATES PAID TO PROVIDERS IN ACCORDANCE WITH
48 THE PROVISIONS OF PARAGRAPH ONE OF SUBDIVISION FOUR OF SECTION
49 FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, PARAGRAPH A-TWO OF
50 SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC
51 HEALTH LAW OR PARAGRAPH A-TWO OF SUBDIVISION TWELVE OF SECTION
52 FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW; AND QUALITY OF
53 LIFE, HEALTH, SAFETY AND COMMUNITY INTEGRATION OF INDIVIDUALS WITH
54 DEVELOPMENTAL DISABILITIES ENROLLED IN MANAGED CARE. THE COMMISSIONER
55 AND COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
56 TIES OR THEIR DESIGNEES SHALL ATTEND ALL MEETINGS OF THE JOINT ADVISORY

COUNCIL. THE JOINT ADVISORY COUNCIL SHALL REPORT ITS FINDINGS, RECOMMENDATIONS, AND ANY PROPOSED AMENDMENTS TO PERTINENT SECTIONS OF THE LAW TO THE COMMISSIONER AND THE COMMISSIONER OF HEALTH, THE SENATE MAJORITY LEADER AND SPEAKER OF THE ASSEMBLY. THE JOINT ADVISORY COUNCIL SHALL HAVE ACCESS TO ANY AND ALL INFORMATION THAT MAY BE LAWFULLY DISCLOSED TO IT AND THAT IS NECESSARY TO PERFORM ITS FUNCTIONS UNDER THIS SECTION.

(G) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE COMMISSIONER AND THE COMMISSIONER OF HEALTH ARE AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND SUBDIVISION TWELVE OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW, PROVIDED, HOWEVER, THAT:

1. THE OFFICE SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(1) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(2) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(3) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(4) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

2. ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN A TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONERS; AND

3. THE COMMISSIONER AND THE COMMISSIONER OF HEALTH MAY JOINTLY SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY AND ECONOMICALLY INTEGRATE HEALTH AND LONG TERM CARE SERVICES AS DEFINED IN SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, AND MEET THE STANDARDS FOR A CERTIFICATE OF AUTHORITY IN THE PUBLIC HEALTH LAW FOR THE PROVISION OF SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND APPLICABLE TO THE TYPE OF MANAGED CARE PLAN THAT SUCH CONTRACTOR PROPOSES TO OPERATE.

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 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ON A CAPITATED BASIS IN ACCORDANCE WITH THIS SECTION, FOR A POPULATION OF PERSONS 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 AVAILABLE THROUGH THE STATE'S HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, STATE PLAN FOR MEDICAL ASSISTANCE, AND ANY OTHER AUTHORIZED FEDERAL FUNDING FOR SUCH SERVICES DESIGNED TO ASSIST PERSONS IN ACQUIRING, RETAINING, AND IMPROVING THE SELF-HELP, SOCIALIZATION, AND ADAPTIVE SKILLS NECESSARY TO RESIDE SUCCESSFULLY IN HOME AND COMMUNITY BASED SETTINGS.

(D) "HEALTH AND LONG TERM CARE SERVICES" MEANS SERVICES, WHETHER PROVIDED BY STATE-OPERATED PROGRAMS OR NOT-FOR-PROFIT ENTITIES, INCLUDING, BUT NOT LIMITED TO, HABILITATION SERVICES, 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 HEALTH AND LONG TERM CARE SERVICES DESIGNED TO ACHIEVE PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON 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 IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE EXTENT THAT SUCH WISHES ARE KNOWN AND IN ACCORDANCE WITH SUCH PERSON'S NEEDS.

2. APPROVAL AUTHORITY. AN APPLICANT SHALL BE ISSUED A CERTIFICATE OF AUTHORITY AS A DISCO FOR PURPOSES OF PARTICIPATING IN THE PEOPLE FIRST WAIVER PROGRAM PURSUANT TO SECTION 13.40 OF THE MENTAL HYGIENE LAW UPON A DETERMINATION BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH 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 THE OFFICE FOR PEOPLE WITH 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 PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION MAKERS 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, AND OF THE INCORPORATORS, DIRECTORS, STOCKHOLDERS OR MEMBERS OF THE APPLICANT;

(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 ACHIEVEMENT OF PERSON-CENTERED OUTCOMES, AS DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE ASSESSED, AS WELL AS A DESCRIPTION OF HOW HEALTH AND LONG TERM CARE SERVICES SHALL BE USED TO MEET SUCH OUTCOMES;

(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 THE OFFICE FOR PEOPLE WITH 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 PERSONS WITH DEVELOPMENTAL DISABILITIES CAN MAKE INFORMED CHOICES EITHER INDIVIDUALLY OR THROUGH AN AUTHORIZED DECISION MAKER REGARDING THE DEVELOPMENT OF A PERSON-CENTERED PLAN, AS DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(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 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE PROGRAM SHALL INCLUDE DATA COLLECTION AND REPORTING FOR STANDARD PERFORMANCE MEASURES AS REQUIRED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

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

1 (F) SATISFACTORY EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE
2 APPLICANT'S PROPOSED OPERATORS, INCORPORATORS, DIRECTORS, STOCKHOLDERS
3 AND MEMBERS;

4 (G) REASONABLE ASSURANCE THAT THE APPLICANT WILL PROVIDE HIGH QUALITY
5 SERVICES TO AN ENROLLED POPULATION, THAT THE APPLICANT'S NETWORK OF
6 PROVIDERS IS ADEQUATE AND THAT SUCH PROVIDERS HAVE DEMONSTRATED SUFFI-
7 CIENT COMPETENCY TO DELIVER HIGH QUALITY SERVICES TO THE ENROLLED POPU-
8 LATION AND THAT POLICIES AND PROCEDURES WILL BE IN PLACE TO ADDRESS THE
9 CULTURAL AND LINGUISTIC NEEDS OF THE ENROLLED POPULATION;

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

13 (I) READINESS AND CAPABILITY TO MAXIMIZE REIMBURSEMENT OF AND COORDI-
14 NATE SERVICES REIMBURSED PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL
15 SECURITY ACT AND ALL OTHER APPLICABLE BENEFITS, WITH SUCH BENEFIT COOR-
16 DINATION INCLUDING, BUT NOT LIMITED TO, MEASURES TO SUPPORT SOUND CLIN-
17 ICAL DECISIONS, REDUCE ADMINISTRATIVE COMPLEXITY, COORDINATE ACCESS TO
18 SERVICES, MAXIMIZE BENEFITS AVAILABLE PURSUANT TO SUCH TITLE AND ENSURE
19 THAT NECESSARY CARE IS PROVIDED;

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

21 (K) WILLINGNESS AND CAPABILITY OF TAKING, OR COOPERATING IN, ALL STEPS
22 NECESSARY TO SECURE AND INTEGRATE ANY POTENTIAL SOURCES OF FUNDING FOR
23 SERVICES PROVIDED BY OR THROUGH THE DISCO, INCLUDING, BUT NOT LIMITED
24 TO, FUNDING AVAILABLE UNDER TITLES XVI, XVIII, XIX AND XX OF THE FEDERAL
25 SOCIAL SECURITY ACT AND ALL OTHER AVAILABLE SOURCES OF FUNDING;

26 (L) THAT THE CONTRACTUAL ARRANGEMENTS FOR PROVIDERS OF HEALTH AND LONG
27 TERM CARE SERVICES IN THE BENEFIT PACKAGE ARE SUFFICIENT TO ENSURE THE
28 AVAILABILITY AND ACCESSIBILITY OF SUCH SERVICES TO THE PROPOSED ENROLLED
29 POPULATION CONSISTENT WITH GUIDELINES ESTABLISHED BY THE COMMISSIONER
30 AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISA-
31 BILITIES. WITH RESPECT TO A PERSON RECEIVING NON-RESIDENTIAL SERVICES
32 OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR
33 PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE DISCO,
34 SUCH GUIDELINES SHALL REQUIRE THE DISCO TO CONTRACT WITH THE CURRENT
35 PROVIDER OF NON-RESIDENTIAL SERVICES AT THE RATES ESTABLISHED BY THE
36 OFFICE FOR NINETY DAYS, IN ORDER TO ENSURE CONTINUITY OF CARE. WITH
37 RESPECT TO A PERSON LIVING IN A RESIDENTIAL FACILITY OPERATED OR CERTI-
38 FIED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO
39 ENROLLMENT IN THE DISCO, SUCH GUIDELINES SHALL REQUIRE THE DISCO TO
40 CONTRACT WITH THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT
41 THE RATES ESTABLISHED BY THE OFFICE FOR SO LONG AS SUCH INDIVIDUAL LIVES
42 IN THAT RESIDENCE PURSUANT TO AN APPROVED PLAN OF CARE;

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

45 (N) THAT THE APPLICANT SHALL ASSESS PERSON-CENTERED OUTCOMES AS
46 DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL
47 DISABILITIES, AND HAS SATISFACTORY MECHANISMS BY WHICH IT WILL ASSESS
48 HOW HEALTH AND LONG TERM CARE SERVICES WILL BE USED TO MEET SUCH
49 OUTCOMES.

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

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

1 (C) NO PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS RECEIVING OR
2 APPLYING FOR MEDICAL ASSISTANCE AND WHO IS RECEIVING, OR ELIGIBLE TO
3 RECEIVE, SERVICES FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE
4 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE REQUIRED TO
5 ENROLL IN A DISCO IN ORDER TO RECEIVE SUCH SERVICES UNTIL PROGRAM
6 FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND
7 THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
8 TIES, AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT
9 NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOP-
10 MENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN SUCH PERSON'S
11 COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL
12 DISABILITIES, AND THAT SUCH DISCOS MEET THE STANDARDS OF THIS SECTION.
13 NO PERSON SHALL BE REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE
14 SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE
15 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THERE ARE AT
16 LEAST TWO PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOP-
17 MENTAL DISABILITIES PURSUANT TO THIS ARTICLE IN SUCH PERSON'S COUNTY OF
18 RESIDENCE, UNLESS FEDERAL APPROVAL IS SECURED TO REQUIRE ENROLLMENT WHEN
19 THERE ARE LESS THAN TWO SUCH ENTITIES OPERATING IN SUCH COUNTY.

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

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

38 (F) A DISCO MAY REQUEST THE INVOLUNTARY DISENROLLMENT OF AN ENROLLED
39 PERSON IN WRITING TO THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
40 TIES. SUCH DISENROLLMENT SHALL NOT BE EFFECTIVE UNTIL THE REQUEST IS
41 REVIEWED AND APPROVED BY SUCH OFFICE. NOTICE SHALL BE PROVIDED TO THE
42 ENROLLEE AND THE ENROLLEE MAY REQUEST A FAIR HEARING REGARDING SUCH
43 DISENROLLMENT. THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOP-
44 MENTAL DISABILITIES SHALL ADOPT RULES AND REGULATIONS GOVERNING THIS
45 PROCESS.

46 6. ASSESSMENTS. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES,
47 OR ITS DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT THAT SHALL
48 INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL,
49 HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROLLEE IN A
50 DISCO AS SUCH NEEDS RELATE TO EACH INDIVIDUAL'S HEALTH, SAFETY, LIVING
51 ENVIRONMENT AND WISHES, TO THE EXTENT THAT SUCH WISHES ARE KNOWN. THIS
52 ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND
53 PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. SUCH PLAN OF
54 CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED OUTCOMES AND
55 SHALL BE CONSISTENT WITH AND HELP INFORM ANY OTHER PERSON-CENTERED PLAN
56 REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE

1 WITH DEVELOPMENTAL DISABILITIES. THE ASSESSMENT SHALL BE COMPLETED BY
2 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR IN CONSULTATION
3 WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY.
4 THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
5 TIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE.
6 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY DESIGNATE THE
7 DISCO TO PERFORM REASSESSMENTS, BUT SHALL NOT DESIGNATE THE DISCO TO
8 PERFORM THE INITIAL ASSESSMENT OF A PROSPECTIVE ENROLLEE.

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

15 (B) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE
16 WITH DEVELOPMENTAL DISABILITIES MAY WAIVE RULES AND REGULATIONS OF THEIR
17 RESPECTIVE DEPARTMENT OR OFFICE, INCLUDING BUT NOT LIMITED TO, THOSE
18 PERTAINING TO DUPLICATIVE REQUIREMENTS CONCERNING RECORD KEEPING, BOARDS
19 OF DIRECTORS, STAFFING AND REPORTING, WHEN SUCH WAIVER SHALL PROMOTE THE
20 EFFICIENT DELIVERY OF APPROPRIATE, QUALITY, COST-EFFECTIVE SERVICES AND
21 WHEN THE HEALTH, SAFETY AND GENERAL WELFARE OF DISCO ENROLLEES SHALL NOT
22 BE IMPAIRED AS A RESULT OF SUCH WAIVER. THE COMMISSIONERS SHALL REPORT
23 ANNUALLY TO THE LEGISLATURE AND TO THE JOINT ADVISORY COUNCIL ESTAB-
24 LISHED PURSUANT TO SECTION 13.40 OF THE MENTAL HYGIENE LAW ON ALL RULES
25 AND REGULATIONS WAIVED PURSUANT TO THIS PARAGRAPH. IN ORDER TO ACHIEVE
26 DISCO SYSTEM EFFICIENCIES AND COORDINATION AND TO PROMOTE THE OBJECTIVES
27 OF HIGH QUALITY, INTEGRATED AND COST EFFECTIVE CARE, THE COMMISSIONERS
28 SHALL ESTABLISH A SINGLE COORDINATED SURVEILLANCE PROCESS, ALLOW FOR A
29 COMPREHENSIVE QUALITY IMPROVEMENT AND REVIEW PROCESS TO MEET COMPONENT
30 QUALITY REQUIREMENTS, AND REQUIRE A UNIFORM COST REPORT. THE COMMISSION-
31 ERS SHALL REQUIRE DISCOS TO UTILIZE QUALITY IMPROVEMENT MEASURES, BASED
32 ON THE ACHIEVEMENT OF PERSONAL OUTCOMES AND QUALITY OF LIFE, HEALTH
33 OUTCOMES DATA, AND ASSESSMENTS OF INDIVIDUAL AND FAMILY SATISFACTION,
34 FOR INTERNAL QUALITY ASSESSMENT PROCESSES AND MAY UTILIZE SUCH MEASURES
35 AS PART OF THE SINGLE COORDINATED SURVEILLANCE PROCESS.

36 (C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THE SOCIAL SERVICES
37 LAW TO THE CONTRARY, THE COMMISSIONER IN CONSULTATION WITH THE COMMIS-
38 SIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL,
39 PURSUANT TO REGULATION, DETERMINE WHETHER AND THE EXTENT TO WHICH THE
40 APPLICABLE PROVISIONS OF THE SOCIAL SERVICES LAW OR REGULATIONS RELATING
41 TO APPROVALS AND AUTHORIZATIONS OF, AND UTILIZATION LIMITATIONS ON,
42 HEALTH AND LONG TERM CARE SERVICES REIMBURSED PURSUANT TO TITLE XIX OF
43 THE FEDERAL SOCIAL SECURITY ACT ARE INCONSISTENT WITH THE FLEXIBILITY
44 NECESSARY FOR THE EFFICIENT ADMINISTRATION OF DISCOS, AND SUCH REGU-
45 LATIONS SHALL PROVIDE THAT SUCH PROVISIONS SHALL NOT BE APPLICABLE TO
46 ENROLLEES OF DISCOS, PROVIDED THAT SUCH DETERMINATIONS ARE CONSISTENT
47 WITH APPLICABLE FEDERAL LAW AND REGULATION.

48 (D) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE
49 WITH DEVELOPMENTAL DISABILITIES SHALL ENSURE, THROUGH PERIODIC REVIEWS
50 OF DISCOS, THAT ORGANIZATION SERVICES ARE PROMPTLY AVAILABLE TO ENROL-
51 LEES WHEN APPROPRIATE. SUCH PERIODIC REVIEWS SHALL BE MADE ACCORDING TO
52 STANDARDS AS DETERMINED BY THE COMMISSIONERS IN REGULATIONS.

53 (E) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE
54 WITH DEVELOPMENTAL DISABILITIES SHALL HAVE THE AUTHORITY TO CONDUCT BOTH
55 ON SITE AND OFF SITE REVIEWS OF DISCOS. SUCH REVIEWS MAY INCLUDE, BUT
56 NOT BE LIMITED TO, THE FOLLOWING COMPONENTS: GOVERNANCE; FISCAL AND

1 FINANCIAL REPORTING; RECORDKEEPING; INTERNAL CONTROLS; MARKETING;
2 NETWORK CONTRACTING AND ADEQUACY; PROGRAM INTEGRITY ASSURANCES; UTILIZA-
3 TION CONTROL AND REVIEW SYSTEMS; GRIEVANCE AND APPEALS SYSTEMS; QUALITY
4 ASSESSMENT AND ASSURANCE SYSTEMS; CARE MANAGEMENT; ENROLLMENT AND DISEN-
5 ROLLMENT; MANAGEMENT INFORMATION SYSTEMS, AND OTHER OPERATIONAL AND
6 MANAGEMENT COMPONENTS.

7 8. SOLVENCY. (A) THE COMMISSIONER, IN CONSULTATION WITH THE COMMIS-
8 SIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL
9 BE RESPONSIBLE FOR EVALUATING, APPROVING AND REGULATING ALL MATTERS
10 RELATING TO FISCAL SOLVENCY, INCLUDING RESERVES, SURPLUS AND PROVIDER
11 CONTRACTS. THE COMMISSIONER SHALL PROMULGATE REGULATIONS TO IMPLEMENT
12 THIS SECTION. THE COMMISSIONER, IN THE ADMINISTRATION OF THIS SUBDIVI-
13 SION:

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

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

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

23 (B) STANDARDS ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE
24 ADEQUATE TO PROTECT THE INTERESTS OF ENROLLEES IN THE DISCO. THE COMMIS-
25 SIONER SHALL BE SATISFIED THAT THE ELIGIBLE APPLICANT IS FINANCIALLY
26 SOUND, AND HAS MADE ADEQUATE PROVISIONS TO PAY FOR QUALITY SERVICES THAT
27 ARE COST EFFECTIVE AND APPROPRIATE TO NEEDS AND THE PROTECTION OF
28 HEALTH, SAFETY, WELFARE AND SATISFACTION OF THOSE SERVED.

29 9. ROLE OF THE SUPERINTENDENT OF FINANCIAL SERVICES. (A) THE SUPER-
30 INTENDENT OF FINANCIAL SERVICES SHALL DETERMINE AND APPROVE PREMIUMS IN
31 ACCORDANCE WITH THE INSURANCE LAW WHENEVER ANY POPULATION OF ENROLLEES
32 NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT IS TO BE
33 COVERED. THE DETERMINATION AND APPROVAL OF THE SUPERINTENDENT OF FINAN-
34 CIAL SERVICES SHALL RELATE TO PREMIUMS CHARGED TO SUCH ENROLLEES NOT
35 ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

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

40 10. PAYMENT RATES FOR DISCO ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE.
41 THE COMMISSIONER SHALL ESTABLISH PAYMENT RATES FOR SERVICES PROVIDED TO
42 ENROLLEES ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.
43 SUCH PAYMENT RATES SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF THE
44 DIVISION OF THE BUDGET. PAYMENT RATES SHALL BE ACTUARIALLY SOUND FOR
45 COVERED SERVICES, INCLUDING BUT NOT LIMITED TO HABILITATION SERVICES,
46 AND, WHEN THERE IS SUFFICIENT RELIABLE DATA TO PERMIT, SHALL BE RISK-AD-
47 JUSTED TO TAKE INTO ACCOUNT THE CHARACTERISTICS OF ENROLLEES, OR
48 PROPOSED ENROLLEES, WHICH MAY INCLUDE: FRAILTY, DISABILITY LEVEL, HEALTH
49 AND FUNCTIONAL STATUS, AGE, GENDER, THE NATURE OF SERVICES PROVIDED TO
50 SUCH ENROLLEES, AND OTHER FACTORS AS DETERMINED BY THE COMMISSIONER AND
51 THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
52 TIES. THE RISK ADJUSTED PREMIUMS MAY ALSO BE COMBINED WITH DISINCENTIVES
53 OR REQUIREMENTS DESIGNED TO MITIGATE ANY INCENTIVES TO OBTAIN HIGHER
54 PAYMENT CATEGORIES.

55 11. CONTINUATION OF CERTIFICATE OF AUTHORITY. CONTINUATION OF A
56 CERTIFICATE OF AUTHORITY ISSUED UNDER THIS SECTION SHALL BE CONTINGENT

1 UPON COMPLIANCE BY THE DISCO WITH APPLICABLE PROVISIONS OF THIS SECTION
2 AND RULES AND REGULATIONS PROMULGATED THEREUNDER; THE CONTINUING FISCAL
3 SOLVENCY OF THE DISCO; AND FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS
4 ON BEHALF OF ENROLLEES WHO ARE ELIGIBLE TO RECEIVE SERVICES UNDER TITLE
5 XIX OF THE FEDERAL SOCIAL SECURITY ACT.

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

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

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

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

24 14. APPLICABILITY OF OTHER LAWS. DISCOS SHALL BE SUBJECT TO THE
25 PROVISIONS OF THE INSURANCE LAW AND REGULATIONS APPLICABLE TO HEALTH
26 MAINTENANCE ORGANIZATIONS, THIS ARTICLE AND REGULATIONS PROMULGATED
27 THEREUNDER. TO THE EXTENT THAT THE PROVISIONS OF THIS SECTION ARE INCON-
28 SISTENT WITH THE PROVISIONS OF THIS CHAPTER OR THE PROVISIONS OF THE
29 INSURANCE LAW, THE PROVISIONS OF THIS SECTION SHALL PREVAIL.

30 15. EFFECTIVENESS. THE PROVISIONS OF THIS SECTION SHALL ONLY BE EFFEC-
31 TIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL
32 PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED BY THE
33 DISCOS TO ENROLLEES WHO ARE RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO
34 TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSION-
35 ER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL
36 ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF
37 THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR
38 WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, IN ORDER TO ENSURE SUCH
39 FEDERAL FINANCIAL PARTICIPATION.

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

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

51 (A) SUCH ORGANIZATION MUST HAVE THE ABILITY TO PROVIDE OR COORDINATE
52 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AS DEMONSTRATED BY
53 CRITERIA TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF
54 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH CRITERIA
55 SHALL INCLUDE, BUT NOT BE LIMITED TO, ADEQUATE EXPERIENCE PROVIDING OR
56 COORDINATING SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

1 (A-1) IF THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR
2 PEOPLE WITH DEVELOPMENTAL DISABILITIES DETERMINE THAT SUCH ORGANIZATION
3 LACKS THE EXPERIENCE REQUIRED IN PARAGRAPH (A) OF THIS SUBDIVISION, THE
4 ORGANIZATION SHALL HAVE AN AFFILIATION ARRANGEMENT WITH AN ENTITY OR
5 ENTITIES WITH EXPERIENCE SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES
6 SUCH THAT THE AFFILIATED ENTITY WILL COORDINATE AND PLAN SERVICES OPER-
7 ATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE
8 WITH DEVELOPMENTAL DISABILITIES OR WILL OVERSEE AND APPROVE SUCH COORDI-
9 NATION AND PLANNING;

10 (A-2) EACH ENROLLEE SHALL RECEIVE SERVICES DESIGNED TO ACHIEVE
11 PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON TO LIVE IN THE MOST
12 INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE
13 THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT
14 POSSIBLE IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED
15 THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE
16 EXTENT THAT SUCH WISHES ARE KNOWN AND THE INDIVIDUAL'S NEEDS. WITH
17 RESPECT TO AN INDIVIDUAL RECEIVING NON-RESIDENTIAL SERVICES OPERATED,
18 CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH
19 DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE ORGANIZATION, SUCH
20 GUIDELINES SHALL REQUIRE THE ORGANIZATION TO CONTRACT WITH THE CURRENT
21 PROVIDER OF SUCH NON-RESIDENTIAL SERVICES AT THE RATES ESTABLISHED BY
22 THE OFFICE FOR NINETY DAYS, IN ORDER TO ENSURE CONTINUITY OF CARE. WITH
23 RESPECT TO AN INDIVIDUAL LIVING IN A RESIDENTIAL FACILITY OPERATED OR
24 CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR
25 TO ENROLLMENT IN THE ORGANIZATION, THE ORGANIZATION SHALL CONTRACT WITH
26 THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT THE RATES
27 ESTABLISHED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR
28 SO LONG AS SUCH PERSON LIVES IN THAT RESIDENCE PURSUANT TO AN APPROVED
29 PLAN OF CARE;

30 (B) THE PROVISION BY SUCH ORGANIZATION OF SERVICES OPERATED, CERTI-
31 FIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH
32 DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO THE JOINT OVERSIGHT AND
33 REVIEW OF BOTH THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOP-
34 MENTAL DISABILITIES. THE DEPARTMENT AND SUCH OFFICE SHALL REQUIRE SUCH
35 ORGANIZATION TO PROVIDE COMPREHENSIVE CARE PLANNING, ASSESS QUALITY,
36 MEET QUALITY ASSURANCE REQUIREMENTS AND ENSURE THE ENROLLEE IS INVOLVED
37 IN CARE PLANNING.

38 (C) SUCH ORGANIZATION SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPER-
39 ATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE
40 WITH DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND THE COMMIS-
41 SIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES APPROVE
42 PROGRAM FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE
43 THAT SUCH ORGANIZATION MEETS THE REQUIREMENTS OF THIS PARAGRAPH AND ANY
44 OTHER REQUIREMENTS SET FORTH BY THE COMMISSIONER OF THE OFFICE FOR
45 PEOPLE WITH DEVELOPMENTAL DISABILITIES;

46 (D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE
47 ORGANIZATION THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR
48 APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL
49 NOT BE INVOLUNTARILY DISENROLLED FROM SUCH ORGANIZATION WITHOUT THE
50 PRIOR APPROVAL OF THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVEL-
51 OPMENTAL DISABILITIES. NOTICE SHALL BE PROVIDED TO THE ENROLLEE AND THE
52 ENROLLEE MAY REQUEST A FAIR HEARING REGARDING SUCH DISENROLLMENT;

53 (E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETER-
54 MINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTI-
55 FIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH A

1 PLAN AND SHALL ENROLL INDIVIDUALS IT DETERMINES ELIGIBLE IN AN ORGANIZA-
2 TION CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

3 (F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS
4 DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES THAT
5 RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY
6 SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN
7 EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS
8 OF EACH PROSPECTIVE ENROLLEE AS SUCH NEEDS RELATE TO SUCH ENROLLEE'S
9 HEALTH, SAFETY, LIVING ENVIRONMENT AND WISHES, TO THE EXTENT SUCH WISHES
10 ARE KNOWN. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVEL-
11 OPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE.
12 SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED
13 OUTCOMES AND SHALL BE CONSISTENT WITH AND HELP INFORM ANY OTHER PERSON-
14 CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF THE
15 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE INITIAL ASSESS-
16 MENT SHALL BE COMPLETED BY SUCH OFFICE OR ITS DESIGNEE OTHER THAN THE
17 ORGANIZATION AND SHALL BE COMPLETED, IN CONSULTATION WITH THE PROSPEC-
18 TIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. REASSESSMENTS
19 SHALL BE COMPLETED BY THE OFFICE OR ITS DESIGNEE, WHICH MAY BE THE
20 ORGANIZATION. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOP-
21 MENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT
22 SHALL BE MADE.

23 (F-1) SUCH ORGANIZATION SHALL PROVIDE THE DEPARTMENT AND THE OFFICE
24 FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES WITH A DESCRIPTION OF THE
25 PROPOSED MARKETING PLAN AND HOW MARKETING MATERIALS WILL BE PRESENTED TO
26 PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION
27 MAKERS FOR THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE.

28 (G) NO PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE REQUIRED TO
29 ENROLL IN A COMPREHENSIVE HEALTH SERVICES PLAN AS A CONDITION OF RECEIV-
30 ING MEDICAL ASSISTANCE AND SERVICES OPERATED, CERTIFIED, FUNDED, AUTHOR-
31 IZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILI-
32 TIES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE
33 COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOP-
34 MENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE
35 ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR
36 PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERAT-
37 ING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS
38 WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH PLANS MEET THE STANDARDS
39 OF THIS SECTION.

40 (H) ORGANIZATIONS PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED,
41 AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISA-
42 BILITIES SHALL BE SUBJECT TO ALL REQUIREMENTS APPLICABLE TO DISCOS OPER-
43 ATING UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE WITH
44 RESPECT TO QUALITY ASSURANCE, GRIEVANCES AND APPEALS, INFORMED CHOICE,
45 PARTICIPATING IN DEVELOPMENT OF PLANS OF CARE AND REQUIREMENTS WITH
46 RESPECT TO MARKETING, TO THE EXTENT THAT SUCH REQUIREMENTS ARE NOT
47 INCONSISTENT WITH THIS SECTION.

48 (I) THE PROVISIONS OF THIS SUBDIVISION SHALL ONLY BE EFFECTIVE IF, FOR
49 SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS
50 AVAILABLE FOR THE COSTS OF SERVICES PROVIDED HEREUNDER TO RECIPIENTS OF
51 MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE
52 SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMEND-
53 MENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO
54 SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR
55 SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECU-
56 RITY ACT, AS MAY BE NECESSARY TO ENSURE SUCH FEDERAL FINANCIAL PARTIC-

1 IPATION. TO THE EXTENT THAT THE PROVISIONS OF THIS SUBDIVISION ARE
2 INCONSISTENT WITH OTHER PROVISIONS OF THIS ARTICLE OR WITH THE
3 PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES
4 LAW, THE PROVISIONS OF THIS SUBDIVISION SHALL PREVAIL.

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

8 The commissioner AND, IN THE CASE OF A PLAN ARRANGING FOR OR PROVIDING
9 SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE
10 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF
11 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, shall, upon
12 request by a managed long term care plan or operating demonstration, and
13 consistent with federal regulations promulgated pursuant to the Health
14 Insurance Portability and Accountability Act, share with such plan or
15 demonstration the following data if it is available:

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

18 12. NOTWITHSTANDING ANY PROVISION TO THE CONTRARY, A MANAGED LONG TERM
19 CARE PLAN MAY EXPAND THE SERVICES IT PROVIDES OR ARRANGES FOR TO INCLUDE
20 SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE
21 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR A POPULATION OF
22 PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN THE
23 MENTAL HYGIENE LAW, INCLUDING HABILITATION SERVICES AS DEFINED IN PARA-
24 GRAPH (C) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF
25 THIS ARTICLE, SUBJECT TO THE FOLLOWING:

26 (A) SUCH PLAN MUST HAVE THE ABILITY TO PROVIDE OR COORDINATE SERVICES
27 FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AS DEMONSTRATED BY CRITERIA
28 TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE
29 FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH CRITERIA SHALL INCLUDE,
30 BUT NOT BE LIMITED TO, ADEQUATE EXPERIENCE PROVIDING OR COORDINATING
31 SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES;

32 (A-1) IF THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR
33 PEOPLE WITH DEVELOPMENTAL DISABILITIES DETERMINE THAT SUCH PLAN LACKS
34 THE EXPERIENCE REQUIRED IN PARAGRAPH (A) OF THIS SUBDIVISION, THE PLAN
35 SHALL HAVE AN AFFILIATION ARRANGEMENT WITH AN ENTITY OR ENTITIES WITH
36 EXPERIENCE SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES SUCH THAT THE
37 AFFILIATED ENTITY WILL COORDINATE AND PLAN SERVICES OPERATED, CERTIFIED,
38 FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOP-
39 MENTAL DISABILITIES OR WILL OVERSEE AND APPROVE SUCH COORDINATION AND
40 PLANNING;

41 (A-2) EACH ENROLLEE SHALL RECEIVE SERVICES DESIGNED TO ACHIEVE
42 PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON TO LIVE IN THE MOST
43 INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE
44 THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT
45 POSSIBLE IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED
46 THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE
47 EXTENT THAT SUCH WISHES ARE KNOWN. WITH RESPECT TO AN INDIVIDUAL RECEIV-
48 ING NON-RESIDENTIAL SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR
49 APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR
50 TO ENROLLMENT IN THE PLAN, SUCH GUIDELINES SHALL REQUIRE THE PLAN TO
51 CONTRACT WITH THE CURRENT PROVIDER OF SUCH NON-RESIDENTIAL SERVICES AT
52 THE RATES ESTABLISHED BY THE OFFICE FOR NINETY DAYS IN ORDER TO ENSURE
53 CONTINUITY OF CARE. WITH RESPECT TO AN INDIVIDUAL LIVING IN A RESIDEN-
54 TIAL FACILITY OPERATED OR CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVEL-
55 OPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE PLAN, THE PLAN SHALL
56 CONTRACT WITH THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT

1 THE RATES ESTABLISHED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISA-
2 BILITIES FOR SO LONG AS SUCH INDIVIDUAL LIVES IN THAT RESIDENCE PURSUANT
3 TO AN APPROVED PLAN OF CARE;

4 (B) THE PROVISION BY SUCH PLAN OF SERVICES OPERATED, CERTIFIED, FUND-
5 ED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL
6 DISABILITIES SHALL BE SUBJECT THE JOINT OVERSIGHT AND REVIEW OF BOTH THE
7 DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.
8 THE DEPARTMENT AND SUCH OFFICE SHALL REQUIRE SUCH ORGANIZATION TO
9 PROVIDE COMPREHENSIVE CARE PLANNING, ASSESS QUALITY, MEET QUALITY ASSUR-
10 ANCE REQUIREMENTS AND ENSURE THE ENROLLEE IS INVOLVED IN CARE PLANNING;

11 (C) SUCH PLAN SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPERATED,
12 CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH
13 DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND THE COMMISSIONER
14 OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES APPROVE PROGRAM
15 FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE THAT SUCH
16 ORGANIZATION MEETS THE REQUIREMENTS OF THIS SUBDIVISION AND ANY OTHER
17 REQUIREMENTS SET FORTH BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH
18 DEVELOPMENTAL DISABILITIES;

19 (D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE PLAN
20 THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE
21 OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL NOT BE INVOLUN-
22 TARILY DISENROLLED FROM SUCH PLAN WITHOUT THE PRIOR APPROVAL OF THE
23 COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.
24 NOTICE SHALL BE PROVIDED TO THE ENROLLEE AND THE ENROLLEE MAY REQUEST A
25 FAIR HEARING REGARDING SUCH DISENROLLMENT;

26 (E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETER-
27 MINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTI-
28 FIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH
29 PLAN AND SHALL ENROLL INDIVIDUALS IT DETERMINES ELIGIBLE IN A PLAN
30 CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

31 (F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS
32 DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES WHO
33 RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY
34 SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN
35 EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS
36 OF EACH PROSPECTIVE ENROLLEE AS SUCH NEEDS RELATE TO EACH INDIVIDUAL'S
37 HEALTH, SAFETY, LIVING ENVIRONMENT AND WISHES, TO THE EXTENT THAT SUCH
38 WISHES ARE KNOWN. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE
39 DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROL-
40 LEE. SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF
41 PERSON-CENTERED OUTCOMES AND SHALL BE CONSISTENT WITH AND HELP INFORM
42 ANY OTHER PERSON-CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMIS-
43 SIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE
44 INITIAL ASSESSMENT SHALL BE COMPLETED BY SUCH OFFICE OR A DESIGNEE OTHER
45 THAN THE PLAN AND SHALL BE COMPLETED IN CONSULTATION WITH THE PROSPEC-
46 TIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. REASSESSMENTS
47 SHALL BE COMPLETED BY SUCH OFFICE OR ITS DESIGNEE, WHICH MAY BE THE
48 MANAGED LONG TERM CARE PLAN IN WHICH THE PERSON IS ENROLLED OR PROPOSES
49 TO ENROLL. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL
50 DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE
51 MADE.

52 (F-1) THE PLAN SHALL PROVIDE THE DEPARTMENT AND THE OFFICE FOR PEOPLE
53 WITH DEVELOPMENTAL DISABILITIES WITH A DESCRIPTION OF THE PROPOSED
54 MARKETING PLAN AND HOW MARKETING MATERIALS WILL BE PRESENTED TO PERSONS
55 WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION MAKERS FOR
56 THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE.

(G) PLANS PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO ALL REQUIREMENTS APPLICABLE TO DISCOS OPERATING UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE WITH RESPECT TO QUALITY ASSURANCE, GRIEVANCES AND APPEALS, INFORMED CHOICE, PARTICIPATION IN DEVELOPMENT OF PLANS OF CARE AND REQUIREMENTS WITH RESPECT TO MARKETING, TO THE EXTENT THAT SUCH REQUIREMENTS ARE NOT INCONSISTENT WITH THIS SECTION.

(H) 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 THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS 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 WHO ARE ELIGIBLE FOR MEDICARE AND MEDICAL ASSISTANCE TO OPERATE MANAGED LONG TERM CARE PLANS THAT ARE AUTHORIZED TO EXCLUSIVELY ENROLL PERSONS 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 MEDICAL ASSISTANCE. THE COMMISSIONER MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR PERSONS 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 SUBDIVISION 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:

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

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

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

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

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

16 (AA) CARE AND SERVICES FURNISHED BY A DEVELOPMENTAL DISABILITY INDI-
17 VIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION (DISCO) THAT HAS
18 RECEIVED A CERTIFICATE OF AUTHORITY PURSUANT TO SECTION FORTY-FOUR
19 HUNDRED THREE-G OF THE PUBLIC HEALTH LAW TO ELIGIBLE INDIVIDUALS RESID-
20 ING IN THE GEOGRAPHIC AREA SERVED BY SUCH ENTITY, WHEN SUCH SERVICES ARE
21 FURNISHED IN ACCORDANCE WITH AN AGREEMENT APPROVED BY THE DEPARTMENT OF
22 HEALTH WHICH MEETS THE REQUIREMENTS OF FEDERAL LAW AND REGULATIONS.

23 S 80. The commissioner of health shall, to the extent necessary,
24 submit the appropriate waivers, including, but not limited to, those
25 authorized pursuant to sections eleven hundred fifteen and nineteen
26 hundred fifteen of the federal social security act, or successor
27 provisions, and any other waivers necessary to achieve the purposes of
28 high quality, integrated and cost effective care and integrated finan-
29 cial eligibility policies under the medical assistance program or pursu-
30 ant to title XVIII of the federal social security act and to require
31 medical assistance recipients with developmental disabilities who
32 require home and community-based services, as specified by the commis-
33 sioner, to receive such services through an available organization
34 certified pursuant to article 44 of the public health law. Copies of
35 such original waiver applications and amendments thereto shall be
36 provided to the chairs of the senate finance committee, the assembly
37 ways and means committee and the senate and assembly health committees
38 simultaneously with their submission to the federal government.

39 S 80-a. Section 364-jj of the social services law, as added by chapter
40 649 of the laws of 1996, is amended to read as follows:

41 S 364-jj. Special advisory review panel on Medicaid managed care. (a)
42 There is hereby established a special advisory review panel on Medicaid
43 managed care. The panel shall consist of [nine] TWELVE members who
44 shall be appointed as follows: [three] FOUR by the governor, one of
45 which shall serve as the chair; [two] THREE each by the temporary presi-
46 dent of the senate and the speaker of the assembly; and one each by the
47 minority leader of the senate and the minority leader of the assembly.
48 [All members shall be appointed no later than September first, nineteen
49 hundred ninety-six.] AT LEAST THREE MEMBERS OF SUCH PANEL SHALL BE
50 MEMBERS OF THE JOINT ADVISORY PANEL ESTABLISHED UNDER SECTION 13.40 OF
51 THE MENTAL HYGIENE LAW. Members shall serve without compensation but
52 shall be reimbursed for appropriate expenses. The department shall
53 provide technical assistance and access to data as is required for the
54 panel to effectuate the mission and purposes established herein.

55 (b) The panel shall:

1 (i) determine whether there is sufficient managed care provider
2 participation in the Medicaid managed care program;

3 (ii) determine whether managed care providers meet proper enrollment
4 targets that permit as many Medicaid recipients as possible to make
5 their own health plan decisions, thus minimizing the number of automatic
6 assignments;

7 (iii) review the phase-in schedule for enrollment, of managed care
8 providers under both the voluntary and mandatory programs;

9 (iv) assess the impact of managed care provider marketing and enroll-
10 ment strategies, and the public education campaign conducted in New York
11 city, on enrollees participation in Medicaid managed care plans;

12 (v) evaluate the adequacy of managed care provider capacity by review-
13 ing established capacity measurements and monitoring actual access to
14 plan practitioners;

15 (vi) examine the cost implications of populations excluded and
16 exempted from Medicaid managed care; [and]

17 (vii) IN ACCORDANCE WITH THE RECOMMENDATIONS OF THE JOINT ADVISORY
18 COUNCIL ESTABLISHED PURSUANT TO SECTION 13.40 OF THE MENTAL HYGIENE LAW,
19 ADVISE THE COMMISSIONERS OF HEALTH AND DEVELOPMENTAL DISABILITIES WITH
20 RESPECT TO THE OVERSIGHT OF DISCOS AND OF HEALTH MAINTENANCE ORGANIZA-
21 TIONS AND MANAGED LONG TERM CARE PLANS PROVIDING SERVICES AUTHORIZED,
22 FUNDED, APPROVED OR CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVELOP-
23 MENTAL DISABILITIES, AND REVIEW ALL MANAGED CARE OPTIONS PROVIDED TO
24 PERSONS WITH DEVELOPMENTAL DISABILITIES, INCLUDING: THE ADEQUACY OF
25 SUPPORT FOR HABILITATION SERVICES; THE RECORD OF COMPLIANCE WITH
26 REQUIREMENTS FOR PERSON-CENTERED PLANNING, PERSON-CENTERED SERVICES AND
27 COMMUNITY INTEGRATION; THE ADEQUACY OF RATES PAID TO PROVIDERS IN
28 ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH 1 OF SUBDIVISION FOUR OF
29 SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, PARAGRAPH
30 (A-2) OF SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE
31 PUBLIC HEALTH LAW OR PARAGRAPH (A-2) OF SUBDIVISION TWELVE OF SECTION
32 FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW; AND THE QUALITY OF
33 LIFE, HEALTH, SAFETY AND COMMUNITY INTEGRATION OF PERSONS WITH DEVELOP-
34 MENTAL DISABILITIES ENROLLED IN MANAGED CARE; AND

35 (VIII) examine other issues as it deems appropriate.

36 (c) Commencing January first, nineteen hundred ninety-seven and quar-
37 terly thereafter the panel shall submit a report regarding the status
38 of Medicaid managed care in the state and provide recommendations if it
39 deems appropriate to the governor, the temporary president and the
40 minority leader of the senate, and the speaker and the minority leader
41 of the assembly.

42 S 81. Notwithstanding any inconsistent provision of law, rule or regu-
43 lation, for purposes of implementing the provisions of the public health
44 law and the social services law, references to titles XIX and XXI of the
45 federal social security act in the public health law and the social
46 services law shall be deemed to include and also to mean any successor
47 titles thereto under the federal social security act.

48 S 82. Notwithstanding any inconsistent provision of law, rule or regu-
49 lation, the effectiveness of the provisions of sections 2807 and 3614 of
50 the public health law, section 18 of chapter 2 of the laws of 1988, and
51 18 NYCRR 505.14(h), as they relate to time frames for notice, approval
52 or certification of rates of payment, are hereby suspended and without
53 force or effect for purposes of implementing the provisions of this act.

54 S 83. Severability clause. If any clause, sentence, paragraph, subdi-
55 vision, section or part of this act shall be adjudged by any court of
56 competent jurisdiction to be invalid, such judgment shall not affect,

1 impair or invalidate the remainder thereof, but shall be confined in its
2 operation to the clause, sentence, paragraph, subdivision, section or
3 part thereof directly involved in the controversy in which such judgment
4 shall have been rendered. It is hereby declared to be the intent of the
5 legislature that this act would have been enacted even if such invalid
6 provisions had not been included herein.

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

10 1. section thirty-three-a of this act shall take effect January 1,
11 2014;

12 1-a. sections seventy-three through eighty-a shall expire and be
13 deemed repealed September 30, 2019

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

18 2-a. Notwithstanding any inconsistent provision of the state adminis-
19 trative procedure act, the commissioner of health and the commissioner
20 of developmental disabilities are authorized to promulgate on an emer-
21 gency basis any regulation he or she determines necessary to implement
22 any provision of sections seventy-two through seventy-nine of this act
23 upon its effective date;

24 3. this act shall not be construed to alter, change, affect, impair or
25 defeat any rights, obligations, duties or interests accrued, incurred or
26 conferred prior to the effective date of this act;

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

30 5. notwithstanding any inconsistent provision of the state administra-
31 tive procedure act or any other provision of law, rule or regulation,
32 the commissioner of health and the superintendent of financial services
33 and any appropriate council is authorized to adopt or amend or promul-
34 gate on an emergency basis any regulation he or she or such council
35 determines necessary to implement any provision of this act on its
36 effective date;

37 6. the provisions of this act shall become effective notwithstanding
38 the failure of the commissioner of health or the superintendent of
39 financial services or any council to adopt or amend or promulgate regu-
40 lations implementing this act;

41 7. the amendments to section 364-j of the social services law made by
42 sections seven, twelve, thirteen, thirty-five-a, thirty-six, thirty-sev-
43 en, thirty-eight, thirty-nine, forty, forty-one, forty-two, forty-three,
44 forty-four, seventy-two, seventy-seven and seventy-eight of this act
45 shall not affect the repeal of such section and shall be deemed repealed
46 therewith;

47 8. section forty-eight-a of this act shall expire and be deemed
48 repealed March 31, 2016;

49 9. the amendments to section 4403-f of the public health law made by
50 sections seven-a, forty-eight, fifty-four, seventy-five and seventy-six
51 of this act shall not affect the repeal of such section and shall be
52 deemed repealed therewith; and

53 10. the provisions of this act shall apply to any pending cause of
54 action brought pursuant to article 13 of the state finance law, and
55 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.

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

1 for state fiscal years beginning on April 1, 2005, based initially on
2 reported 2000 reconciled data as further reconciled to actual reported
3 data for 2005, and for state fiscal years beginning on April 1, 2006,
4 based initially on reported 2000 reconciled data as further reconciled
5 to actual reported data for 2006, for state fiscal years beginning on
6 and after April 1, 2007 through March 31, 2009, based initially on
7 reported 2000 reconciled data as further reconciled to actual reported
8 data for 2007 and 2008, respectively, for state fiscal years beginning
9 on and after April 1, 2009, based initially on reported 2007 reconciled
10 data, adjusted for authorized Medicaid rate changes applicable to the
11 state fiscal year, and as further reconciled to actual reported data for
12 2009, for state fiscal years beginning on and after April 1, 2010, based
13 initially on reported reconciled data from the base year two years prior
14 to the payment year, adjusted for authorized Medicaid rate changes
15 applicable to the state fiscal year, and further reconciled to actual
16 reported data from such payment year, and to actual reported data for
17 each respective succeeding year. The payments may be added to rates of
18 payment or made as aggregate payments to an eligible public general
19 hospital.

20 S 3. Section 11 of chapter 884 of the laws of 1990, amending the
21 public health law relating to authorizing bad debt and charity care
22 allowances for certified home health agencies, as amended by section 3
23 of part D of chapter 59 of the laws of 2011, is amended to read as
24 follows:

25 S 11. This act shall take effect immediately and:

26 (a) sections one and three shall expire on December 31, 1996,

27 (b) sections four through ten shall expire on June 30, [2013] 2015,
28 and

29 (c) provided that the amendment to section 2807-b of the public health
30 law by section two of this act shall not affect the expiration of such
31 section 2807-b as otherwise provided by law and shall be deemed to
32 expire therewith.

33 S 4. Subdivision 2 of section 246 of chapter 81 of the laws of 1995,
34 amending the public health law and other laws relating to medical
35 reimbursement and welfare reform, as amended by section 4 of part D of
36 chapter 59 of the laws of 2011, is amended to read as follows:

37 2. Sections five, seven through nine, twelve through fourteen, and
38 eighteen of this act shall be deemed to have been in full force and
39 effect on and after April 1, 1995 through March 31, 1999 and on and
40 after July 1, 1999 through March 31, 2000 and on and after April 1, 2000
41 through March 31, 2003 and on and after April 1, 2003 through March 31,
42 2006 and on and after April 1, 2006 through March 31, 2007 and on and
43 after April 1, 2007 through March 31, 2009 and on and after April 1,
44 2009 through March 31, 2011 and sections twelve, thirteen and fourteen
45 of this act shall be deemed to be in full force and effect on and after
46 April 1, 2011 through March 31, [2013] 2015;

47 S 5. Subparagraph (vi) of paragraph (b) of subdivision 2 of section
48 2807-d of the public health law, as amended by section 102 of part H of
49 chapter 59 of the laws of 2011, is amended to read as follows:

50 (vi) Notwithstanding any contrary provision of this paragraph or any
51 other provision of law or regulation to the contrary, for residential
52 health care facilities the assessment shall be six percent of each resi-
53 dential health care facility's gross receipts received from all patient
54 care services and other operating income on a cash basis for the period
55 April first, two thousand two through March thirty-first, two thousand
56 three for hospital or health-related services, including adult day

1 services; provided, however, that residential health care facilities'
2 gross receipts attributable to payments received pursuant to title XVIII
3 of the federal social security act (medicare) shall be excluded from the
4 assessment; provided, however, that for all such gross receipts received
5 on or after April first, two thousand three through March thirty-first,
6 two thousand five, such assessment shall be five percent, and further
7 provided that for all such gross receipts received on or after April
8 first, two thousand five through March thirty-first, two thousand nine,
9 and on or after April first, two thousand nine through March thirty-
10 first, two thousand eleven such assessment shall be six percent, and
11 further provided that for all such gross receipts received on or after
12 April first, two thousand eleven through March thirty-first, two thou-
13 sand thirteen such assessment shall be six percent, AND FURTHER PROVIDED
14 THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO
15 THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN SUCH
16 ASSESSMENT SHALL BE SIX PERCENT.

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

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

25 S 7. Subparagraph (v) of paragraph (b) of subdivision 35 of section
26 2807-c of the public health law, as amended by section 2 of part G of
27 chapter 56 of the laws of 2012, is amended to read as follows:

28 (v) such regulations shall incorporate quality related measures,
29 including, but not limited to, potentially preventable re-admissions
30 (PPRs) and provide for rate adjustments or payment disallowances related
31 to PPRs and other potentially preventable negative outcomes (PPNOs),
32 which shall be calculated in accordance with methodologies as determined
33 by the commissioner, provided, however, that such methodologies shall be
34 based on a comparison of the actual and risk adjusted expected number of
35 PPRs and other PPNOs in a given hospital and with benchmarks established
36 by the commissioner and provided further that such rate adjustments or
37 payment disallowances shall result in an aggregate reduction in Medicaid
38 payments of no less than thirty-five million dollars for the period July
39 first, two thousand ten through March thirty-first, two thousand eleven
40 and no less than fifty-one million dollars for annual periods beginning
41 April first, two thousand eleven through March thirty-first, two thou-
42 sand [thirteen] FOURTEEN, provided further that such aggregate
43 reductions shall be offset by Medicaid payment reductions occurring as a
44 result of decreased PPRs during the period July first, two thousand ten
45 through March thirty-first, two thousand eleven and the period April
46 first, two thousand eleven through March thirty-first, two thousand
47 [thirteen] FOURTEEN and as a result of decreased PPNOs during the period
48 April first, two thousand eleven through March thirty-first, two thou-
49 sand [thirteen] FOURTEEN; and provided further that for the period July
50 first, two thousand ten through March thirty-first, two thousand [thir-
51 teen] FOURTEEN, such rate adjustments or payment disallowances shall not
52 apply to behavioral health PPRs; or to readmissions that occur on or
53 after fifteen days following an initial admission. By no later than July
54 first, two thousand eleven the commissioner shall enter into consulta-
55 tions with representatives of the health care facilities subject to this
56 section regarding potential prospective revisions to applicable method-

ologies 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 364-1 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] FOURTEEN. 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

1 outpatient services provided by general hospitals and for inpatient
2 services and outpatient adult day health care services provided by resi-
3 dential health care facilities pursuant to article 28 of the public
4 health law, the commissioner of health shall apply a trend factor
5 projection of two and twenty-five hundredths percent attributable to the
6 period January 1, 2006 through December 31, 2006, and on and after Janu-
7 ary 1, 2007, provided, however, that on reconciliation of such trend
8 factor for the period January 1, 2006 through December 31, 2006 pursuant
9 to paragraph (c) of subdivision 10 of section 2807-c of the public
10 health law, such trend factor shall be the final US Consumer Price Index
11 (CPI) for all urban consumers, as published by the US Department of
12 Labor, Bureau of Labor Statistics less twenty-five hundredths of a
13 percentage point.

14 S 11. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of
15 the laws of 1995, amending the public health law and other laws relating
16 to medical reimbursement and welfare reform, as amended by section 11 of
17 part D of chapter 59 of the laws of 2011, is amended to read as follows:

18 (f) Prior to February 1, 2001, February 1, 2002, February 1, 2003,
19 February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007,
20 February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011,
21 February 1, 2012, [and] February 1, 2013 AND FEBRUARY 1, 2014 AND FEBRU-
22 ARY 1, 2015 the commissioner of health shall calculate the result of the
23 statewide total of residential health care facility days of care
24 provided to beneficiaries of title XVIII of the federal social security
25 act (medicare), divided by the sum of such days of care plus days of
26 care provided to residents eligible for payments pursuant to title 11 of
27 article 5 of the social services law minus the number of days provided
28 to residents receiving hospice care, expressed as a percentage, for the
29 period commencing January 1, through November 30, of the prior year
30 respectively, based on such data for such period. This value shall be
31 called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009,
32 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide target percentage
33 respectively.

34 S 12. Subparagraph (ii) of paragraph (b) of subdivision 3 of section
35 64 of chapter 81 of the laws of 1995, amending the public health law and
36 other laws relating to medical reimbursement and welfare reform, as
37 amended by section 12 of part D of chapter 59 of the laws of 2011, is
38 amended to read as follows:

39 (ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006,
40 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide
41 target percentages are not for each year at least three percentage
42 points higher than the statewide base percentage, the commissioner of
43 health shall determine the percentage by which the statewide target
44 percentage for each year is not at least three percentage points higher
45 than the statewide base percentage. The percentage calculated pursuant
46 to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002,
47 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013,
48 2014 AND 2015 statewide reduction percentage respectively. If the 1997,
49 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010,
50 2011, 2012, [and] 2013; 2014 AND 2015 statewide target percentage for
51 the respective year is at least three percentage points higher than the
52 statewide base percentage, the statewide reduction percentage for the
53 respective year shall be zero.

54 S 13. Subparagraph (iii) of paragraph (b) of subdivision 4 of section
55 64 of chapter 81 of the laws of 1995, amending the public health law and
56 other laws relating to medical reimbursement and welfare reform, as

1 amended by section 13 of part D of chapter 59 of the laws of 2011, is
2 amended to read as follows:

3 (iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008,
4 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction
5 percentage shall be multiplied by one hundred two million dollars
6 respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005,
7 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015
8 statewide aggregate reduction amount. If the 1998 and the 2000, 2001,
9 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and]
10 2013, 2014 AND 2015 statewide reduction percentage shall be zero respec-
11 tively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005,
12 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015
13 reduction amount.

14 S 14. Paragraph (b) of subdivision 5 of section 64 of chapter 81 of
15 the laws of 1995, amending the public health law and other laws relating
16 to medical reimbursement and welfare reform, as amended by section 14 of
17 part D of chapter 59 of the laws of 2011, is amended to read as follows:

18 (b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005,
19 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015
20 statewide aggregate reduction amounts shall for each year be allocated
21 by the commissioner of health among residential health care facilities
22 that are eligible to provide services to beneficiaries of title XVIII of
23 the federal social security act (medicare) and residents eligible for
24 payments pursuant to title 11 of article 5 of the social services law on
25 the basis of the extent of each facility's failure to achieve a two
26 percentage points increase in the 1996 target percentage, a three
27 percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003,
28 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014
29 AND 2015 target percentage and a two and one-quarter percentage point
30 increase in the 1999 target percentage for each year, compared to the
31 base percentage, calculated on a facility specific basis for this
32 purpose, compared to the statewide total of the extent of each facili-
33 ty's failure to achieve a two percentage points increase in the 1996 and
34 a three percentage point increase in the 1997 and a three percentage
35 point increase in the 1998 and a two and one-quarter percentage point
36 increase in the 1999 target percentage and a three percentage point
37 increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008,
38 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 target percentage
39 compared to the base percentage. These amounts shall be called the 1996,
40 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008,
41 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 facility specific
42 reduction amounts respectively.

43 S 14-a. Section 228 of chapter 474 of the laws of 1996, amending the
44 education law and other laws relating to rates for residential health
45 care facilities, as amended by section 14-a of part D of chapter 59 of
46 the laws of 2011, is amended to read as follows:

47 S 228. 1. Definitions. (a) Regions, for purposes of this section,
48 shall mean a downstate region to consist of Kings, New York, Richmond,
49 Queens, Bronx, Nassau and Suffolk counties and an upstate region to
50 consist of all other New York state counties. A certified home health
51 agency or long term home health care program shall be located in the
52 same county utilized by the commissioner of health for the establishment
53 of rates pursuant to article 36 of the public health law.

54 (b) Certified home health agency (CHHA) shall mean such term as
55 defined in section 3602 of the public health law.

1 (c) Long term home health care program (LTHHCP) shall mean such term
2 as defined in subdivision 8 of section 3602 of the public health law.

3 (d) Regional group shall mean all those CHHAs and LTHHCPs, respective-
4 ly, located within a region.

5 (e) Medicaid revenue percentage, for purposes of this section, shall
6 mean CHHA and LTHHCP revenues attributable to services provided to
7 persons eligible for payments pursuant to title 11 of article 5 of the
8 social services law divided by such revenues plus CHHA and LTHHCP reven-
9 ues attributable to services provided to beneficiaries of Title XVIII of
10 the federal social security act (medicare).

11 (f) Base period, for purposes of this section, shall mean calendar
12 year 1995.

13 (g) Target period. For purposes of this section, the 1996 target peri-
14 od shall mean August 1, 1996 through March 31, 1997, the 1997 target
15 period shall mean January 1, 1997 through November 30, 1997, the 1998
16 target period shall mean January 1, 1998 through November 30, 1998, the
17 1999 target period shall mean January 1, 1999 through November 30, 1999,
18 the 2000 target period shall mean January 1, 2000 through November 30,
19 2000, the 2001 target period shall mean January 1, 2001 through November
20 30, 2001, the 2002 target period shall mean January 1, 2002 through
21 November 30, 2002, the 2003 target period shall mean January 1, 2003
22 through November 30, 2003, the 2004 target period shall mean January 1,
23 2004 through November 30, 2004, and the 2005 target period shall mean
24 January 1, 2005 through November 30, 2005, the 2006 target period shall
25 mean January 1, 2006 through November 30, 2006, and the 2007 target
26 period shall mean January 1, 2007 through November 30, 2007 and the 2008
27 target period shall mean January 1, 2008 through November 30, 2008, and
28 the 2009 target period shall mean January 1, 2009 through November 30,
29 2009 and the 2010 target period shall mean January 1, 2010 through
30 November 30, 2010 and the 2011 target period shall mean January 1, 2011
31 through November 30, 2011 and the 2012 target period shall mean January
32 1, 2012 through November 30, 2012 and the 2013 target period shall mean
33 January 1, 2013 through November 30, 2013, AND THE 2014 TARGET PERIOD
34 SHALL MEAN JANUARY 1, 2014 THROUGH NOVEMBER 30, 2014 AND THE 2015 TARGET
35 PERIOD SHALL MEAN JANUARY 1, 2015 THROUGH NOVEMBER 30, 2015.

36 2. (a) Prior to February 1, 1997, for each regional group the commis-
37 sioner of health shall calculate the 1996 medicaid revenue percentages
38 for the period commencing August 1, 1996 to the last date for which such
39 data is available and reasonably accurate.

40 (b) Prior to February 1, 1998, prior to February 1, 1999, prior to
41 February 1, 2000, prior to February 1, 2001, prior to February 1, 2002,
42 prior to February 1, 2003, prior to February 1, 2004, prior to February
43 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to
44 February 1, 2008, prior to February 1, 2009, prior to February 1, 2010,
45 prior to February 1, 2011, prior to February 1, 2012 [and], prior to
46 February 1, 2013, PRIOR TO FEBRUARY 1, 2014 AND PRIOR TO FEBRUARY 1,
47 2015 for each regional group the commissioner of health shall calculate
48 the prior year's medicaid revenue percentages for the period commencing
49 January 1 through November 30 of such prior year.

50 3. By September 15, 1996, for each regional group the commissioner of
51 health shall calculate the base period medicaid revenue percentage.

52 4. (a) For each regional group, the 1996 target medicaid revenue
53 percentage shall be calculated by subtracting the 1996 medicaid revenue
54 reduction percentages from the base period medicaid revenue percentages.
55 The 1996 medicaid revenue reduction percentage, taking into account

1 regional and program differences in utilization of medicaid and medicare
2 services, for the following regional groups shall be equal to:

3 (i) one and one-tenth percentage points for CHHAs located within the
4 downstate region;

5 (ii) six-tenths of one percentage point for CHHAs located within the
6 upstate region;

7 (iii) one and eight-tenths percentage points for LTHHCPs located with-
8 in the downstate region; and

9 (iv) one and seven-tenths percentage points for LTHHCPs located within
10 the upstate region.

11 (b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007,
12 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each
13 regional group, the target medicaid revenue percentage for the respec-
14 tive year shall be calculated by subtracting the respective year's medi-
15 caid revenue reduction percentage from the base period medicaid revenue
16 percentage. The medicaid revenue reduction percentages for 1997, 1998,
17 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011,
18 2012, [and] 2013, 2014 AND 2015 taking into account regional and program
19 differences in utilization of medicaid and medicare services, for the
20 following regional groups shall be equal to for each such year:

21 (i) one and one-tenth percentage points for CHHAs located within the
22 downstate region;

23 (ii) six-tenths of one percentage point for CHHAs located within the
24 upstate region;

25 (iii) one and eight-tenths percentage points for LTHHCPs located with-
26 in the downstate region; and

27 (iv) one and seven-tenths percentage points for LTHHCPs located within
28 the upstate region.

29 (c) For each regional group, the 1999 target medicaid revenue percent-
30 age shall be calculated by subtracting the 1999 medicaid revenue
31 reduction percentage from the base period medicaid revenue percentage.
32 The 1999 medicaid revenue reduction percentages, taking into account
33 regional and program differences in utilization of medicaid and medicare
34 services, for the following regional groups shall be equal to:

35 (i) eight hundred twenty-five thousandths (.825) of one percentage
36 point for CHHAs located within the downstate region;

37 (ii) forty-five hundredths (.45) of one percentage point for CHHAs
38 located within the upstate region;

39 (iii) one and thirty-five hundredths percentage points (1.35) for
40 LTHHCPs located within the downstate region; and

41 (iv) one and two hundred seventy-five thousandths percentage points
42 (1.275) for LTHHCPs located within the upstate region.

43 5. (a) For each regional group, if the 1996 medicaid revenue percent-
44 age is not equal to or less than the 1996 target medicaid revenue
45 percentage, the commissioner of health shall compare the 1996 medicaid
46 revenue percentage to the 1996 target medicaid revenue percentage to
47 determine the amount of the shortfall which, when divided by the 1996
48 medicaid revenue reduction percentage, shall be called the 1996
49 reduction factor. These amounts, expressed as a percentage, shall not
50 exceed one hundred percent. If the 1996 medicaid revenue percentage is
51 equal to or less than the 1996 target medicaid revenue percentage, the
52 1996 reduction factor shall be zero.

53 (b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006,
54 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each
55 regional group, if the medicaid revenue percentage for the respective
56 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

1 provider specific basis utilizing revenues for this purpose, expressed
2 as a proportion of the total of each CHHA's and LTHHCP's failure to
3 achieve the 1996 target medicaid revenue percentage within the applica-
4 ble regional group. This proportion shall be multiplied by the applica-
5 ble 1996 state share reduction amount calculation pursuant to paragraph
6 (a) of subdivision 6 of this section. This amount shall be called the
7 1996 provider specific state share reduction amount.

8 (b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006,
9 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each
10 regional group, the state share reduction amount for the respective year
11 shall be allocated by the commissioner of health among CHHAs and LTHHCPs
12 on the basis of the extent of each CHHA's and LTHHCP's failure to
13 achieve the target medicaid revenue percentage for the applicable year,
14 calculated on a provider specific basis utilizing revenues for this
15 purpose, expressed as a proportion of the total of each CHHA's and
16 LTHHCP's failure to achieve the target medicaid revenue percentage for
17 the applicable year within the applicable regional group. This propor-
18 tion shall be multiplied by the applicable year's state share reduction
19 amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of
20 this section. This amount shall be called the provider specific state
21 share reduction amount for the applicable year.

22 8. (a) The 1996 provider specific state share reduction amount shall
23 be due to the state from each CHHA and LTHHCP and may be recouped by the
24 state by March 31, 1997 in a lump sum amount or amounts from payments
25 due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the
26 social services law.

27 (b) The provider specific state share reduction amount for 1997, 1998,
28 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010,
29 2011, 2012, [and] 2013, 2014 AND 2015 respectively, shall be due to the
30 state from each CHHA and LTHHCP and each year the amount due for such
31 year may be recouped by the state by March 31 of the following year in a
32 lump sum amount or amounts from payments due to the CHHA and LTHHCP
33 pursuant to title 11 of article 5 of the social services law.

34 9. CHHAs and LTHHCPs shall submit such data and information at such
35 times as the commissioner of health may require for purposes of this
36 section. The commissioner of health may use data available from third-
37 party payors.

38 10. On or about June 1, 1997, for each regional group the commissioner
39 of health shall calculate for the period August 1, 1996 through March
40 31, 1997 a medicaid revenue percentage, a reduction factor, a state
41 share reduction amount, and a provider specific state share reduction
42 amount in accordance with the methodology provided in paragraph (a) of
43 subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivi-
44 sion 6 and paragraph (a) of subdivision 7 of this section. The provider
45 specific state share reduction amount calculated in accordance with this
46 subdivision shall be compared to the 1996 provider specific state share
47 reduction amount calculated in accordance with paragraph (a) of subdivi-
48 sion 7 of this section. Any amount in excess of the amount determined in
49 accordance with paragraph (a) of subdivision 7 of this section shall be
50 due to the state from each CHHA and LTHHCP and may be recouped in
51 accordance with paragraph (a) of subdivision 8 of this section. If the
52 amount is less than the amount determined in accordance with paragraph
53 (a) of subdivision 7 of this section, the difference shall be refunded
54 to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs
55 and LTHHCPs shall submit data for the period August 1, 1996 through
56 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 medicated 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

1 thousand five, through December thirty-first, two thousand five, and for
2 the period January first, two thousand six through March thirty-first,
3 two thousand seven, and on and after April first, two thousand seven
4 through March thirty-first, two thousand nine, and on and after April
5 first, two thousand nine through March thirty-first, two thousand elev-
6 en, and on and after April first, two thousand eleven through March
7 thirty-first, two thousand thirteen AND ON AND AFTER APRIL FIRST, TWO
8 THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, the
9 reimbursable base year administrative and general costs of a provider of
10 services shall not exceed the statewide average of total reimbursable
11 base year administrative and general costs of such providers of
12 services.

13 S 19. Intentionally omitted.

14 S 20. Subdivision 6-a of section 93 of part C of chapter 58 of the
15 laws of 2007 amending the social services law and the public health law
16 relating to adjustments of rates, as amended by section 40 of part D of
17 chapter 58 of the laws of 2009, is amended to read as follows:

18 6-a. section fifty-seven of this act shall expire and be deemed
19 repealed on December 31, [2013] 2018; provided that the amendments made
20 by such section to subdivision 4 of section 366-c of the social services
21 law shall apply with respect to determining initial and continuing
22 eligibility for medical assistance, including the continued eligibility
23 of recipients originally determined eligible prior to the effective date
24 of this act, and provided further that such amendments shall not apply
25 to any person or group of persons if it is subsequently determined by
26 the Centers for Medicare and Medicaid services or by a court of compe-
27 tent jurisdiction that medical assistance with federal financial partic-
28 ipation is available for the costs of services provided to such person
29 or persons under the provisions of subdivision 4 of section 366-c of the
30 social services law in effect immediately prior to the effective date of
31 this act.

32 S 21. Subdivision 12 of section 246 of chapter 81 of the laws of 1995,
33 amending the public health law and other laws relating to medical
34 reimbursement and welfare reform, as amended by section 23 of part D of
35 chapter 59 of the laws of 2011, is amended to read as follows:

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

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

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

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

48 S 5. This act shall take effect immediately, provided however that the
49 provisions of this act shall remain in full force and effect until March
50 31, [2013] 2018 at which time the provisions of this act shall be deemed
51 to be repealed.

52 S 24. Subparagraph (ii) of paragraph (c) of subdivision 11 of section
53 230 of the public health law, as amended by chapter 36 of the laws of
54 2008, is amended to read as follows:

55 (ii) Participation and membership during a three year demonstration
56 period in a physician committee of the Medical Society of the State of

1 New York or the New York State Osteopathic Society whose purpose is to
2 confront and refer to treatment physicians who are thought to be suffer-
3 ing from alcoholism, drug abuse or mental illness. Such demonstration
4 period shall commence on April first, nineteen hundred eighty and termi-
5 nate on May thirty-first, nineteen hundred eighty-three. An additional
6 demonstration period shall commence on June first, nineteen hundred
7 eighty-three and terminate on March thirty-first, nineteen hundred
8 eighty-six. An additional demonstration period shall commence on April
9 first, nineteen hundred eighty-six and terminate on March thirty-first,
10 nineteen hundred eighty-nine. An additional demonstration period shall
11 commence April first, nineteen hundred eighty-nine and terminate March
12 thirty-first, nineteen hundred ninety-two. An additional demonstration
13 period shall commence April first, nineteen hundred ninety-two and
14 terminate March thirty-first, nineteen hundred ninety-five. An addi-
15 tional demonstration period shall commence on April first, nineteen
16 hundred ninety-five and terminate on March thirty-first, nineteen
17 hundred ninety-eight. An additional demonstration period shall commence
18 on April first, nineteen hundred ninety-eight and terminate on March
19 thirty-first, two thousand three. An additional demonstration period
20 shall commence on April first, two thousand three and terminate on March
21 thirty-first, two thousand thirteen[;]. AN ADDITIONAL DEMONSTRATION
22 PERIOD SHALL COMMENCE APRIL FIRST, TWO THOUSAND THIRTEEN AND TERMINATE
23 ON MARCH THIRTY-FIRST, TWO THOUSAND EIGHTEEN provided, however, that the
24 commissioner may prescribe requirements for the continuation of such
25 demonstration program, including periodic reviews of such programs and
26 submission of any reports and data necessary to permit such reviews.
27 During these additional periods, the provisions of this subparagraph
28 shall also apply to a physician committee of a county medical society.

29 S 25. Section 4 of part X2 of chapter 62 of the laws of 2003, amending
30 the public health law relating to allowing for the use of funds of the
31 office of professional medical conduct for activities of the patient
32 health information and quality improvement act of 2000, as amended by
33 section 27 of part A of chapter 59 of the laws of 2011, is amended to
34 read as follows:

35 S 4. This act shall take effect immediately; provided that the
36 provisions of section one of this act shall be deemed to have been in
37 full force and effect on and after April 1, 2003, and shall expire March
38 31, [2013] 2015 when upon such date the provisions of such section shall
39 be deemed repealed.

40 S 25-a. Section 3 of chapter 906 of the laws of 1984, amending the
41 social services law relating to expanding medical assistance eligibility
42 and the scope of services available to certain persons with disabili-
43 ties, as amended by section 69-a of part C of chapter 58 of the laws of
44 2008, is amended to read as follows:

45 S 3. This act shall take effect on the thirtieth day after it shall
46 have become a law and shall be of no further force and effect after
47 December 31, [2013] 2018, at which time the provisions of this act shall
48 be deemed to be repealed.

49 S 26. Notwithstanding any inconsistent provision of law, rule or regu-
50 lation, the effectiveness of the provisions of sections 2807 and 3614 of
51 the public health law, section 18 of chapter 2 of the laws of 1988, and
52 18 NYCRR 505.14(h), as they relate to time frames for notice, approval
53 or certification of rates of payment, are hereby suspended and without
54 force or effect for purposes of implementing the provisions of this act.

55 S 27. Severability clause. If any clause, sentence, paragraph, subdi-
56 vision, 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 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

1 THAN THE PERCENTAGES, AS SPECIFIED IN CLAUSE (C) OF THIS SUBPARAGRAPH AS
2 COMPARED TO THE AVERAGE DISTRIBUTION THAT EACH SUCH FACILITY RECEIVED
3 FOR THE THREE CALENDAR YEARS PRIOR TO TWO THOUSAND THIRTEEN PURSUANT TO
4 THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE.

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

12 (C) NO FACILITY SHALL EXPERIENCE A REDUCTION IN INDIGENT CARE POOL
13 PAYMENTS PURSUANT TO THIS SUBDIVISION THAT: FOR THE CALENDAR YEAR BEGIN-
14 NING JANUARY FIRST, TWO THOUSAND THIRTEEN, IS GREATER THAN TWO AND ONE-
15 HALF PERCENT; FOR THE CALENDAR YEAR BEGINNING JANUARY FIRST, TWO THOU-
16 SAND FOURTEEN, IS GREATER THAN FIVE PERCENT; AND, FOR THE CALENDAR YEAR
17 BEGINNING ON JANUARY FIRST, TWO THOUSAND FIFTEEN, IS GREATER THAN SEVEN
18 AND ONE-HALF PERCENT.

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

29 (C) THE COMMISSIONER SHALL ANNUALLY REPORT TO THE GOVERNOR AND THE
30 LEGISLATURE ON THE DISTRIBUTION OF FUNDS UNDER THIS SUBDIVISION INCLUD-
31 ING, BUT NOT LIMITED TO:

32 (I) THE IMPACT ON SAFETY NET PROVIDERS, INCLUDING COMMUNITY PROVIDERS,
33 RURAL GENERAL HOSPITALS AND MAJOR PUBLIC GENERAL HOSPITALS;

34 (II) THE PROVISION OF INDIGENT CARE BY UNITS OF SERVICES AND FUNDS
35 DISTRIBUTED BY GENERAL HOSPITALS; AND

36 (III) THE EXTENT TO WHICH ACCESS TO CARE HAS BEEN ENHANCED.

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

39 14-f. Public general hospital indigent care adjustment. Notwithstand-
40 ing any inconsistent provision of this section AND SUBJECT TO THE AVAIL-
41 ABILITY OF FEDERAL FINANCIAL PARTICIPATION, payment for inpatient hospi-
42 tal services for persons eligible for payments made by state
43 governmental agencies for the period January first, nineteen hundred
44 ninety-seven through December thirty-first, nineteen hundred ninety-nine
45 and periods on and after January first, two thousand applicable to
46 patients eligible for federal financial participation under title XIX of
47 the federal social security act in medical assistance provided pursuant
48 to title eleven of article five of the social services law determined in
49 accordance with this section shall include for eligible public general
50 hospitals a public general hospital indigent care adjustment equal to
51 the aggregate amount of the adjustments provided for such public general
52 hospital for the period January first, nineteen hundred ninety-six
53 through December thirty-first, nineteen hundred ninety-six pursuant to
54 subdivisions fourteen-a and fourteen-d of this section on an annualized
55 basis, [provided all federal approvals necessary by federal law and
56 regulation for federal financial participation in payments made for

1 beneficiaries eligible for medical assistance under title XIX of the
2 federal social security act based upon the adjustment provided herein as
3 a component of such payments are granted] PROVIDED, HOWEVER, THAT FOR
4 PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN AN ANNUAL
5 AMOUNT OF FOUR HUNDRED TWELVE MILLION DOLLARS SHALL BE ALLOCATED TO
6 ELIGIBLE MAJOR PUBLIC HOSPITALS BASED ON EACH HOSPITAL'S PROPORTIONATE
7 SHARE OF MEDICAID AND UNINSURED LOSSES TO TOTAL MEDICAID AND UNINSURED
8 LOSSES FOR ALL ELIGIBLE MAJOR PUBLIC HOSPITALS, NET OF ANY DISPROPOR-
9 TIONATE SHARE HOSPITAL PAYMENTS RECEIVED PURSUANT TO SECTIONS
10 TWENTY-EIGHT HUNDRED SEVEN-K AND TWENTY-EIGHT HUNDRED SEVEN-W OF THIS
11 ARTICLE. The adjustment may be made to rates of payment or as aggregate
12 payments to an eligible hospital.

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

16 (i) Notwithstanding any provision of law to the contrary, rates of
17 payment by governmental agencies for general hospital outpatient
18 services, general hospital emergency services and ambulatory surgical
19 services provided by a general hospital established pursuant to para-
20 graphs (a), (c) and (d) of this subdivision shall result in an aggregate
21 increase in such rates of payment of fifty-six million dollars for the
22 period December first, two thousand eight through March thirty-first,
23 two thousand nine and one hundred seventy-eight million dollars for
24 periods after April first, two thousand nine, THROUGH MARCH
25 THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND ONE HUNDRED FIFTY-THREE MILLION
26 DOLLARS FOR STATE FISCAL YEAR PERIODS ON AND AFTER APRIL FIRST, TWO
27 THOUSAND THIRTEEN, provided, however, that for periods on and after
28 April first, two thousand nine, such amounts may be adjusted to reflect
29 projected decreases in fee-for-service Medicaid utilization and changes
30 in case-mix with regard to such services from the two thousand seven
31 calendar year to the applicable rate year, and provided further, howev-
32 er, that funds made available as a result of any such decreases may be
33 utilized by the commissioner to increase capitation rates paid to Medi-
34 caid managed care plans and family health plus plans to cover increased
35 payments to health care providers for ambulatory care services and to
36 increase such other ambulatory care payment rates as the commissioner
37 determines necessary to facilitate access to quality ambulatory care
38 services.

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

43 Notwithstanding any inconsistent provision of this subdivision or any
44 other contrary provision of law and subject to the availability of
45 federal financial participation, for the period July first, two thousand
46 ten through March thirty-first, two thousand eleven, and each state
47 fiscal year period thereafter, the commissioner shall make additional
48 inpatient hospital payments up to the aggregate upper payment limit for
49 inpatient hospital services after all other medical assistance payments,
50 but not to exceed two hundred thirty-five million five hundred thousand
51 dollars for the period July first, two thousand ten through March thir-
52 ty-first, two thousand eleven [and], three hundred fourteen million
53 dollars for each state fiscal year BEGINNING APRIL FIRST, TWO THOUSAND
54 ELEVEN, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND NO LESS
55 THAN THREE HUNDRED THIRTY-NINE MILLION DOLLARS FOR EACH STATE FISCAL
56 YEAR thereafter, to general hospitals, other than major public general

1 hospitals, providing emergency room services and including safety net
2 hospitals, which shall, for the purpose of this paragraph, be defined as
3 having either: a Medicaid share of total inpatient hospital discharges
4 of at least thirty-five percent, including both fee-for-service and
5 managed care discharges for acute and exempt services; or a Medicaid
6 share of total discharges of at least thirty percent, including both
7 fee-for-service and managed care discharges for acute and exempt
8 services, and also providing obstetrical services. Eligibility to
9 receive such additional payments shall be based on data from the period
10 two years prior to the rate year, as reported on the institutional cost
11 report submitted to the department as of October first of the prior rate
12 year. Such payments shall be made as medical assistance payments for
13 fee-for-service inpatient hospital services pursuant to title eleven of
14 article five of the social services law for patients eligible for federal
15 financial participation under title XIX of the federal social security
16 act and in accordance with the following:

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

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

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

25

PART D

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

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

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

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

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

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

40 (3) "FAMILY SIZE" MEANS THE NUMBER OF PERSONS COUNTED AS MEMBERS OF AN
41 INDIVIDUAL'S HOUSEHOLD; WITH RESPECT TO INDIVIDUALS WHOSE MEDICAL
42 ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, IN
43 DETERMINING THE FAMILY SIZE OF A PREGNANT WOMAN, OR OF OTHER INDIVIDUALS
44 WHO HAVE A PREGNANT WOMAN IN THEIR HOUSEHOLD, THE PREGNANT WOMAN IS
45 COUNTED AS HERSELF PLUS THE NUMBER OF CHILDREN SHE IS EXPECTED TO DELIVER;
46

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

49 (5) "HOUSEHOLD", FOR PURPOSES OF DETERMINING THE FINANCIAL ELIGIBILITY
50 OF INDIVIDUALS WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED
51 ADJUSTED GROSS INCOME, SHALL MEAN:

52 (I) BASIC RULE FOR TAXPAYERS NOT CLAIMED AS A TAX DEPENDENT. IN THE
53 CASE OF AN INDIVIDUAL WHO EXPECTS TO FILE A TAX RETURN FOR THE TAXABLE
54 YEAR IN WHICH AN INITIAL DETERMINATION OR RENEWAL OF ELIGIBILITY IS

1 BEING MADE, AND WHO DOES NOT EXPECT TO BE CLAIMED AS A TAX DEPENDENT BY
2 ANOTHER TAXPAYER, THE HOUSEHOLD CONSISTS OF THE TAXPAYER AND, SUBJECT TO
3 CLAUSE (V) OF THIS SUBPARAGRAPH, ALL PERSONS WHOM SUCH INDIVIDUAL
4 EXPECTS TO CLAIM AS A TAX DEPENDENT;

5 (II) BASIC RULE FOR INDIVIDUALS CLAIMED AS A TAX DEPENDENT. IN THE
6 CASE OF AN INDIVIDUAL WHO EXPECTS TO BE CLAIMED AS A TAX DEPENDENT BY
7 ANOTHER TAXPAYER FOR THE TAXABLE YEAR IN WHICH AN INITIAL DETERMINATION
8 OR RENEWAL OF ELIGIBILITY IS BEING MADE, THE HOUSEHOLD IS THE HOUSEHOLD
9 OF THE TAXPAYER CLAIMING SUCH INDIVIDUAL AS A TAX DEPENDENT, EXCEPT THAT
10 THE HOUSEHOLD MUST BE DETERMINED IN ACCORDANCE WITH CLAUSE (III) OF THIS
11 SUBPARAGRAPH IN THE CASE OF:

12 (A) INDIVIDUALS OTHER THAN A SPOUSE OR CHILD WHO EXPECT TO BE CLAIMED
13 AS A TAX DEPENDENT BY ANOTHER TAXPAYER; AND

14 (B) INDIVIDUALS UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS
15 OF AGE IF A FULL-TIME STUDENT, WHO EXPECT TO BE CLAIMED BY ONE PARENT AS
16 A TAX DEPENDENT AND ARE LIVING WITH BOTH PARENTS BUT WHOSE PARENTS DO
17 NOT EXPECT TO FILE A JOINT TAX RETURN; AND

18 (C) INDIVIDUALS UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS
19 OF AGE IF A FULL-TIME STUDENT, WHO EXPECT TO BE CLAIMED AS A TAX DEPEND-
20 ENT BY A NON-CUSTODIAL PARENT. FOR PURPOSES OF THIS SUBCLAUSE:

21 (1) A COURT ORDER OR BINDING SEPARATION, DIVORCE, OR CUSTODY AGREEMENT
22 ESTABLISHING PHYSICAL CUSTODY CONTROLS; OR

23 (2) IF THERE IS NO SUCH ORDER OR AGREEMENT OR IN THE EVENT OF A SHARED
24 CUSTODY AGREEMENT, THE CUSTODIAL PARENT IS THE PARENT WITH WHOM THE
25 CHILD SPENDS MOST NIGHTS;

26 (III) RULES FOR INDIVIDUALS WHO NEITHER FILE A TAX RETURN NOR ARE
27 CLAIMED AS A TAX DEPENDENT. IN THE CASE OF INDIVIDUALS WHO DO NOT EXPECT
28 TO FILE A FEDERAL TAX RETURN AND DO NOT EXPECT TO BE CLAIMED AS A TAX
29 DEPENDENT FOR THE TAXABLE YEAR IN WHICH AN INITIAL DETERMINATION OR
30 RENEWAL OF ELIGIBILITY IS BEING MADE, OR WHO ARE DESCRIBED IN SUBCLAUSES
31 (A), (B), OR (C) OF CLAUSE (II) OF THIS SUBPARAGRAPH, THE HOUSEHOLD
32 CONSISTS OF THE INDIVIDUAL AND, IF LIVING WITH THE INDIVIDUAL:

33 (A) THE INDIVIDUAL'S SPOUSE;

34 (B) THE INDIVIDUAL'S CHILDREN UNDER NINETEEN YEARS OF AGE, OR UNDER
35 TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT; AND

36 (C) IN THE CASE OF AN INDIVIDUAL UNDER NINETEEN YEARS OF AGE, OR UNDER
37 TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT, THE INDIVIDUAL'S PARENTS
38 AND THE INDIVIDUAL'S SIBLINGS UNDER NINETEEN YEARS OF AGE, OR UNDER
39 TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT;

40 (IV) MARRIED COUPLES. IN THE CASE OF A MARRIED COUPLE LIVING TOGETHER,
41 EACH SPOUSE WILL BE INCLUDED IN THE HOUSEHOLD OF THE OTHER SPOUSE,
42 REGARDLESS OF WHETHER THEY EXPECT TO FILE A JOINT TAX RETURN UNDER
43 SECTION SIX THOUSAND THIRTEEN OF THE INTERNAL REVENUE CODE OR WHETHER
44 ONE SPOUSE EXPECTS TO BE CLAIMED AS A TAX DEPENDENT BY THE OTHER SPOUSE.

45 (V) FOR PURPOSES OF CLAUSE (I) OF THIS SUBPARAGRAPH, IF A TAXPAYER
46 CANNOT REASONABLY ESTABLISH THAT ANOTHER INDIVIDUAL IS A TAX DEPENDENT
47 OF THE TAXPAYER FOR THE TAX YEAR IN WHICH MEDICAID IS SOUGHT, THE INCLU-
48 SION OF SUCH INDIVIDUAL IN THE HOUSEHOLD OF THE TAXPAYER IS DETERMINED
49 IN ACCORDANCE WITH CLAUSE (III) OF THIS SUBPARAGRAPH.

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

51 (7) "MAGI-BASED INCOME" MEANS INCOME CALCULATED USING THE SAME METHOD-
52 OLOGIES USED TO DETERMINE MAGI UNDER SECTION 36B(D)(2)(B) OF THE INTER-
53 NAL REVENUE CODE, WITH THE EXCEPTION OF LUMP SUM PAYMENTS, CERTAIN
54 EDUCATIONAL SCHOLARSHIPS, AND CERTAIN AMERICAN INDIAN AND ALASKA NATIVE
55 INCOME, AS SPECIFIED BY THE COMMISSIONER OF HEALTH CONSISTENT WITH
56 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

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

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

21 (6) AN INDIVIDUAL WHO IS NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE
22 UNDER THIS SECTION IS ELIGIBLE FOR COVERAGE OF FAMILY PLANNING SERVICES
23 REIMBURSED BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT, AND
24 FOR COVERAGE OF THOSE SERVICES IDENTIFIED BY THE COMMISSIONER OF HEALTH
25 AS SERVICES GENERALLY PERFORMED AS PART OF OR AS A FOLLOW-UP TO A
26 SERVICE ELIGIBLE FOR SUCH NINETY PERCENT REIMBURSEMENT, INCLUDING TREAT-
27 MENT FOR SEXUALLY TRANSMITTED DISEASES, IF HIS OR HER INCOME DOES NOT
28 EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY
29 LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN
30 ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES
31 DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

38 (7-A) AN INDIVIDUAL IS ELIGIBLE FOR BENCHMARK COVERAGE IF HIS OR HER
39 MAGI HOUSEHOLD INCOME EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE
40 FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE AND HE OR SHE:

41 (I) WAS ELIGIBLE OR WOULD HAVE BEEN ELIGIBLE FOR THE FAMILY HEALTH
42 PLUS PROGRAM WITHOUT FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF
43 MEDICAL CARE AND SERVICES UNDER SUCH PROGRAM; AND

44 (II) IS NOT ELIGIBLE TO ENROLL IN A QUALIFIED HEALTH PLAN OFFERED
45 THROUGH THE STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE
46 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS
47 AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF
48 2010 (P.L. 111-152).

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

54 (1) AN INDIVIDUAL RECEIVING OR ELIGIBLE TO RECEIVE FEDERAL SUPPLE-
55 MENTAL SECURITY INCOME PAYMENTS AND/OR ADDITIONAL STATE PAYMENTS PURSU-
56 ANT TO TITLE SIX OF THIS ARTICLE; ANY INCONSISTENT PROVISION OF THIS

1 CHAPTER OR OTHER LAW NOTWITHSTANDING, THE DEPARTMENT MAY DESIGNATE THE
2 OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE AS ITS AGENT TO DISCHARGE
3 ITS RESPONSIBILITY, OR SO MUCH OF ITS RESPONSIBILITY AS IS PERMITTED BY
4 FEDERAL LAW, FOR DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE WITH
5 RESPECT TO PERSONS WHO ARE NOT ELIGIBLE TO RECEIVE FEDERAL SUPPLEMENTAL
6 SECURITY INCOME PAYMENTS BUT WHO ARE RECEIVING A STATE ADMINISTERED
7 SUPPLEMENTARY PAYMENT OR MANDATORY MINIMUM SUPPLEMENT IN ACCORDANCE WITH
8 THE PROVISIONS OF SUBDIVISION ONE OF SECTION TWO HUNDRED TWELVE OF THIS
9 ARTICLE.

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

18 (3) AN INDIVIDUAL WHO, ALTHOUGH NOT RECEIVING PUBLIC ASSISTANCE OR
19 CARE FOR HIS OR HER MAINTENANCE UNDER OTHER PROVISIONS OF THIS CHAPTER,
20 HAS INCOME, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE RELATIVES, THAT
21 DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION
22 TWO OF THIS SECTION, AND IS (I) UNDER THE AGE OF TWENTY-ONE YEARS, OR
23 (II) A SPOUSE OF A CASH PUBLIC ASSISTANCE RECIPIENT LIVING WITH HIM OR
24 HER AND ESSENTIAL OR NECESSARY TO HIS OR HER WELFARE AND WHOSE NEEDS ARE
25 TAKEN INTO ACCOUNT IN DETERMINING THE AMOUNT OF HIS OR HER CASH PAYMENT,
26 OR (III) FOR REASONS OTHER THAN INCOME, WOULD MEET THE ELIGIBILITY
27 REQUIREMENTS OF THE AID TO DEPENDENT CHILDREN PROGRAM AS IT EXISTED ON
28 THE SIXTEENTH DAY OF JULY, NINETEEN HUNDRED NINETY-SIX.

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

31 (5) A DISABLED INDIVIDUAL AT LEAST SIXTEEN YEARS OF AGE, BUT UNDER THE
32 AGE OF SIXTY-FIVE, WHO: WOULD BE ELIGIBLE FOR BENEFITS UNDER THE
33 SUPPLEMENTAL SECURITY INCOME PROGRAM BUT FOR EARNINGS IN EXCESS OF THE
34 ALLOWABLE LIMIT; HAS NET AVAILABLE INCOME THAT DOES NOT EXCEED TWO
35 HUNDRED FIFTY PERCENT OF THE APPLICABLE FEDERAL INCOME OFFICIAL POVERTY
36 LINE, AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH
37 AND HUMAN SERVICES, FOR A ONE-PERSON OR TWO-PERSON HOUSEHOLD, AS DEFINED
38 BY THE COMMISSIONER IN REGULATION; HAS HOUSEHOLD RESOURCES, AS DEFINED
39 IN PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SIX-C
40 OF THIS TITLE, OTHER THAN RETIREMENT ACCOUNTS, THAT DO NOT EXCEED TWENTY
41 THOUSAND DOLLARS FOR A ONE-PERSON HOUSEHOLD OR THIRTY THOUSAND DOLLARS
42 FOR A TWO-PERSON HOUSEHOLD, AS DEFINED BY THE COMMISSIONER IN REGU-
43 LATION; AND CONTRIBUTES TO THE COST OF MEDICAL ASSISTANCE PROVIDED
44 PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH SUBDIVISION TWELVE OF
45 SECTION THREE HUNDRED SIXTY-SEVEN-A OF THIS TITLE; FOR PURPOSES OF THIS
46 SUBPARAGRAPH, DISABLED MEANS HAVING A MEDICALLY DETERMINABLE IMPAIRMENT
47 OF SUFFICIENT SEVERITY AND DURATION TO QUALIFY FOR BENEFITS UNDER
48 SECTION 1902(A)(10)(A)(II)(XV) OF THE SOCIAL SECURITY ACT.

49 (6) AN INDIVIDUAL AT LEAST SIXTEEN YEARS OF AGE, BUT UNDER THE AGE OF
50 SIXTY-FIVE, WHO: IS EMPLOYED; CEASES TO BE IN RECEIPT OF MEDICAL ASSIST-
51 ANCE UNDER SUBPARAGRAPH FIVE OF THIS PARAGRAPH BECAUSE THE PERSON, BY
52 REASON OF MEDICAL IMPROVEMENT, IS DETERMINED AT THE TIME OF A REGULARLY
53 SCHEDULED CONTINUING DISABILITY REVIEW TO NO LONGER BE ELIGIBLE FOR
54 SUPPLEMENTAL SECURITY INCOME PROGRAM BENEFITS OR DISABILITY INSURANCE
55 BENEFITS UNDER THE SOCIAL SECURITY ACT; CONTINUES TO HAVE A SEVERE
56 MEDICALLY DETERMINABLE IMPAIRMENT, TO BE DETERMINED IN ACCORDANCE WITH

1 APPLICABLE FEDERAL REGULATIONS; AND CONTRIBUTES TO THE COST OF MEDICAL
2 ASSISTANCE PROVIDED PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH
3 SUBDIVISION TWELVE OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THIS TITLE;
4 FOR PURPOSES OF THIS SUBPARAGRAPH, A PERSON IS CONSIDERED TO BE EMPLOYED
5 IF THE PERSON IS EARNING AT LEAST THE APPLICABLE MINIMUM WAGE UNDER
6 SECTION SIX OF THE FEDERAL FAIR LABOR STANDARDS ACT AND WORKING AT LEAST
7 FORTY HOURS PER MONTH; OR

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

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

16 (9) AN INDIVIDUAL WHO:

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

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

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

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

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

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

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

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

49 (3) COOPERATES WITH THE APPROPRIATE SOCIAL SERVICES OFFICIAL OR THE
50 DEPARTMENT IN ESTABLISHING PATERNITY OR IN ESTABLISHING, MODIFYING, OR
51 ENFORCING A SUPPORT ORDER WITH RESPECT TO HIS OR HER CHILD; PROVIDED,
52 HOWEVER, THAT NOTHING HEREIN CONTAINED SHALL BE CONSTRUED TO REQUIRE A
53 PAYMENT UNDER THIS TITLE FOR CARE OR SERVICES, THE COST OF WHICH MAY BE
54 MET IN WHOLE OR IN PART BY A THIRD PARTY; NOTWITHSTANDING THE FOREGOING,
55 A SOCIAL SERVICES OFFICIAL SHALL NOT REQUIRE SUCH COOPERATION IF THE
56 SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT DETERMINES THAT SUCH ACTIONS

1 WOULD BE DETRIMENTAL TO THE BEST INTEREST OF THE CHILD, APPLICANT, OR
2 RECIPIENT, OR WITH RESPECT TO PREGNANT WOMEN DURING PREGNANCY AND DURING
3 THE SIXTY-DAY PERIOD BEGINNING ON THE LAST DAY OF PREGNANCY, IN ACCORD-
4 ANCE WITH PROCEDURES AND CRITERIA ESTABLISHED BY REGULATIONS OF THE
5 DEPARTMENT CONSISTENT WITH FEDERAL LAW; AND

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

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

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

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

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

34 4. SPECIAL ELIGIBILITY PROVISIONS.

35 (A) TRANSITIONAL MEDICAL ASSISTANCE.

36 (1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, EACH FAMILY WHICH WAS
37 ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARA-
38 GRAPH (B) OF SUBDIVISION ONE OF THIS SECTION IN AT LEAST ONE OF THE SIX
39 MONTHS IMMEDIATELY PRECEDING THE MONTH IN WHICH SUCH FAMILY BECAME INEL-
40 IGIBLE FOR SUCH ASSISTANCE BECAUSE OF INCOME FROM THE EMPLOYMENT OF THE
41 CARETAKER RELATIVE SHALL, WHILE SUCH FAMILY INCLUDES A DEPENDENT CHILD,
42 REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE FOR TWELVE CALENDAR MONTHS IMME-
43 DIATELY FOLLOWING THE MONTH IN WHICH SUCH FAMILY WOULD OTHERWISE BE
44 DETERMINED TO BE INELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THE
45 PROVISIONS OF THIS TITLE AND THE REGULATIONS OF THE DEPARTMENT GOVERNING
46 INCOME AND RESOURCE LIMITATIONS RELATING TO ELIGIBILITY DETERMINATIONS
47 FOR FAMILIES DESCRIBED IN SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVI-
48 SION ONE OF THIS SECTION.

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

54 (II) THE DEPARTMENT SHALL PROMULGATE REGULATIONS IMPLEMENTING THE
55 REQUIREMENTS OF THIS SUBPARAGRAPH AND SUBPARAGRAPH ONE OF THIS PARAGRAPH
56 RELATING TO THE CONDITIONS UNDER WHICH EXTENDED COVERAGE HEREUNDER MAY

1 BE TERMINATED, THE SCOPE OF COVERAGE, AND THE CONDITIONS UNDER WHICH
2 COVERAGE MAY BE EXTENDED PENDING A REDETERMINATION OF ELIGIBILITY. SUCH
3 REGULATIONS SHALL, AT A MINIMUM, PROVIDE FOR: TERMINATION OF SUCH COVER-
4 AGE AT THE CLOSE OF THE FIRST MONTH IN WHICH THE FAMILY CEASES TO
5 INCLUDE A DEPENDENT CHILD; NOTICE OF TERMINATION PRIOR TO THE EFFECTIVE
6 DATE OF ANY TERMINATIONS; COVERAGE UNDER EMPLOYEE HEALTH PLANS AND
7 HEALTH MAINTENANCE ORGANIZATIONS; AND DISQUALIFICATION OF PERSONS FOR
8 EXTENDED COVERAGE BENEFITS UNDER THIS PARAGRAPH FOR FRAUD.

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

20 (B) PREGNANT WOMEN AND CHILDREN.

21 (1) A PREGNANT WOMAN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUBPARA-
22 GRAPH TWO OR FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION ON
23 ANY DAY OF HER PREGNANCY WILL CONTINUE TO BE ELIGIBLE FOR SUCH CARE AND
24 SERVICES THROUGH THE END OF THE MONTH IN WHICH THE SIXTIETH DAY FOLLOW-
25 ING THE END OF THE PREGNANCY OCCURS, WITHOUT REGARD TO ANY CHANGE IN THE
26 INCOME OF THE FAMILY THAT INCLUDES THE PREGNANT WOMAN, EVEN IF SUCH
27 CHANGE OTHERWISE WOULD HAVE RENDERED HER INELIGIBLE FOR MEDICAL ASSIST-
28 ANCE.

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

36 (3) A CHILD UNDER THE AGE OF NINETEEN WHO IS DETERMINED ELIGIBLE FOR
37 MEDICAL ASSISTANCE UNDER THE PROVISIONS OF THIS SECTION, SHALL, CONSIST-
38 ENT WITH APPLICABLE FEDERAL REQUIREMENTS, REMAIN ELIGIBLE FOR SUCH
39 ASSISTANCE UNTIL THE EARLIER OF:

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

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

44 (4) AN INFANT ELIGIBLE UNDER SUBPARAGRAPH TWO OR FOUR OF PARAGRAPH (B)
45 OF SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY
46 IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE
47 THE CHILD ATTAINS ONE YEAR OF AGE, AND WHO, BUT FOR ATTAINING SUCH AGE,
48 WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPH,
49 SHALL CONTINUE TO REMAIN ELIGIBLE UNTIL THE END OF THE STAY FOR WHICH
50 IN-PATIENT SERVICES ARE BEING FURNISHED.

51 (5) A CHILD ELIGIBLE UNDER SUBPARAGRAPH THREE OF PARAGRAPH (B) OF
52 SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY
53 IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE
54 THE CHILD ATTAINS NINETEEN YEARS OF AGE, AND WHO, BUT FOR ATTAINING SUCH
55 AGE, WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH,

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

3 (6) A WOMAN WHO WAS PREGNANT WHILE IN RECEIPT OF MEDICAL ASSISTANCE
4 WHO SUBSEQUENTLY LOSES HER ELIGIBILITY FOR MEDICAL ASSISTANCE SHALL HAVE
5 HER ELIGIBILITY FOR MEDICAL ASSISTANCE CONTINUED FOR A PERIOD OF TWEN-
6 TY-FOUR MONTHS FROM THE END OF THE MONTH IN WHICH THE SIXTIETH DAY
7 FOLLOWING THE END OF HER PREGNANCY OCCURS, BUT ONLY FOR FEDERAL TITLE X
8 SERVICES WHICH ARE ELIGIBLE FOR REIMBURSEMENT BY THE FEDERAL GOVERNMENT
9 AT A RATE OF NINETY PERCENT; PROVIDED, HOWEVER, THAT SUCH NINETY PERCENT
10 LIMITATION SHALL NOT APPLY TO THOSE SERVICES IDENTIFIED BY THE COMMIS-
11 SIONER AS SERVICES, INCLUDING TREATMENT FOR SEXUALLY TRANSMITTED
12 DISEASES, GENERALLY PERFORMED AS PART OF OR AS A FOLLOW-UP TO A SERVICE
13 ELIGIBLE FOR SUCH NINETY PERCENT REIMBURSEMENT; AND PROVIDED FURTHER,
14 HOWEVER, THAT NOTHING IN THIS PARAGRAPH SHALL BE DEEMED TO AFFECT
15 PAYMENT FOR SUCH TITLE X SERVICES IF FEDERAL FINANCIAL PARTICIPATION IS
16 NOT AVAILABLE FOR SUCH CARE, SERVICES AND SUPPLIES.

17 (C) CONTINUOUS COVERAGE FOR ADULTS. NOTWITHSTANDING ANY OTHER
18 PROVISION OF LAW, A PERSON WHOSE ELIGIBILITY FOR MEDICAL ASSISTANCE IS
19 BASED ON THE MODIFIED ADJUSTED GROSS INCOME OF THE PERSON OR THE
20 PERSON'S HOUSEHOLD, AND WHO LOSES ELIGIBILITY FOR SUCH ASSISTANCE FOR A
21 REASON OTHER THAN CITIZENSHIP STATUS, LACK OF STATE RESIDENCE, OR FAIL-
22 URE TO PROVIDE A VALID SOCIAL SECURITY NUMBER, BEFORE THE END OF A
23 TWELVE MONTH PERIOD BEGINNING ON THE EFFECTIVE DATE OF THE PERSON'S
24 INITIAL ELIGIBILITY FOR SUCH ASSISTANCE, OR BEFORE THE END OF A TWELVE
25 MONTH PERIOD BEGINNING ON THE DATE OF ANY SUBSEQUENT DETERMINATION OF
26 ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME, SHALL HAVE HIS OR
27 HER ELIGIBILITY FOR SUCH ASSISTANCE CONTINUED UNTIL THE END OF SUCH
28 TWELVE MONTH PERIOD, PROVIDED THAT FEDERAL FINANCIAL PARTICIPATION IN
29 THE COSTS OF SUCH ASSISTANCE IS AVAILABLE.

30 (D) BREAST AND CERVICAL CANCER TREATMENT.

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

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

45 (II) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS
46 WHO MEET THE REQUIREMENTS OF CLAUSE (I) OF THIS SUBPARAGRAPH BUT FOR
47 THEIR AGE AND/OR GENDER, WHO HAVE BEEN SCREENED FOR BREAST AND/OR CERI-
48 CAL CANCER UNDER THE PROGRAM DESCRIBED IN TITLE ONE-A OF ARTICLE TWEN-
49 TY-FOUR OF THE PUBLIC HEALTH LAW AND NEED TREATMENT FOR BREAST OR CERI-
50 CAL CANCER, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS
51 DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT; PROVIDED HOWEVER THAT
52 MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS CLAUSE ONLY IF
53 AND FOR SO LONG AS THE PROVISIONS OF CLAUSE (I) OF THIS SUBPARAGRAPH ARE
54 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.

(E) 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.

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

4 (a) An individual shall be presumed to be eligible for medical assist-
5 ance under this title beginning on the date that a qualified entity, as
6 defined in paragraph (c) of this subdivision, determines, on the basis
7 of preliminary information, that the individual meets the requirements
8 of paragraph [(v) or (v-1)] (D) OR (E) of subdivision four of section
9 three hundred sixty-six of this title.

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

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

32 (a-2) At the time of application for presumptive eligibility pursuant
33 to this subdivision, a pregnant woman who resides in a social services
34 district that has implemented the state's managed care program pursuant
35 to section three hundred sixty-four-j of this title must choose a
36 managed care provider. If a managed care provider is not chosen at the
37 time of application, the pregnant woman will be assigned to a managed
38 care provider in accordance with subparagraphs (ii), (iii), (iv) and (v)
39 of paragraph (f) of subdivision four of section three hundred sixty-
40 four-j of this title.

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

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

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

1 exceed one hundred percent of the federal poverty line (as defined and
2 annually revised by the United States department of health and human
3 services) for a family of the same size; or

4 (ii) prenatal care services as described in subparagraph four of para-
5 graph (o) of subdivision four of section three hundred sixty-six of this
6 title, if the woman's family has: (A) subject to the approval of the
7 federal Centers for Medicare and Medicaid Services, gross income that
8 exceeds one hundred twenty percent of the federal poverty line (as
9 defined and annually revised by the United States department of health
10 and human services) for families of the same size, but does not exceed
11 two hundred thirty percent of such federal poverty line, or (B) in the
12 absence of such approval, net income that exceeds one hundred percent
13 but does not exceed two hundred percent of the federal poverty line (as
14 defined and annually revised by the United States department of health
15 and human services) for a family of the same size.

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

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

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

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

43 S 6. Subdivision 1 and the opening paragraph of subdivision 2 of
44 section 365-a of the social services law, subdivision 1 as amended by
45 chapter 110 of the laws of 1971 and the opening paragraph of subdivision
46 2 as amended by chapter 41 of the laws of 1992, are amended to read as
47 follows:

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

52 1. "BENCHMARK COVERAGE" SHALL MEAN PAYMENT OF PART OR ALL OF THE COST
53 OF MEDICALLY NECESSARY MEDICAL, DENTAL, AND REMEDIAL CARE, SERVICES, AND
54 SUPPLIES DESCRIBED IN SUBDIVISION TWO OF THIS SECTION, AND TO THE EXTENT
55 NOT INCLUDED THEREIN, ANY ESSENTIAL BENEFITS AS DEFINED IN 42 U.S.C.
56 18022(B), WITH THE EXCEPTION OF INSTITUTIONAL LONG TERM CARE SERVICES;

1 SUCH CARE, SERVICES AND SUPPLIES SHALL BE PROVIDED CONSISTENT WITH THE
2 MANAGED CARE PROGRAM DESCRIBED IN SECTION THREE HUNDRED SIXTY-FOUR-J OF
3 THIS TITLE.

4 ["Medical assistance"] "STANDARD COVERAGE" shall mean payment of part
5 or all of the cost of medically necessary medical, dental and remedial
6 care, services and supplies, as authorized in this title or the regu-
7 lations of the department, which are necessary to prevent, diagnose,
8 correct or cure conditions in the person that cause acute suffering,
9 endanger life, result in illness or infirmity, interfere with such
10 person's capacity for normal activity, or threaten some significant
11 handicap and which are furnished an eligible person in accordance with
12 this title and the regulations of the department. Such care, services
13 and supplies shall include the following medical care, services and
14 supplies, together with such medical care, services and supplies
15 provided for in subdivisions three, four and five of this section, and
16 such medical care, services and supplies as are authorized in the regu-
17 lations of the department:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 [(e)] (D) The commissioner of health shall verify the accuracy of the
43 information provided by [the] AN APPLICANT OR recipient [pursuant to
44 paragraph (d) of this subdivision] by matching it against information to
45 which the commissioner of health has access, including under subdivision
46 eight of this section. In the event [there is an inconsistency between]
47 the information reported by the recipient [and] IS NOT REASONABLY
48 COMPATIBLE WITH any information obtained by the commissioner of health
49 from other sources and such [inconsistency] INCOMPATIBILITY is material
50 to medical assistance eligibility, the commissioner of health shall
51 request that the recipient provide adequate documentation to verify his
52 or her place of residence or income, as applicable. In addition to the
53 documentation of residence and income authorized by this paragraph, the
54 commissioner of health is authorized to periodically require a reason-
55 able sample of recipients to provide documentation of residence and
56 income at recertification. The commissioner of health shall consult with

1 the medicaid inspector general regarding income and residence verifica-
2 tion practices and procedures necessary to maintain program integrity
3 and deter fraud and abuse.

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

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

10 (D) is not described in clause (A), (B) or (C) of this subparagraph
11 and has gross family income equal to or less than two hundred percent of
12 the federal income official poverty line (as defined and updated by the
13 United States Department of Health and Human Services) for a family of
14 the same size; provided, however, that eligibility under this clause is
15 subject to sources of federal and non-federal funding for such purpose
16 described in section sixty-seven-a of [the] PART C OF chapter
17 FIFTY-EIGHT of the laws of two thousand nine [that added this clause] or
18 as may be available under the waiver agreement entered into with the
19 federal government under section eleven hundred fifteen of the federal
20 social security act, as jointly determined by the commissioner and the
21 director of the division of the budget. In no case shall state funds be
22 utilized to support the non-federal share of expenditures pursuant to
23 this subparagraph, provided however that the commissioner may demon-
24 strate to the United States department of health and human services the
25 existence of non-federally participating state expenditures as necessary
26 to secure federal funding under an eleven hundred fifteen waiver for the
27 purposes herein. Eligibility under this clause may be provided to resi-
28 dents of all counties or, at the joint discretion of the commissioner
29 and the director of the division of the budget, a subset of counties of
30 the state[.]; AND

31 (VI) MAKES APPLICATION FOR BENEFITS PURSUANT TO THIS TITLE ON OR
32 BEFORE DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN.

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

35 (D) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVI-
36 SION OR ANY OTHER PROVISION OF LAW, IN THE CASE OF A PERSON RECEIVING
37 HEALTH CARE SERVICES PURSUANT TO THIS TITLE ON JANUARY FIRST, TWO THOU-
38 SAND FOURTEEN, SUCH PERSON'S ELIGIBILITY SHALL BE RECERTIFIED AS SOON AS
39 PRACTICABLE THEREAFTER, AND SUCH PERSON'S COVERAGE UNDER THIS TITLE
40 SHALL END ON THE EARLIEST OF: (I) THE DATE THE PERSON IS ENROLLED IN A
41 QUALIFIED HEALTH PLAN OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTAB-
42 LISHED IN ACCORDANCE WITH THE REQUIREMENTS OF THE FEDERAL PATIENT
43 PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE
44 FEDERAL HEALTH CARE AND EDUCATION ACT OF 2010 (P.L. 111-152); (II)
45 DECEMBER THIRTY-FIRST, TWO THOUSAND FOURTEEN; OR (III) THE DATE ON WHICH
46 THE DEPARTMENT OF HEALTH CEASES TO HAVE ALL NECESSARY APPROVALS UNDER
47 FEDERAL LAW AND REGULATION TO RECEIVE FEDERAL FINANCIAL PARTICIPATION,
48 UNDER THE PROGRAM DESCRIBED IN TITLE ELEVEN OF THIS ARTICLE, IN THE
49 COSTS OF HEALTH SERVICES PROVIDED PURSUANT TO THIS SECTION.

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

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

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

54 (E) (1) PAYMENT OF PREMIUMS FOR ENROLLING INDIVIDUALS IN QUALIFIED
55 HEALTH PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTABLISHED
56 PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L.

1 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILI-
2 IATION ACT OF 2010 (P.L. 111-152), SHALL BE AVAILABLE TO INDIVIDUALS
3 WHO:

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

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

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

15 (2) PAYMENT PURSUANT TO THIS PARAGRAPH SHALL BE FOR PREMIUM OBLI-
16 GATIONS OF THE INDIVIDUAL UNDER THE QUALIFIED HEALTH PLAN AND SHALL
17 CONTINUE ONLY IF AND FOR SO LONG AS THE INDIVIDUAL'S MAGI HOUSEHOLD
18 INCOME EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT, BUT DOES NOT EXCEED ONE
19 HUNDRED FIFTY PERCENT, OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE
20 FAMILY SIZE.

21 (3) THE COMMISSIONER OF HEALTH SHALL SUBMIT AMENDMENTS TO THE STATE
22 PLAN FOR MEDICAL ASSISTANCE AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR
23 WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT AS MAY BE NECESSARY TO
24 RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF PAYMENTS MADE
25 PURSUANT TO THIS PARAGRAPH; PROVIDED FURTHER, HOWEVER, THAT NOTHING IN
26 THIS SUBPARAGRAPH SHALL BE DEEMED TO AFFECT PAYMENTS FOR PREMIUMS PURSU-
27 ANT TO THIS PARAGRAPH IF FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF
28 SUCH PAYMENTS IS NOT AVAILABLE.

29 S 16-a. (a) The commissioner of health shall convene a workgroup to
30 consider issues pertaining to the federal option to establish a basic
31 health program for individuals who are not eligible for medical assist-
32 ance under title eleven of article five of the social services law.

33 (b) The workgroup shall: evaluate federal guidance related to basic
34 health programs; discuss fiscal, consumer, and health care impacts of a
35 basic health program; and consider benefit package, premium and cost-
36 sharing options for a basic health program.

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

39 13. "HOUSEHOLD INCOME" MEANS THE SUM OF THE MODIFIED ADJUSTED GROSS
40 INCOME OF EVERY INDIVIDUAL INCLUDED IN A CHILD'S HOUSEHOLD CALCULATED IN
41 ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS, AS MAY BE
42 AMENDED.

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

45 14. "STATE ENROLLMENT CENTER" MEANS THE CENTRALIZED SYSTEM AND OPERA-
46 TION OF ELIGIBILITY DETERMINATIONS BY THE STATE OR ITS CONTRACTOR FOR
47 ALL INSURANCE AFFORDABILITY PROGRAMS, INCLUDING THE CHILD HEALTH INSUR-
48 ANCE PROGRAM ESTABLISHED PURSUANT TO THIS TITLE.

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

51 S 19. Subparagraphs (iv) and (vi) of paragraph (f) of subdivision 2 of
52 section 2511 of the public health law, subparagraph (iv) as added by
53 section 44 of part A of chapter 1 of the laws of 2002 and subparagraph
54 (vi) as added by section 45-b of part C of chapter 58 of the laws of
55 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, WHICH-EVER 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:

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

7 (b) An approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS
8 APPLICABLE, shall promptly review all information relating to a poten-
9 tial change in eligibility based on information provided pursuant to
10 subdivision four of this section. Within at least thirty days after
11 receipt of such information, the approved organization OR STATE ENROLL-
12 MENT CENTER shall make a determination whether the child is still eligi-
13 ble for a subsidy payment and shall notify the household and the commis-
14 sioner if it determines the child is not eligible for a subsidy payment.

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

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

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

34 12. The commissioner shall, in consultation with the superintendent,
35 establish procedures to coordinate the child health insurance plan with
36 the medical assistance program, including but not limited to, procedures
37 to maximize enrollment of eligible children under those programs by
38 identification and transfer of children who are eligible or who become
39 eligible to receive medical assistance and procedures to facilitate
40 changes in enrollment status for children who are ineligible for subsi-
41 dies under this section and for children who are no longer eligible for
42 medical assistance in order to facilitate and ensure continuity of
43 coverage. The commissioner shall review, on an annual basis, the eligi-
44 bility verification and recertification procedures of approved organiza-
45 tions under this title to insure the appropriate enrollment of children.
46 Such review shall include, but not be limited to, an audit of a statis-
47 tically representative sample of cases from among all approved organiza-
48 tions AND SHALL BE APPLICABLE TO ANY PERIOD DURING WHICH AN APPROVED
49 ORGANIZATION'S RESPONSIBILITIES INCLUDE DETERMINING ELIGIBILITY. In the
50 event such review and audit reveals cases which do not meet the eligi-
51 bility criteria for coverage set forth in this section, that information
52 shall be forwarded to the approved organization and the commissioner for
53 appropriate action.

54 S 25. Paragraph (e) of subdivision 12-a of section 2511 of the public
55 health law, as added by chapter 2 of the laws of 1998, is amended and a
56 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 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 REASONABLY COMPATIBLE WITH INFORMATION OBTAINED FROM AVAILABLE DATA SOURCES, NO FURTHER INFORMATION OR DOCUMENTATION IS REQUIRED. IF THE ATTESTATION IS NOT REASONABLY COMPATIBLE 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

1 and shall provide the social security numbers for each parent and legal-
2 ly responsible adult who is a member of the household and whose income
3 is available to the child, subject to subparagraph (v) of this para-
4 graph. The] THE commissioner [may verify the accuracy of such income
5 information provided by the household by matching it against income] MAY
6 MAKE A REDETERMINATION OF ELIGIBILITY WITHOUT REQUIRING INFORMATION FROM
7 THE INDIVIDUAL IF ABLE TO DO SO BASED ON RELIABLE INFORMATION CONTAINED
8 IN THE INDIVIDUAL'S ENROLLMENT FILE OR OTHER MORE CURRENT information
9 contained in databases to which the commissioner has access, including
10 the state's wage reporting system and by means of an income verification
11 performed pursuant to a cooperative agreement with the department of
12 taxation and finance pursuant to subdivision four of section one hundred
13 seventy-one-b of the tax law. THE COMMISSIONER SHALL REQUIRE AN ATTES-
14 TATION BY THE HOUSEHOLD THAT THE INCOME INFORMATION CONTAINED IN THE
15 ENROLLMENT FILE OR OBTAINED FROM ELECTRONIC DATA SOURCES IS ACCURATE.
16 SUCH ATTESTATION SHALL INCLUDE ANY OTHER HOUSEHOLD INCOME INFORMATION
17 NOT OBTAINED FROM AN ELECTRONIC DATA SOURCE THAT IS NECESSARY TO REDE-
18 TERMINE A CHILD'S FINANCIAL ELIGIBILITY FOR A SUBSIDY PAYMENT UNDER THIS
19 TITLE. In the event that there is an inconsistency between the income
20 information attested to by the household and any information obtained by
21 the commissioner from other sources pursuant to this subparagraph, and
22 such inconsistency is material to the household's eligibility for a
23 subsidy payment under this title, the commissioner shall require the
24 [approved organization to obtain] HOUSEHOLD TO PROVIDE income documenta-
25 tion [from the household] as specified in subparagraph (iii) of this
26 paragraph.

27 (iii) IF THE ATTESTATION OF HOUSEHOLD INCOME REQUIRED BY SUBPARAGRAPHS
28 (I) AND (II) OF THIS PARAGRAPH IS NOT REASONABLY COMPATIBLE WITH INFOR-
29 MATION OBTAINED FROM DATA SOURCES, FURTHER INFORMATION, INCLUDING
30 DOCUMENTATION, SHALL BE REQUIRED. Income documentation shall include,
31 but not be limited to, one or more of the following for each parent and
32 legally responsible adult who is a member of the household and whose
33 income is available to the child;

34 (A) current annual income tax returns;

35 (B) paycheck stubs;

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

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

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

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

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

50 (v) In the event a household chooses not to provide the social securi-
51 ty numbers required by [subparagraph] SUBPARAGRAPHS (I) AND (ii) of this
52 paragraph, such household shall provide income documentation specified
53 in subparagraph (iii) of this paragraph as a condition of the child's
54 enrollment. Nothing in this paragraph shall be construed as obligating a
55 household to provide social security numbers of parents or legally

1 responsible adults as a condition of a child's enrollment or eligibility
2 for a subsidy payment under this title.

3 S 27. Subparagraph (ii) of paragraph (g) of subdivision 2 of section
4 2511 of the public health law, as amended by section 29 of part A of
5 chapter 58 of the laws of 2007, is amended to read as follows:

6 (ii) Effective September first two thousand seven, THROUGH MARCH THIR-
7 TY-FIRST, TWO THOUSAND FOURTEEN temporary enrollment pursuant to subpar-
8 agraph (i) of this paragraph shall be provided only to children who
9 apply for recertification of coverage under this title who appear to be
10 eligible for medical assistance under title eleven of article five of
11 the social services law.

12 S 28. Paragraph (a) of subdivision 2-b of section 2511 of the public
13 health law, as added by section 5 of part B of chapter 58 of the laws of
14 2010, is amended to read as follows:

15 (a) [Effective October first, two thousand ten, for] FOR purposes of
16 claiming federal financial participation under paragraph nine of
17 subsection (c) of section twenty-one hundred five of the federal social
18 security act, [for individuals declaring to be citizens at initial
19 application,] a household shall provide:

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

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

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

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

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

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

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

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

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

54 (vi) sixty dollars per month for each eligible child whose family
55 [gross] household income is between three hundred fifty-one percent and

1 four hundred percent of the non-farm federal poverty level, but no more
2 than one hundred eighty dollars per month per family.

3 S 30. Subparagraph (iii) of paragraph (a) of subdivision 2 of section
4 2511 of the public health law, as amended by section 32 of part B of
5 chapter 58 of the laws of 2008, is amended to read as follows:

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

10 S 31. Subparagraph (ii) of paragraph (d) of subdivision 2 of section
11 2511 of the public health law, as amended by section 33 of part A of
12 chapter 58 of the laws of 2007, clause (B) as amended by section 3 of
13 part 00 of chapter 57 of the laws of 2008, is amended to read as
14 follows:

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

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

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

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

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

1 S 33. Subparagraph (iv) of paragraph (b) and paragraph (d) of subdivi-
2 sion 9 of section 2511 of the public health law, as amended by section
3 18-a of chapter 2 of the laws of 1998, are amended to read as follows:

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

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

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

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

40 (I) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT
41 CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL BEGIN ACCEPTING APPLI-
42 CATIONS ON OCTOBER FIRST, TWO THOUSAND THIRTEEN;

43 (II) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLL-
44 MENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL CERTIFY QUALIFIED
45 HEALTH PLANS;

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

48 (IV) THE NUMBER OF NAVIGATORS APPROVED;

49 (V) THE PLAN FOR FULL OPERATION BY JANUARY FIRST, TWO THOUSAND FOUR-
50 TEEN; AND

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

53 S 34. Paragraphs 9 and 10 of subsection (a) of section 2101 of the
54 insurance law, as added by chapter 687 of the laws of 2003, are amended
55 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, AS SUCH TERM IS USED IN 42 U.S.C. S 18031(I), PROVIDED THAT THE PERSON:

(A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031(I)(3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

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, AS SUCH TERM IS USED IN 42 U.S.C. S 18031(I), INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031(I)(3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

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:

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

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

13 (12) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED
14 BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF
15 THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031 TO ACT AS A NAVIGATOR, AS
16 SUCH TERM IS USED IN 42 U.S.C. S 18031(I), INCLUDING ANY PERSON EMPLOYED
17 BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON: (A) HAS COMPLETED
18 THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL
19 INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE
20 NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031 (I) (3) AND REGULATIONS
21 THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A
22 NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR
23 AN INSURER.

24 S 37. Subsection (b) of section 2102 of the insurance law is amended
25 by adding a new paragraph 5 to read as follows:

26 (5) PARAGRAPHS ONE AND THREE OF THIS SUBSECTION SHALL NOT APPLY TO ANY
27 PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE
28 HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE
29 AFFORDABLE CARE ACT, 42 U.S.C. S 18031 (I), INCLUDING PERSONS EMPLOYED
30 BY CERTIFIED NAVIGATORS; PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE
31 TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL
32 INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE
33 NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031 (I) (3) AND REGULATIONS
34 THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A
35 NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR
36 AN INSURER.

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

42 (a) (1) No agent or representative of any insurer or health mainte-
43 nance organization authorized to transact life, accident or health
44 insurance or health maintenance organization business in this state [and
45 no], insurance broker, [and no] PERSON WHO HAS RECEIVED A GRANT FROM AND
46 HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT
47 TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS
48 A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, OR
49 other person, firm, association or corporation, shall issue or circulate
50 or cause or permit to be issued or circulated, any illustration, circu-
51 lar, statement or memorandum misrepresenting the terms, benefits or
52 advantages of any policy or contract of life, accident or health insur-
53 ance, any annuity contract or any health maintenance organization
54 contract, delivered or issued for delivery or to be delivered or issued
55 for delivery, in this state, or shall make any misleading estimate as to
56 the dividends or share of surplus or additional amounts to be received

1 in the future on such policy or contract, or shall make any false or
2 misleading statement as to the dividends or share of surplus or addi-
3 tional amounts previously paid by any such insurer or health maintenance
4 organization on similar policies or contracts, or shall make any
5 misleading representation, or any misrepresentation, as to the financial
6 condition of any such insurer or health maintenance organization, or as
7 to the legal reserve system upon which such insurer or health mainte-
8 nance organization operates.

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

15 (3) Any replacement of individual life insurance policies or individ-
16 ual annuity contracts of an insurer by an agent, representative of the
17 same or different insurer or broker shall conform to standards promul-
18 gated by regulation by the superintendent. Such regulation shall:

19 (A) specify what constitutes the replacement of a life insurance poli-
20 cy or annuity contract and the proper disclosure and notification proce-
21 dures to replace a policy or contract;

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

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

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

32 (d) Any agent or representative of an insurer or health maintenance
33 organization, [any] insurance broker [and], PERSON WHO HAS RECEIVED A
34 GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTAB-
35 LISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
36 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTI-
37 FIED NAVIGATOR, OR any other person, firm, association or corporation
38 who, or which, shall violate any of the provisions of this section and
39 shall knowingly receive any compensation or commission for the SOLICITA-
40 TION, sale OR NEGOTIATION of any insurance policy, health maintenance
41 organization or annuity contract induced by a violation of this section
42 shall also be liable for a civil penalty in the amount received by such
43 violator as compensation or commission, which penalty may be sued for
44 and recovered for his, HER, OR ITS own use and benefit by any person
45 induced to purchase an insurance policy, health maintenance organization
46 or annuity contract by such violation. In addition, such agent, repre-
47 sentative, broker, person, firm, association or corporation violating
48 this section shall be liable for a civil penalty in the amount of any
49 compensation or commission lost by any agent, representative or broker
50 as a result of a violation of this section or the making of such false
51 or misleading statement, which penalty may be sued for and recovered for
52 his, HER, OR ITS own use and benefit by such agent, representative or
53 broker.

54 S 37-b. The insurance law is amended by adding a new section 2138 to
55 read as follows:

1 S 2138. HEALTH BENEFIT EXCHANGE NAVIGATORS. A PERSON WHO HAS RECEIVED
2 A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE
3 ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42
4 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY
5 A CERTIFIED NAVIGATOR, SHALL NOT RECEIVE, COLLECT OR HOLD ANY FUNDS THAT
6 WOULD CONSTITUTE FIDUCIARY FUNDS WITHIN THE MEANING OF SECTION TWO THOU-
7 SAND ONE HUNDRED TWENTY OF THIS ARTICLE.

8 S 38. Subparagraph (B) of paragraph 25 of subsection (i) of section
9 3216 of the insurance law, as amended by chapter 596 of the laws of
10 2011, is amended to read as follows:

11 (B) Every policy [which] THAT provides physician services, medical,
12 major medical or similar comprehensive-type coverage shall provide
13 coverage for the screening, diagnosis and treatment of autism spectrum
14 disorder in accordance with this paragraph and shall not exclude cover-
15 age for the screening, diagnosis or treatment of medical conditions
16 otherwise covered by the policy because the individual is diagnosed with
17 autism spectrum disorder. Such coverage may be subject to annual deduct-
18 ibles, copayments and coinsurance as may be deemed appropriate by the
19 superintendent and shall be consistent with those imposed on other bene-
20 fits under the policy. Coverage for applied behavior analysis shall be
21 subject to a maximum benefit of [forty-five thousand dollars] SIX
22 HUNDRED EIGHTY HOURS OF TREATMENT per POLICY OR CALENDAR year per
23 covered individual [and such maximum annual benefit will increase by the
24 amount calculated from the average ten year rolling average increase of
25 the medical component of the consumer price index]. This paragraph shall
26 not be construed as limiting the benefits that are otherwise available
27 to an individual under the policy, provided however that such policy
28 shall not contain any limitations on visits that are solely applied to
29 the treatment of autism spectrum disorder. No insurer shall terminate
30 coverage or refuse to deliver, execute, issue, amend, adjust, or renew
31 coverage to an individual solely because the individual is diagnosed
32 with autism spectrum disorder or has received treatment for autism spec-
33 trum disorder. Coverage shall be subject to utilization review and
34 external appeals of health care services pursuant to article forty-nine
35 of this chapter as well as, case management, and other managed care
36 provisions.

37 S 39. Subparagraph (B) of paragraph 17 of subsection (1) of section
38 3221 of the insurance law, as amended by chapter 596 of the laws of
39 2011, is amended to read as follows:

40 (B) Every group or blanket policy [which] THAT provides physician
41 services, medical, major medical or similar comprehensive-type coverage
42 shall provide coverage for the screening, diagnosis and treatment of
43 autism spectrum disorder in accordance with this paragraph and shall not
44 exclude coverage for the screening, diagnosis or treatment of medical
45 conditions otherwise covered by the policy because the individual is
46 diagnosed with autism spectrum disorder. Such coverage may be subject to
47 annual deductibles, copayments and coinsurance as may be deemed appro-
48 priate by the superintendent and shall be consistent with those imposed
49 on other benefits under the group or blanket policy. Coverage for
50 applied behavior analysis shall be subject to a maximum benefit of
51 [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per
52 POLICY OR CALENDAR year per covered individual [and such maximum annual
53 benefit will increase by the amount calculated from the average ten year
54 rolling average increase of the medical component of the consumer price
55 index]. This paragraph shall not be construed as limiting the benefits
56 that are otherwise available to an individual under the group or blanket

1 policy, provided however that such policy shall not contain any limita-
2 tions on visits that are solely applied to the treatment of autism spec-
3 trum disorder. No insurer shall terminate coverage or refuse to deliver,
4 execute, issue, amend, adjust, or renew coverage to an individual solely
5 because the individual is diagnosed with autism spectrum disorder or has
6 received treatment for autism spectrum disorder. Coverage shall be
7 subject to utilization review and external appeals of health care
8 services pursuant to article forty-nine of this chapter as well as, case
9 management, and other managed care provisions.

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

13 (2) Every contract [which] THAT provides physician services, medical,
14 major medical or similar comprehensive-type coverage shall provide
15 coverage for the screening, diagnosis and treatment of autism spectrum
16 disorder in accordance with this [subsection] PARAGRAPH and shall not
17 exclude coverage for the screening, diagnosis or treatment of medical
18 conditions otherwise covered by the contract because the individual is
19 diagnosed with autism spectrum disorder. Such coverage may be subject to
20 annual deductibles, copayments and coinsurance as may be deemed appro-
21 priate by the superintendent and shall be consistent with those imposed
22 on other benefits under the contract. Coverage for applied behavior
23 analysis shall be subject to a maximum benefit of [forty-five thousand
24 dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per CONTRACT OR CALENDAR
25 year per covered individual [and such maximum annual benefit will
26 increase by the amount calculated from the average ten year rolling
27 average increase of the medical component of the consumer price index].
28 This paragraph shall not be construed as limiting the benefits that are
29 otherwise available to an individual under the contract, provided howev-
30 er that such contract shall not contain any limitations on visits that
31 are solely applied to the treatment of autism spectrum disorder. No
32 insurer shall terminate coverage or refuse to deliver, execute, issue,
33 amend, adjust, or renew coverage to an individual solely because the
34 individual is diagnosed with autism spectrum disorder or has received
35 treatment for autism spectrum disorder. Coverage shall be subject to
36 utilization review and external appeals of health care services pursuant
37 to article forty-nine of this chapter as well as, case management, and
38 other managed care provisions.

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

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

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

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

53 (1) "STUDENT ACCIDENT AND HEALTH INSURANCE" MEANS A POLICY OR CONTRACT
54 OF HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE DELIVERED OR ISSUED
55 FOR DELIVERY IN THIS STATE ON OR AFTER JANUARY FIRST, TWO THOUSAND
56 FOURTEEN, BY AN INSURER OR A CORPORATION, TO AN INSTITUTION OF HIGHER

1 EDUCATION COVERING STUDENTS ENROLLED IN THE INSTITUTION AND THE
2 STUDENTS' DEPENDENTS.

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

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

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

9 (B) AN INSURER OR CORPORATION SHALL NOT IMPOSE ANY PRE-EXISTING CONDI-
10 TION EXCLUSION IN A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR
11 CONTRACT. AN INSURER OR CORPORATION SHALL NOT CONDITION ELIGIBILITY,
12 INCLUDING CONTINUED ELIGIBILITY, FOR A STUDENT ACCIDENT AND HEALTH
13 INSURANCE POLICY OR CONTRACT ON HEALTH STATUS, MEDICAL CONDITION,
14 INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES, CLAIMS EXPERIENCE, RECEIPT
15 OF HEALTH CARE, MEDICAL HISTORY, GENETIC INFORMATION, EVIDENCE OF INSUR-
16 ABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE,
17 OR DISABILITY.

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

22 (D) A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT SHALL
23 PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS AS DEFINED IN SECTION
24 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

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

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

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

32 (F) OTHER THAN THE PROVISIONS HEREIN ALSO REQUIRED BY ARTICLE
33 FORTY-THREE OF THIS CHAPTER, THIS SECTION SHALL NOT APPLY TO COVERAGE
34 UNDER A STUDENT HEALTH PLAN ISSUED PURSUANT TO SECTION ONE THOUSAND ONE
35 HUNDRED TWENTY-FOUR OF THIS CHAPTER.

36 (G) THE SUPERINTENDENT MAY PROMULGATE REGULATIONS REGARDING STUDENT
37 ACCIDENT AND HEALTH INSURANCE, WHICH MAY INCLUDE MINIMUM STANDARDS FOR
38 THE FORM, CONTENT AND SALE OF THE POLICIES AND CONTRACTS AND, NOTWITH-
39 STANDING THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED THIRTY-ONE
40 AND FOUR THOUSAND THREE HUNDRED EIGHT OF THIS CHAPTER, THE ESTABLISHMENT
41 OF RATING METHODOLOGY TO BE APPLIED TO THE POLICIES AND CONTRACTS;
42 PROVIDED THAT ANY SUCH REGULATIONS SHALL BE NO LESS FAVORABLE TO THE
43 INSURED THAN THAT WHICH IS PROVIDED UNDER FEDERAL LAW AND STATE LAW
44 APPLICABLE TO INDIVIDUAL INSURANCE.

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

48 (I) EVERY INSURER OR CORPORATION SHALL REPORT TO THE SUPERINTENDENT
49 ANNUALLY, ON A DATE SPECIFIED BY THE SUPERINTENDENT IN A REGULATION,
50 CLAIMS EXPERIENCE AND OTHER DATA IN A MANNER ACCEPTABLE TO THE SUPER-
51 INTENDENT THAT SHALL DEMONSTRATE THE INSURER'S OR CORPORATION'S COMPLI-
52 ANCE WITH THE APPLICABLE RULES AND REGULATIONS, INCLUDING THE MINIMUM
53 LOSS RATIO REQUIRED BY SUBSECTION (H) OF THIS SECTION. FAILURE TO COMPLY
54 WITH SUBSECTION (H) OF THIS SECTION IS SUBJECT TO CORRECTIVE ACTION,
55 WHICH MAY INCLUDE THE SUBMISSION, TO THE SUPERINTENDENT, OF AN APPROPRI-
56 ATE RATE FILING OR FORM AND RATE FILING TO REDUCE FUTURE PREMIUMS,

1 INCREASE BENEFITS, ISSUE DIVIDENDS, ISSUE PREMIUM REFUNDS OR CREDITS, OR
2 ANY COMBINATION OF THESE SUCH THAT THE MINIMUM LOSS RATIO CAN REASONABLY
3 BE EXPECTED TO BE ACHIEVED.

4 S 42. Subsection (1) of section 3216 of the insurance law is REPEALED
5 and a new subsection (1) is added to read as follows:

6 (L) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, AN INSURER
7 SHALL NOT OFFER INDIVIDUAL HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSUR-
8 ANCE POLICIES UNLESS THE POLICIES MEET THE REQUIREMENTS OF SUBSECTION
9 (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER.
10 SUCH POLICIES THAT ARE OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTAB-
11 LISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
12 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER, ALSO SHALL MEET ANY
13 REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE.

14 S 43. Subsection (1) of section 4304 of the insurance law is REPEALED
15 and a new subsection (1) is added to read as follows:

16 (1) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, A CORPORATION
17 SHALL NOT OFFER INDIVIDUAL HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSUR-
18 ANCE CONTRACTS UNLESS THE CONTRACTS MEET THE REQUIREMENTS OF SUBSECTION
19 (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS ARTICLE.
20 SUCH CONTRACTS THAT ARE OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE
21 ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42
22 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER, ALSO SHALL
23 MEET ANY REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE. TO THE
24 EXTENT THAT A HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY
25 ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE
26 PUBLIC HEALTH LAW OFFERS INDIVIDUAL HOSPITAL, MEDICAL, OR SURGICAL
27 EXPENSE INSURANCE CONTRACTS, THE CONTRACTS SHALL MEET THE REQUIREMENTS
28 OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF
29 THIS ARTICLE.

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

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

55 S 44. The section heading and subsection (a) of section 4321 of the
56 insurance law, the section heading as added by chapter 504 of the laws

1 of 1995 and subsection (a) as amended by chapter 342 of the laws of
2 2004, are amended to read as follows:

3 Standardization of individual enrollee direct payment contracts
4 offered by health maintenance organizations PRIOR TO OCTOBER FIRST, TWO
5 THOUSAND THIRTEEN. (a) On and after January first, nineteen hundred
6 ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN all
7 health maintenance organizations issued a certificate of authority under
8 article forty-four of the public health law or licensed under this arti-
9 cle shall offer a standardized individual enrollee contract on an open
10 enrollment basis as prescribed by section forty-three hundred seventeen
11 of this article and section forty-four hundred six of the public health
12 law, and regulations promulgated thereunder, provided, however, that
13 such requirements shall not apply to a health maintenance organization
14 exclusively serving individuals enrolled pursuant to title eleven of
15 article five of the social services law, title eleven-D of article five
16 of the social services law, title one-A of article twenty-five of the
17 public health law or title eighteen of the federal Social Security Act[,
18 and, further provided, that such health maintenance organization shall
19 not discontinue a contract for an individual receiving comprehensive-
20 type coverage in effect prior to January first, two thousand four who is
21 ineligible to purchase policies offered after such date pursuant to this
22 section or section four thousand three hundred twenty-two of this arti-
23 cle due to the provision of 42 U.S.C. 1395ss in effect prior to January
24 first, two thousand four]. On and after January first, nineteen hundred
25 ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, the
26 enrollee contracts issued pursuant to this section and section four
27 thousand three hundred twenty-two of this article shall be the only
28 contracts offered by health maintenance organizations to individuals.
29 The enrollee contracts issued by a health maintenance organization under
30 this section and section four thousand three hundred twenty-two of this
31 article shall also be the only contracts issued by health maintenance
32 organizations for purposes of conversion pursuant to sections four thou-
33 sand three hundred four and four thousand three hundred five of this
34 article. However, nothing in this section shall be deemed to require
35 health maintenance organizations to terminate individual direct payment
36 contracts issued prior to January first, nineteen hundred ninety-six or
37 prevent health maintenance organizations from terminating individual
38 direct payment contracts issued prior to January first, nineteen hundred
39 ninety-six.

40 S 45. The section heading and subsection (a) of section 4322 of the
41 insurance law, the section heading as added by chapter 504 of the laws
42 of 1995 and subsection (a) as amended by chapter 342 of the laws of
43 2004, are amended and a new subsection (i) is added to read as follows:

44 Standardization of individual enrollee direct payment contracts
45 offered by health maintenance organizations which provide out-of-plan
46 benefits PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. (a) On and after
47 January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTI-
48 ETH, TWO THOUSAND THIRTEEN, all health maintenance organizations issued
49 a certificate of authority under article forty-four of the public health
50 law or licensed under this article shall offer to individuals, in addi-
51 tion to the standardized contract required by section four thousand
52 three hundred twenty-one of this article, a standardized individual
53 enrollee direct payment contract on an open enrollment basis as
54 prescribed by section four thousand three hundred seventeen of this
55 article and section four thousand four hundred six of the public health
56 law, and regulations promulgated thereunder, with an out-of-plan benefit

1 system, provided, however, that such requirements shall not apply to a
2 health maintenance organization exclusively serving individuals enrolled
3 pursuant to title eleven of article five of the social services law,
4 title eleven-D of article five of the social services law, title one-A
5 of article twenty-five of the public health law or title eighteen of the
6 federal Social Security Act[, and, further provided, that such health
7 maintenance organization shall not discontinue a contract for an indi-
8 vidual receiving comprehensive-type coverage in effect prior to January
9 first, two thousand four who is ineligible to purchase policies offered
10 after such date pursuant to this section or section four thousand three
11 hundred twenty-two of this article due to the provision of 42 U.S.C.
12 1395ss in effect prior to January first, two thousand four]. The out-of-
13 plan benefit system shall either be provided by the health maintenance
14 organization pursuant to subdivision two of section four thousand four
15 hundred six of the public health law or through an accompanying insur-
16 ance contract providing out-of-plan benefits offered by a company appro-
17 priately licensed pursuant to this chapter. On and after January first,
18 nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND
19 THIRTEEN, the contracts issued pursuant to this section and section four
20 thousand three hundred twenty-one of this article shall be the only
21 contracts offered by health maintenance organizations to individuals.
22 The enrollee contracts issued by a health maintenance organization under
23 this section and section four thousand three hundred twenty-one of this
24 article shall also be the only contracts issued by the health mainte-
25 nance organization for purposes of conversion pursuant to sections four
26 thousand three hundred four and four thousand three hundred five of this
27 article. However, nothing in this section shall be deemed to require
28 health maintenance organizations to terminate individual direct payment
29 contracts issued prior to January first, nineteen hundred ninety-six or
30 prohibit health maintenance organizations from terminating individual
31 direct payment contracts issued prior to January first, nineteen hundred
32 ninety-six.

33 (I) ON AND AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, EACH CONTRACT
34 THAT IS NOT A GRANDFATHERED HEALTH PLAN SHALL PROVIDE COVERAGE FOR THE
35 ESSENTIAL HEALTH BENEFIT PACKAGE. FOR PURPOSES OF THIS SUBSECTION:

36 (1) "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET
37 FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
38 18022(A); AND

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

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

46 S 4328. INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS OFFERED BY HEALTH
47 MAINTENANCE ORGANIZATION ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIR-
48 TEEN. (A) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, EVERY
49 HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE OF AUTHORITY UNDER
50 ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTI-
51 CLE SHALL OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT IN
52 ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION; PROVIDED, HOWEVER,
53 THAT THIS REQUIREMENT SHALL NOT APPLY TO A HOLDER OF A SPECIAL PURPOSE
54 CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR
55 HUNDRED THREE-A OF THE PUBLIC HEALTH LAW, EXCEPT AS OTHERWISE REQUIRED
56 UNDER SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS

1 ARTICLE, OR A HEALTH MAINTENANCE ORGANIZATION EXCLUSIVELY SERVING INDI-
2 VIDUALS ENROLLED PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL
3 SERVICES LAW, TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW,
4 TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW OR TITLE
5 EIGHTEEN OF THE FEDERAL SOCIAL SECURITY ACT. THE SUPERINTENDENT MAY,
6 AFTER GIVING CONSIDERATION TO THE PUBLIC INTEREST, EXEMPT A HEALTH MAIN-
7 TENANCE ORGANIZATION FROM THE REQUIREMENTS OF THIS SECTION PROVIDED THAT
8 ANOTHER HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION WITHIN THE
9 HEALTH MAINTENANCE ORGANIZATION'S SAME HOLDING COMPANY SYSTEM, AS
10 DEFINED IN ARTICLE FIFTEEN OF THIS CHAPTER, INCLUDING A HEALTH MAINTE-
11 NANCE ORGANIZATION OPERATED AS A LINE OF BUSINESS OF A HEALTH SERVICE
12 CORPORATION LICENSED UNDER THIS ARTICLE, OFFERS AN INDIVIDUAL ENROLLEE
13 DIRECT PAYMENT CONTRACT THAT, AT A MINIMUM, COMPLIES WITH THIS SECTION
14 AND PROVIDES ALL OF THE CONSUMER PROTECTIONS REQUIRED TO BE PROVIDED BY
15 A HEALTH MAINTENANCE ORGANIZATION PURSUANT TO THE PUBLIC HEALTH LAW AND
16 REGULATIONS, INCLUDING THOSE CONSUMER PROTECTIONS CONTAINED IN SECTIONS
17 FOUR THOUSAND FOUR HUNDRED THREE AND FOUR THOUSAND FOUR HUNDRED EIGHT-A
18 OF THE PUBLIC HEALTH LAW. THE ENROLLEE CONTRACTS ISSUED BY A HEALTH
19 MAINTENANCE ORGANIZATION UNDER THIS SECTION ALSO SHALL BE THE ONLY
20 CONTRACTS ISSUED BY THE HEALTH MAINTENANCE ORGANIZATION FOR PURPOSES OF
21 CONVERSION PURSUANT TO SECTIONS FOUR THOUSAND THREE HUNDRED FOUR AND
22 FOUR THOUSAND THREE HUNDRED FIVE OF THIS ARTICLE.

23 (B) (1) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSU-
24 ANT TO THIS SECTION SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH
25 BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH
26 SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS PARAGRAPH,
27 "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN
28 SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A).

29 (2) A HEALTH MAINTENANCE ORGANIZATION SHALL OFFER AT LEAST ONE INDI-
30 VIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT EACH LEVEL OF COVERAGE AS
31 DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
32 18022(D). A HEALTH MAINTENANCE ORGANIZATION ALSO SHALL OFFER ONE CHILD-
33 ONLY PLAN AT EACH LEVEL OF COVERAGE AS REQUIRED IN SECTION 2707(C) OF
34 THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(C).

35 (3) WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION
36 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, A HEALTH MAINTENANCE
37 ORGANIZATION MAY OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT
38 THAT IS A CATASTROPHIC HEALTH PLAN AS DEFINED IN SECTION 1302(E) OF THE
39 AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), OR ANY REGULATIONS PROMULGAT-
40 ED THEREUNDER.

41 (4) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT
42 TO THIS SECTION SHALL HAVE THE SAME ENROLLMENT PERIODS, INCLUDING
43 SPECIAL ENROLLMENT PERIODS, AS REQUIRED FOR AN INDIVIDUAL DIRECT
44 PAYMENT CONTRACT OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED
45 PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031,
46 OR ANY REGULATIONS PROMULGATED THEREUNDER.

47 (5) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT
48 TO THIS SECTION SHALL BE ISSUED WITHOUT REGARD TO EVIDENCE OF INSURABIL-
49 ITY AND WITHOUT AN EXCLUSION FOR PRE-EXISTING CONDITIONS.

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

55 (A) HEALTH STATUS;

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

1 (C) CLAIMS EXPERIENCE;

2 (D) RECEIPT OF HEALTH CARE;

3 (E) MEDICAL HISTORY;

4 (F) GENETIC INFORMATION;

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

7 (H) DISABILITY.

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

14 (8) A HEALTH MAINTENANCE ORGANIZATION SHALL MAKE AVAILABLE AT LEAST
15 ONE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT THE PLATINUM LEVEL OF
16 COVERAGE, AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42
17 USC S 18022(D), THAT INCLUDES AN OUT-OF-PLAN BENEFITS OPTION TO ENROL-
18 LEES COVERED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN, BY THE
19 HEALTH MAINTENANCE ORGANIZATION UNDER CONTRACTS SUBJECT TO SECTION FOUR
20 THOUSAND THREE HUNDRED TWENTY-TWO OF THIS ARTICLE. THE HEALTH MAINTE-
21 NANCE ORGANIZATION SHALL PROVIDE THE PLATINUM LEVEL OF COVERAGE WITH AN
22 OUT-OF-PLAN BENEFIT RIDER TO ANY ENROLLEE THAT ELECTS THE COVERAGE.
23 ENROLLEES WHO TERMINATE THE RIDER OR ARE TERMINATED FOLLOWING THE EFFEC-
24 TIVE DATE OF THIS PARAGRAPH SHALL BE INELIGIBLE TO PURCHASE SUCH RIDER
25 FOLLOWING THE TERMINATION. NOTHING IN THIS PARAGRAPH SHALL REQUIRE A
26 HEALTH MAINTENANCE ORGANIZATION TO OFFER AN OUT-OF-PLAN BENEFIT TO ANY
27 OTHER ENROLLEE, INCLUDING THROUGH THE HEALTH BENEFIT EXCHANGE. A HEALTH
28 MAINTENANCE ORGANIZATION SHALL PROVIDE NOTICE OF THE AVAILABILITY OF THE
29 OUT-OF-PLAN BENEFITS PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN OR
30 SHALL INCORPORATE NOTICE OF SUCH AVAILABILITY INTO DISCONTINUANCE
31 NOTICES ISSUED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED FOUR OF
32 THIS ARTICLE.

33 (C) IN ADDITION TO OR IN LIEU OF THE INDIVIDUAL ENROLLEE DIRECT
34 PAYMENT CONTRACTS REQUIRED UNDER THIS SECTION, ALL HEALTH MAINTENANCE
35 ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR
36 OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTICLE MAY OFFER INDIV-
37 IDUAL ENROLLEE DIRECT PAYMENT CONTRACTS WITHIN THE HEALTH BENEFIT
38 EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE
39 ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER,
40 SUBJECT TO ANY REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE.
41 IF A HEALTH MAINTENANCE ORGANIZATION SATISFIES THE REQUIREMENTS OF
42 SUBSECTION (A) OF THIS SECTION BY OFFERING INDIVIDUAL ENROLLEE DIRECT
43 PAYMENT CONTRACTS, ONLY WITHIN THE HEALTH BENEFIT EXCHANGE, THE HEALTH
44 MAINTENANCE ORGANIZATION, NOT INCLUDING A HOLDER OF A SPECIAL PURPOSE
45 CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR
46 HUNDRED THREE-A OF THE PUBLIC HEALTH LAW, SHALL ALSO OFFER AT LEAST ONE
47 INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT EACH LEVEL OF COVERAGE AS
48 DEFINED IN SECTION 1302 (D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S
49 18022 (D), OUTSIDE THE HEALTH BENEFIT EXCHANGE.

50 (D)(1) NOTHING IN THIS SECTION SHALL BE DEEMED TO REQUIRE HEALTH MAIN-
51 TENANCE ORGANIZATIONS TO DISCONTINUE INDIVIDUAL DIRECT PAYMENT CONTRACTS
52 ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN OR PREVENT HEALTH
53 MAINTENANCE ORGANIZATIONS FROM DISCONTINUING INDIVIDUAL DIRECT PAYMENT
54 CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. IF A
55 HEALTH MAINTENANCE ORGANIZATION DISCONTINUES INDIVIDUAL DIRECT PAYMENT
56 CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN, REGARD-

1 LESS OF WHETHER IT IS A GRANDFATHERED HEALTH PLAN, THEN THE HEALTH MAIN-
2 TENANCE ORGANIZATION SHALL COMPLY WITH THE REQUIREMENTS OF SUBSECTION
3 (C) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS ARTICLE.

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

9 (E) THE SUPERINTENDENT MAY PROMULGATE REGULATIONS IMPLEMENTING THE
10 REQUIREMENTS OF THIS SECTION, INCLUDING REGULATIONS THAT MODIFY OR ADD
11 ADDITIONAL STANDARDIZED INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS IF
12 THE SUPERINTENDENT DETERMINES ADDITIONAL CONTRACTS WITH DIFFERENT LEVELS
13 OF COVERAGE ARE NECESSARY TO MEET THE NEEDS OF THE PUBLIC.

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

16 1. The contract between a health maintenance organization and an
17 enrollee shall be subject to regulation by the superintendent as if it
18 were a health insurance subscriber contract, and shall include, but not
19 be limited to, all mandated benefits required by article forty-three of
20 the insurance law. Such contract shall fully and clearly state the bene-
21 fits and limitations therein provided or imposed, so as to facilitate
22 understanding and comparisons, and to exclude provisions which may be
23 misleading or unreasonably confusing. Such contract shall be issued to
24 any individual and dependents of such individual and any group of fifty
25 or fewer employees or members, exclusive of spouses and dependents, or
26 any employee or member of the group, including dependents, applying for
27 such contract at any time throughout the year, and may include a pre-ex-
28 isting condition provision as provided for in section four thousand
29 three hundred eighteen of the insurance law, provided, however, that
30 [such], THE SUPERINTENDENT MAY, AFTER GIVING CONSIDERATION TO THE PUBLIC
31 INTEREST, EXEMPT A HEALTH MAINTENANCE ORGANIZATION FROM THE REQUIREMENTS
32 OF THIS SECTION PROVIDED THAT ANOTHER HEALTH INSURER OR HEALTH MAINTE-
33 NANCE ORGANIZATION WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S SAME
34 HOLDING COMPANY SYSTEM, AS DEFINED IN ARTICLE FIFTEEN OF THE INSURANCE
35 LAW, INCLUDING A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A LINE OF
36 BUSINESS OF A HEALTH SERVICE CORPORATION LICENSED UNDER ARTICLE
37 FORTY-THREE OF THE INSURANCE LAW, OFFERS COVERAGE THAT, AT A MINIMUM,
38 COMPLIES WITH THIS SECTION AND PROVIDES ALL OF THE CONSUMER PROTECTIONS
39 REQUIRED TO BE PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION PURSUANT TO
40 THIS CHAPTER AND REGULATIONS, INCLUDING THOSE CONSUMER PROTECTIONS
41 CONTAINED IN SECTIONS FOUR THOUSAND FOUR HUNDRED THREE AND FOUR THOUSAND
42 FOUR HUNDRED EIGHT-A OF THIS CHAPTER. THE requirements shall not apply
43 to a health maintenance organization exclusively serving individuals
44 enrolled pursuant to title eleven of article five of the social services
45 law, title eleven-D of article five of the social services law, title
46 one-A of article twenty-five of the public health law or title eighteen
47 of the federal Social Security Act, and, further provided, that such
48 health maintenance organization shall not discontinue a contract for an
49 individual receiving comprehensive-type coverage in effect prior to
50 January first, two thousand four who is ineligible to purchase policies
51 offered after such date pursuant to this section or section four thou-
52 sand three hundred twenty-two of this article due to the provision of 42
53 U.S.C. 1395ss in effect prior to January first, two thousand four.
54 Subject to the creditable coverage requirements of subsection (a) of
55 section four thousand three hundred eighteen of the insurance law, the
56 organization may, as an alternative to the use of a pre-existing condi-

1 tion provision, elect to offer contracts without a pre-existing condi-
2 tion provision to such groups but may require that coverage shall not
3 become effective until after a specified affiliation period of not more
4 than sixty days after the application for coverage is submitted. The
5 organization is not required to provide health care services or benefits
6 during such period and no premium shall be charged for any coverage
7 during the period. After January first, nineteen hundred ninety-six,
8 all individual direct payment contracts shall be issued only pursuant to
9 sections four thousand three hundred twenty-one and four thousand three
10 hundred twenty-two of the insurance law. Such contracts may not, with
11 respect to an eligible individual (as defined in section 2741(b) of the
12 federal Public Health Service Act, 42 U.S.C. S 300gg-41(b), impose any
13 pre-existing condition exclusion.

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

16 (5) (A) Any family policy providing hospital or surgical expense
17 insurance (but not including such insurance against accidental injury
18 only) shall provide that, in the event such insurance on any person,
19 other than the policyholder, is terminated because the person is no
20 longer within the definition of the family as set forth in the policy
21 but before such person has attained the limiting age, if any, for cover-
22 age of adults specified in the policy, such person shall be entitled to
23 have issued to [him] THAT PERSON by the insurer, without evidence of
24 insurability, upon application therefor and payment of the first premi-
25 um, within [thirty-one] SIXTY days after such insurance shall have
26 terminated, an individual conversion policy THAT CONTAINS THE BENEFITS
27 DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND
28 THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER. THE INSURER SHALL OFFER ONE
29 POLICY AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE
30 AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). THE INDIVIDUAL MAY CHOOSE ANY
31 SUCH POLICY OFFERED BY THE INSURER. The conversion privilege afforded
32 herein shall also be available upon the divorce or annulment of the
33 marriage of the policyholder to the former spouse of such policyholder.

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

43 (C) Such individual conversion policy shall be subject to the follow-
44 ing terms and conditions:

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

48 (ii) [Such policy shall provide, on a basis specified in the family
49 policy, the same or substantially the same benefits as those provided in
50 the family policy or such benefits as are provided in a policy specif-
51 ically approved as an individual conversion policy by the superinten-
52 dent.

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

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

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

21 [(vi) The policy may include a provision whereby the insurer may
22 request information at any premium due date of the policy of the person
23 covered thereunder as to whether he is then covered by another policy or
24 hospital service or medical expense indemnity corporation subscriber
25 contract providing similar benefits or is then covered by a group
26 contract or policy providing similar benefits or is then provided with
27 similar benefits required by any statute or provided by any welfare plan
28 or program. If any such person is so covered or so provided and fails to
29 furnish the details of such coverage when requested, the benefits paya-
30 ble under the conversion policy may be based on the hospital surgical or
31 medical expenses actually incurred after excluding expenses to the
32 extent they are payable under such other coverage or provided under such
33 statute, plan, or program.]

34 S 47. Paragraphs 4, 6, 9 and 10 of subsection (e) of section 3221 of
35 the insurance law are REPEALED, paragraphs 5, 7, 8, 11 and 12 are renum-
36 bered paragraphs 4, 5, 6, 7 and 8 and paragraph 1, as amended by chapter
37 306 of the laws of 1987, is amended to read as follows:

38 (1) A group policy providing hospital, MEDICAL or surgical expense
39 insurance for other than specific diseases or accident only, shall
40 provide that if the insurance on an employee or member insured under the
41 group policy ceases because of termination of [(I)] (A) employment or of
42 membership in the class or classes eligible for coverage under the poli-
43 cy or [(II)] (B) the policy, for any reason whatsoever, unless the poli-
44 cyholder has replaced the group policy with similar and continuous
45 coverage for the same group whether insured or self-insured, such
46 employee or member who has been insured under the group policy [for at
47 least three months] shall be entitled to have issued to [him] THE
48 INSURED by the insurer without evidence of insurability upon application
49 made to the insurer within [forty-five] SIXTY days after such termi-
50 nation, and payment of the quarterly, or, at the option of the employee
51 or member, a less frequent premium applicable to the [class of risk to
52 which the person belongs, the age of such person, and the] form and
53 amount of insurance, an individual policy of insurance. The insurer may,
54 at its option elect to provide the insurance coverage under a group
55 insurance policy, delivered in this state, in lieu of the issuance of a
56 converted individual policy of insurance. Such individual policy, or

1 group policy, as the case may be is hereafter referred to as the
2 converted policy. The benefits provided under the converted policy shall
3 be those required by subsection (f)[,] AND (g)[, (h) or (i) hereof] OF
4 THIS SECTION, [whichever is applicable and,] in the event of termination
5 of the converted group policy of insurance, each insured thereunder
6 shall have a right of conversion to a converted individual policy of
7 insurance.

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

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

27 S 49. Subsections (f) and (g) of section 3221 of the insurance law are
28 REPEALED and two new subsections (f) and (g) are added to read as
29 follows:

30 (F) IF THE GROUP INSURANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR
31 HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, OR IF THE GROUP INSUR-
32 ANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR MAJOR MEDICAL OR SIMILAR
33 COMPREHENSIVE-TYPE COVERAGE, THEN THE CONVERSION PRIVILEGE SHALL ENTITLE
34 THE EMPLOYEE OR MEMBER TO OBTAIN COVERAGE UNDER A CONVERTED POLICY
35 PROVIDING, AT THE INSURED'S OPTION, COVERAGE UNDER ANY ONE OF THE PLANS
36 DESCRIBED IN SUBSECTION (G) OF THIS SECTION ON AN EXPENSE INCURRED
37 BASIS.

38 (G) FOR CONVERSION PURPOSES, AN INSURER SHALL OFFER TO THE EMPLOYEE OR
39 MEMBER A POLICY AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D)
40 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D) THAT CONTAINS THE BENE-
41 FITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOU-
42 SAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER.

43 S 50. Subparagraph (D) of paragraph 4 of subsection (l) of section
44 3221 of the insurance law, as amended by chapter 230 of the laws of
45 2004, is amended to read as follows:

46 (D) In addition to the requirements of subparagraph (A) of this para-
47 graph, every insurer issuing a group policy for delivery in this state
48 [which] WHERE THE policy provides reimbursement to insureds for psychi-
49 atric or psychological services or for the diagnosis and treatment of
50 mental, nervous or emotional disorders and ailments, however defined in
51 such policy, by physicians, psychiatrists or psychologists, [must] SHALL
52 provide the same coverage to insureds for such services when performed
53 by a licensed clinical social worker, within the lawful scope of his or
54 her practice, who is licensed pursuant to subdivision two of section
55 seven thousand seven hundred four of the education law and in addition
56 shall have either: (i) three or more additional years experience in

1 psychotherapy, which for the purposes of this subparagraph shall mean
2 the use of verbal methods in interpersonal relationships with the intent
3 of assisting a person or persons to modify attitudes and behavior
4 [which] THAT are intellectually, socially or emotionally maladaptive,
5 under supervision, satisfactory to the state board for social work, in a
6 facility, licensed or incorporated by an appropriate governmental
7 department, providing services for diagnosis or treatment of mental,
8 nervous or emotional disorders or ailments[, or]; (ii) three or more
9 additional years experience in psychotherapy under the supervision,
10 satisfactory to the state board for social work, of a psychiatrist, a
11 licensed and registered psychologist or a licensed clinical social work-
12 er qualified for reimbursement pursuant to subsection [(h)] (E) of this
13 section, or (iii) a combination of the experience specified in items (i)
14 and (ii) OF THIS SUBPARAGRAPH totaling three years, satisfactory to the
15 state board for social work.

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

19 S 51. Paragraph 3 of subsection (e) of section 4304 of the insurance
20 law is REPEALED and paragraphs 4 and 5 are renumbered paragraphs 3 and
21 4, and paragraphs 1 and 2 of such subsection (e), paragraph 1 as amended
22 by chapter 661 of the laws of 1997, and as further amended by section
23 104 of part A of chapter 62 of the laws of 2011, are amended to read as
24 follows:

25 (1) If any such contract is terminated in accordance with the
26 provisions of paragraph one of subsection (c) [hereof] OF THIS SECTION,
27 or any such contract is terminated because of a default by the remitting
28 agent in the payment of premiums not cured within the grace period and
29 the remitting agent has not replaced the contract with similar and
30 continuous coverage for the same group whether insured or self-insured,
31 or any such contract is terminated in accordance with the provisions of
32 subparagraph (E) of paragraph two of subsection (c) [hereof] OF THIS
33 SECTION, or if an individual other than the contract holder is no longer
34 covered under a "family contract" because [he] THE INDIVIDUAL is no
35 longer within the definition set forth in the contract, or a spouse is
36 no longer covered under the contract because of divorce from the
37 contract holder or annulment of the marriage, or any such contract is
38 terminated because of the death of the contract holder, then such indi-
39 vidual, former spouse, or in the case of the death of the contract hold-
40 er the surviving spouse or other dependents of the deceased contract
41 holder covered under the contract, as the case may be, shall be entitled
42 to convert, without evidence of insurability, upon application therefor
43 and the making of the first payment thereunder within [thirty-one] SIXTY
44 days after the date of termination of such contract, to a contract [of a
45 type which provides coverage most nearly comparable to the type of
46 coverage under the contract from which the individual converted, which
47 coverage shall be no less than the minimum standards for basic hospital,
48 basic medical, or major medical as provided for in department of finan-
49 cial services regulation; provided, however, that if the corporation
50 does not issue such a major medical contract, then to a comprehensive or
51 comparable type of coverage which is most commonly being sold to group
52 remitting agents. Notwithstanding the previous sentence, a corporation
53 may elect to issue a standardized individual enrollee contract pursuant
54 to section four thousand three hundred twenty-two of this article in
55 lieu of a major medical contract, comprehensive or comparable type of
56 coverage required to be offered upon conversion from an indemnity

1 contract] THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF
2 SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF
3 THIS CHAPTER. THE CORPORATION SHALL OFFER ONE CONTRACT AT EACH LEVEL OF
4 COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42
5 U.S.C. S 18022(D). THE INDIVIDUAL MAY CHOOSE ANY SUCH CONTRACT OFFERED
6 BY THE CORPORATION. The effective date of the coverage provided by the
7 converted direct payment contract shall be the date of the termination
8 of coverage under the contract from which conversion was made.

9 (2) The corporation shall not be required to issue any such converted
10 individual direct payment contract if its issuance would result in over-
11 insurance or duplication of benefits according to standards on file with
12 the superintendent and approved by [him] THE SUPERINTENDENT with regard
13 to such contracts. [The individual direct payment contract may include a
14 provision whereby the corporation may request information when any
15 payment is due under the contract of the person covered thereunder as to
16 whether he is then covered by another individual contract providing
17 similar benefits or is then covered by a group contract policy providing
18 similar benefits or is then provided with similar benefits required by
19 any statute or provided by any welfare plan or program which together
20 with the converted individual direct payment contract would result in
21 overinsurance or duplication of benefits according to the standards on
22 file with the superintendent relating to individual contracts. If any
23 such person is so covered or so provided and fails to furnish the
24 details of such coverage when requested, the benefits provided under the
25 converted individual direct payment contract may be based on the hospi-
26 tal, surgical or medical expenses actually incurred after excluding
27 expenses to the extent they are payable under such other coverage or
28 provided under such statute, plan or program.]

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

33 (1) (A) A group contract issued pursuant to this section shall contain
34 a provision to the effect that in case of a termination of coverage
35 under such contract of any member of the group because of [(I)] (I)
36 termination for any reason whatsoever of [his] THE MEMBER'S employment
37 or membership, [if he has been covered under the group contract for at
38 least three months,] or [(II)] (II) termination for any reason whatsoev-
39 er of the group contract itself unless the group contract holder has
40 replaced the group contract with similar and continuous coverage for the
41 same group whether insured or self-insured, [he] THE MEMBER shall be
42 entitled to have issued to [him] THE MEMBER by the corporation, without
43 evidence of insurability, upon application therefor and payment of the
44 first premium made to the corporation within [forty-five] SIXTY days
45 after termination of the coverage, an individual direct payment
46 contract, covering such member and [his] THE MEMBER'S eligible depen-
47 dents who were covered by the group contract, which provides coverage
48 [most nearly comparable to the type of coverage under the group
49 contract, which coverage shall be no less than the minimum standards for
50 basic hospital, basic medical, or major medical as provided for in
51 department of financial services regulation; provided, however, that if
52 the corporation does not issue such a major medical contract, then to a
53 comprehensive or comparable type of coverage which is most commonly
54 being sold to group remitting agents. Notwithstanding the previous
55 sentence, a corporation may elect to issue a standardized individual
56 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 CHAPTER. THE CORPORATION SHALL OFFER ONE CONTRACT AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). THE MEMBER MAY CHOOSE ANY SUCH CONTRACT OFFERED BY THE CORPORATION.

(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. Section 3216 of the insurance law is amended by adding a new subsection (m) to read as follows:

(M) AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF THE BENEFITS MUST BE COVERED AS ESSENTIAL HEALTH BENEFITS. FOR ANY POLICY ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION. FOR PURPOSES OF THIS SUBSECTION, "ESSENTIAL HEALTH BENEFITS" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 54. Subsections (h) and (i) of section 3221 of the insurance law are REPEALED and two new subsections (h) and (i) are added to read as follows:

(H) EVERY SMALL GROUP POLICY OR ASSOCIATION GROUP POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE AND IS NOT A GRANDFATHERED HEALTH PLAN 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:

(1) "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);

(2) "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER 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);

(3) "SMALL GROUP" MEANS A GROUP OF FIFTY OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; PROVIDED, HOWEVER, THAT BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN, "SMALL GROUP" MEANS A GROUP OF ONE HUNDRED OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; AND

(4) "ASSOCIATION GROUP" MEANS A GROUP DEFINED IN SUBPARAGRAPHS (B), (D), (H), (K), (L) OR (M) OF PARAGRAPH ONE OF SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, PROVIDED THAT:

(A) THE GROUP INCLUDES ONE OR MORE INDIVIDUAL MEMBERS; OR

(B) THE GROUP INCLUDES ONE OR MORE MEMBER EMPLOYERS OR OTHER MEMBER GROUPS THAT ARE SMALL GROUPS.

(I) AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF THE BENEFITS MUST BE COVERED PURSUANT TO SUBSECTION (H) OF THIS SECTION. FOR ANY POLICY ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION.

S 55. Subsection (gg) of section 4303 of the insurance law, as added by chapter 536 of the laws of 2010, is relettered to be subsection (jj), subsection (hh), as added by chapter 597 of the laws of 2011, is relettered to be subsection (kk) and two new subsections (ll) and (mm) are added to read as follows:

(LL) EVERY SMALL GROUP CONTRACT OR ASSOCIATION GROUP CONTRACT DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE AND IS NOT A GRANDFATHERED HEALTH PLAN 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:

(1) "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);

(2) "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

(3) "SMALL GROUP" MEANS A GROUP OF FIFTY OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS. BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN, "SMALL GROUP" MEANS A GROUP OF ONE HUNDRED OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; AND

(4) "ASSOCIATION GROUP" MEANS A GROUP DEFINED IN SUBPARAGRAPHS (B), (D), (H), (K), (L) OR (M) OF PARAGRAPH ONE OF SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, PROVIDED THAT:

(A) THE GROUP INCLUDES ONE OR MORE INDIVIDUAL MEMBERS; OR

(B) THE GROUP INCLUDES ONE OR MORE MEMBER EMPLOYERS OR OTHER MEMBER GROUPS THAT ARE SMALL GROUPS.

(MM) A CORPORATION SHALL NOT BE REQUIRED TO OFFER THE CONTRACT HOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF SUCH BENEFITS MUST BE COVERED PURSUANT TO SUBSECTION (KK) OF THIS SECTION. FOR ANY CONTRACT ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, A CORPORATION SHALL NOT BE REQUIRED TO OFFER THE CONTRACT HOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION.

S 55-a. Section 3221 of the insurance law is amended by adding a new subsection (s) to read as follows:

(S) AN INSURER SUBJECT TO THE PROVISIONS OF THIS ARTICLE OR AN INSURANCE PRODUCER SUBJECT TO THIS CHAPTER SHALL NOT PERMIT THE RENEWAL OF A SMALL GROUP POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL EXPENSE COVERAGE THAT RENEWS ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BUT BEFORE JULY FIRST, TWO THOUSAND FOURTEEN, SO AS TO RENEW THE SAME POLICY PRIOR TO THE POLICY'S ANNUAL RENEWAL DATE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT AND REGULATIONS PROMULGATED THEREUNDER WITH RESPECT TO SUCH POLICY. AN ISOLATED, INADVERTENT RENEWAL DATE CHANGE WHICH WAS NOT MADE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT SHALL NOT BE DEEMED A VIOLATION OF THIS SUBSECTION.

S 55-b. Section 4303 of the insurance law is amended by adding a new subsection (nn) to read as follows:

(NN) A CORPORATION SUBJECT TO THE PROVISIONS OF THIS ARTICLE OR AN INSURANCE PRODUCER SUBJECT TO THIS CHAPTER SHALL NOT PERMIT THE RENEWAL OF A SMALL GROUP POLICY WHICH PROVIDES HOSPITAL, SURGICAL OR MEDICAL EXPENSE COVERAGE THAT RENEWS ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BUT BEFORE JULY FIRST, TWO THOUSAND FOURTEEN, SO AS TO RENEW THE SAME POLICY PRIOR TO THE POLICY'S ANNUAL RENEWAL DATE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT AND REGULATIONS PROMULGATED THEREUNDER WITH RESPECT TO SUCH POLICY. AN ISOLATED, INADVERTENT RENEWAL DATE CHANGE WHICH WAS NOT MADE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT SHALL NOT BE DEEMED A VIOLATION OF THIS SUBSECTION.

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, para-

graphs 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 twenty-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;

1 (iii) except that the requirements set forth in item (i) of this
2 subparagraph shall not be applicable where an individual proprietor had
3 health insurance coverage during the previous twelve months and such
4 coverage terminated due to one of the reasons set forth in items (i)
5 through (viii) of subparagraph (C) of paragraph three of subsection (c)
6 of this section; or
7 (B) An] AN employer with:
8 (i) not more than fifty [eligible] employees;
9 (ii) no group health insurance [which] THAT provides benefits on an
10 expense reimbursed or prepaid basis covering employees in effect during
11 the twelve month period prior to application for a qualifying group
12 health insurance contract under the program established by this section;
13 and
14 (iii) at least thirty percent of its [eligible] employees receiving
15 annual wages from the employer at a level equal to or less than thirty
16 thousand dollars. The thirty thousand dollar figure shall be adjusted
17 periodically pursuant to subparagraph [(F)] (D) of this paragraph.
18 [(C) The requirements set forth in item (i) of subparagraph (A) of
19 this paragraph and in item (ii) of subparagraph (B) of this paragraph
20 shall not be applicable where an individual proprietor or employer is
21 transferring from a health insurance contract issued pursuant to the New
22 York state small business health insurance partnership program estab-
23 lished by section nine hundred twenty-two of the public health law or
24 from health care coverage issued pursuant to a regional pilot project
25 for the uninsured established by section one thousand one hundred eigh-
26 teen of this chapter.
27 (D)] (B) The twelve month period set forth [in item (i) of subpara-
28 graph (A) of this paragraph and] in item (ii) of subparagraph [(B)] (A)
29 of this paragraph may be adjusted by the superintendent from twelve
30 months to eighteen months if he determines that the twelve month period
31 is insufficient to prevent inappropriate substitution of [other health
32 insurance contracts for] qualifying group health insurance contracts FOR
33 OTHER HEALTH INSURANCE CONTRACTS.
34 [(E)] (C) An [individual proprietor or] employer shall cease to be a
35 qualifying small employer if any health insurance [which] THAT provides
36 benefits on an expense reimbursed or prepaid basis covering [the indi-
37 vidual proprietor or] an employer's employees, other than qualifying
38 group health insurance purchased pursuant to this section, is purchased
39 or otherwise takes effect subsequent to purchase of qualifying group
40 health insurance under the program established by this section.
41 [(F)] (D) The wage levels utilized in subparagraph [(B)] (A) of this
42 paragraph shall be adjusted annually, beginning in two thousand two. The
43 adjustment shall take effect on July first of each year. For July first,
44 two thousand two, the adjustment shall be a percentage of the annual
45 wage figure specified in subparagraph [(B)] (A) of this paragraph. For
46 subsequent years, the adjustment shall be a percentage of the annual
47 wage figure [which] THAT took effect on July first of the prior year.
48 The percentage adjustment shall be the same percentage by which the
49 current year's non-farm federal poverty level, as defined and updated by
50 the federal department of health and human services, for a family unit
51 of four persons for the forty-eight contiguous states and Washington,
52 D.C., changed from the same level established for the prior year.
53 (2) A qualifying group health insurance contract is a group contract
54 purchased from a health maintenance organization, corporation or insurer
55 by a qualifying small employer [which] THAT provides the benefits set

1 forth in subsection (d) of this section. The contract must insure not
2 less than fifty percent of the employees [eligible for coverage].

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

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

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

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

17 (iv) is ineligible for Medicare.

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

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

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

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

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

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

39 (v) discontinuation of a group health insurance contract with benefits
40 on an expense reimbursed or prepaid basis covering the qualifying indi-
41 vidual as an employee or dependent;

42 (vi) expiration of the coverage periods established by the continua-
43 tion provisions of the Employee Retirement Income Security Act, 29
44 U.S.C. section 1161 et seq. and the Public Health Service Act, 42
45 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus
46 Budget Reconciliation Act of 1985, as amended, or the continuation
47 provisions of subsection (m) of section three thousand two hundred twen-
48 ty-one, subsection (k) of section four thousand three hundred four and
49 subsection (e) of section four thousand three hundred five of this chap-
50 ter;

51 (vii) legal separation, divorce or annulment which results in termi-
52 nation of coverage under a health insurance contract under which the
53 individual is covered; or

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

55 (D) The twelve month period set forth in items (i) and (ii) of subpar-
56 agraph (A) of this paragraph may be adjusted by the superintendent from

12 twelve months to eighteen months if he determines that the twelve month
13 period is insufficient to prevent inappropriate substitution of other
14 health insurance contracts for qualifying individual health insurance
15 contracts.

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

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

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

29 (2) outpatient hospital services consisting of diagnostic and treat-
30 ment services;

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

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

37 (5) preadmission testing;

38 (6) maternity care;

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

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

44 (9) equipment, supplies and self-management education for the treat-
45 ment of diabetes;

46 (10) diagnostic x-ray and laboratory services;

47 (11) emergency services;

48 (12) therapeutic services consisting of radiologic services, chemoth-
49 erapy and hemodialysis;

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

52 (14) prescription drugs obtained at a participating pharmacy. In addi-
53 tion to providing coverage at a participating pharmacy, health mainte-
54 nance organizations may utilize a mail order prescription drug program.
55 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 preven-
tive services task force;

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

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

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

9 (E) For purposes of this paragraph, "grandfathered health plan" means
10 coverage provided by a corporation in which an individual was enrolled
11 on March twenty-third, two thousand ten for as long as the coverage
12 maintains grandfathered status in accordance with section 1251(e) of the
13 Affordable Care Act, 42 U.S.C. S 18011(e)] A QUALIFYING GROUP HEALTH
14 INSURANCE CONTRACT SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENE-
15 FIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE
16 ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS SUBSECTION "ESSENTIAL
17 HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION
18 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A).

19 (d-1) Covered services shall not include drugs, procedures and
20 supplies for the treatment of erectile dysfunction when provided to, or
21 prescribed for use by, a person who is required to register as a sex
22 offender pursuant to article six-C of the correction law, provided that:

23 (1) any denial of coverage pursuant to this subsection shall provide the
24 enrollee with the means of obtaining additional information concerning
25 both the denial and the means of challenging such denial; (2) all drugs,
26 procedures and supplies for the treatment of erectile dysfunction may be
27 subject to prior authorization by corporations, insurers or health main-
28 tenance organizations for the purposes of implementing this subsection;
29 and (3) the superintendent shall promulgate regulations to implement the
30 denial of coverage pursuant to this subsection giving health maintenance
31 organizations, corporations and insurers at least sixty days following
32 promulgation of the regulations to implement their denial procedures
33 pursuant to this subsection.

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

40 (d-3) Notwithstanding any other provision of law, if the commissioner
41 of health makes a finding pursuant to subdivision twenty-three of
42 section two hundred six of the public health law, the superintendent is
43 authorized to remove a drug, procedure or supply from the services
44 covered by the standardized health insurance contract established by
45 this section for those persons required to register as sex offenders
46 pursuant to article six-C of the correction law.

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

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

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

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

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

3 (5) prescription drugs shall have a one hundred dollar calendar year
4 deductible per individual. After the deductible is satisfied, each thir-
5 ty-four day supply of a prescription drug will be subject to a copay-
6 ment. The copayment will be ten dollars if the drug is generic. The
7 copayment for a brand name drug will be twenty dollars plus the differ-
8 ence in cost between the brand name drug and the equivalent generic
9 drug. If a mail order drug program is utilized, a twenty dollar copay-
10 ment shall be imposed on a ninety day supply of generic prescription
11 drugs. A forty dollar copayment plus the difference in cost between the
12 brand name drug and the equivalent generic drug shall be imposed on a
13 ninety day supply of brand name prescription drugs. In no event shall
14 the copayment exceed the cost of the prescribed drug;

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

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

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

27 (7) all other services shall have a twenty dollar copayment with the
28 exception of prenatal care which shall have a ten dollar copayment or
29 preventive health services provided pursuant to paragraph fifteen of
30 subsection (d) of this section, for which no copayment shall apply] A
31 QUALIFYING GROUP HEALTH INSURANCE CONTRACT ISSUED TO A QUALIFYING SMALL
32 EMPLOYER PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DOES NOT
33 INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION
34 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A), SHALL
35 BE DISCONTINUED, INCLUDING GRANDFATHERED HEALTH PLANS. FOR THE PURPOSES
36 OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLANS" MEANS COVERAGE PROVIDED
37 BY A CORPORATION TO INDIVIDUALS WHO WERE ENROLLED ON MARCH TWENTY-THIRD,
38 TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED
39 STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42
40 U.S.C. S 18011(E). A QUALIFYING SMALL EMPLOYER SHALL BE TRANSITIONED TO
41 A PLAN THAT PROVIDES: (1) A LEVEL OF COVERAGE THAT IS DESIGNED TO
42 PROVIDE BENEFITS THAT ARE ACTUARIALLY EQUIVALENT TO EIGHTY PERCENT OF
43 THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN; AND
44 (2) COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN
45 SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S
46 300GG-6(A). THE SUPERINTENDENT SHALL STANDARDIZE THE BENEFIT PACKAGE AND
47 COST SHARING REQUIREMENTS OF QUALIFIED GROUP HEALTH INSURANCE CONTRACTS
48 CONSISTENT WITH COVERAGE OFFERED THROUGH THE HEALTH BENEFIT EXCHANGE
49 ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42
50 U.S.C. S 18031.

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

1 shall be subject to the deductibles and copayments set forth in
2 subsection (e) of this section.]

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

11 (h)] A health maintenance organization, corporation or insurer must
12 offer the benefit package without change or additional benefits. [Quali-
13 fying] A QUALIFYING small [employers] EMPLOYER shall be issued the bene-
14 fit package in a qualifying group health insurance contract. [Qualifying
15 individuals shall be issued the benefit package in a qualifying individ-
16 ual health insurance contract.

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

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

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

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

52 [(3) For purposes of paragraphs one and two of this subsection,
53 "grandfathered health plan" means coverage provided by a corporation in
54 which an individual was enrolled on March twenty-third, two thousand ten
55 for as long as the coverage maintains grandfathered status in accordance
56 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] THE SUPERINTENDENT SHALL SET STANDARD RATING TIERS FOR FAMILY UNITS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL CONTRACTS SUBJECT TO THIS SECTION; AND

(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; 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

1 hundred twenty-two of the public health law, the voucher insurance
2 program established by section one thousand one hundred twenty-one of
3 this chapter, or uninsured pilot programs established pursuant to chap-
4 ter seven hundred three of the laws of nineteen hundred eighty-eight
5 shall be eligible for participation in the standardized health insurance
6 contracts established by this section, regardless of any of the eligi-
7 bility requirements established pursuant to subsection (c) of this
8 section.]

9 S 57. The insurance law is amended by adding a new section 4326-a to
10 read as follows:

11 S 4326-A. TRANSITION OF HEALTHY NEW YORK ENROLLEES. (A) ON DECEMBER
12 THIRTY-FIRST, TWO THOUSAND THIRTEEN, COVERAGE ISSUED TO QUALIFYING INDIV-
13 IDUALS AND QUALIFYING SMALL EMPLOYERS WHO ARE SOLE PROPRIETORS AS
14 DEFINED IN SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX SHALL END
15 CONTINGENT UPON THE AVAILABILITY OF COVERAGE FOR INDIVIDUAL AND SOLE
16 PROPRIETORS THROUGH THE HEALTH BENEFIT EXCHANGE.

17 (B) A HEALTH MAINTENANCE ORGANIZATION, CORPORATION, OR INSURER SHALL
18 PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCONTINUANCE TO EACH ENROLLED
19 INDIVIDUAL AND INDIVIDUAL PROPRIETOR AT LEAST ONE HUNDRED AND EIGHTY
20 DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. EVERY NOTICE OF
21 PROGRAM DISCONTINUANCE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMA-
22 TION AS THE SUPERINTENDENT REQUIRES.

23 (C) QUALIFYING GROUP HEALTH INSURANCE CONTRACTS ISSUED TO QUALIFYING
24 SMALL EMPLOYERS PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DO
25 NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION
26 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A); SHALL
27 BE DISCONTINUED. QUALIFYING SMALL EMPLOYERS THAT ARE IMPACTED BY THE
28 DISCONTINUANCE SHALL BE TRANSITIONED TO A PLAN THAT MEETS THE REQUIRE-
29 MENTS OF SUBSECTION (E) OF SECTION FOUR THOUSAND THREE HUNDRED
30 TWENTY-SIX OF THIS CHAPTER. A HEALTH MAINTENANCE ORGANIZATION, CORPO-
31 RATION, OR INSURER SHALL PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCON-
32 TINUANCE TO EACH ENROLLED QUALIFYING SMALL EMPLOYER AT LEAST ONE HUNDRED
33 EIGHTY DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. EVERY NOTICE OF
34 PROGRAM DISCONTINUANCE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMA-
35 TION AS REQUIRED BY THE SUPERINTENDENT.

36 S 58. Section 4327 of the insurance law, as added by chapter 1 of the
37 laws of 1999, subsection (h) as amended by chapter 419 of the laws of
38 2000, subsection (m-1) as added by section 12 of part B of chapter 58 of
39 the laws of 2010, subsection (s) as amended and subsection (t) as added
40 by chapter 441 of the laws of 2006, is amended to read as follows:

41 S 4327. Stop loss funds for standardized health insurance contracts
42 issued to qualifying small employers and qualifying individuals. (a) The
43 superintendent shall establish a fund from which health maintenance
44 organizations, corporations or insurers may receive reimbursement, to
45 the extent of funds available therefor, for claims paid by such health
46 maintenance organizations, corporations or insurers for members covered
47 under qualifying group health insurance contracts issued pursuant to
48 section four thousand three hundred twenty-six of this article. This
49 fund shall be known as the "small employer stop loss fund". [The super-
50 intendent shall establish a separate and distinct fund from which health
51 maintenance organizations, corporations or insurers may receive
52 reimbursement, to the extent of funds available therefor, for claims
53 paid by such health maintenance organizations, corporations or insurers
54 for members covered under qualifying individual health insurance
55 contracts issued pursuant to section four thousand three hundred twen-

ty-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.]

1 (g) For [each] THE stop loss fund, the superintendent shall calculate
2 the total claims reimbursement amount for all health maintenance organ-
3 izations, corporations or insurers for the calendar year for which
4 claims are being reported.

5 (1) In the event that the total amount requested for reimbursement for
6 a calendar year exceeds funds available for distribution for claims paid
7 during that same calendar year, the superintendent shall provide for the
8 pro-rata distribution of the available funds. Each health maintenance
9 organization, corporation or insurer shall be eligible to receive only
10 such proportionate amount of the available funds as the individual
11 health maintenance organization's, corporation's or insurer's total
12 eligible claims paid bears to the total eligible claims paid by all
13 health maintenance organizations, corporations or insurers.

14 (2) In the event that funds available for distribution for claims paid
15 by all health maintenance organizations, corporations or insurers during
16 a calendar year exceeds the total amount requested for reimbursement by
17 all health maintenance organizations, corporations or insurers during
18 that same calendar year, any excess funds shall be carried forward and
19 made available for distribution in the next calendar year. Such excess
20 funds shall be in addition to the monies appropriated for the stop loss
21 fund in the next calendar year.

22 (h) Upon the request of the superintendent, each health maintenance
23 organization shall be required to furnish such data as the superinten-
24 dent deems necessary to oversee the operation of the small employer [and
25 qualifying individual] stop loss [funds] FUND. Such data shall be
26 furnished in a form prescribed by the superintendent. Each health main-
27 tenance organization, corporation or insurer shall provide the super-
28 intendent with monthly reports of the total enrollment under the quali-
29 fying group health insurance contracts [and the qualifying individual
30 health insurance contracts] issued pursuant to section four thousand
31 three hundred twenty-six of this article. The reports shall be in a form
32 prescribed by the superintendent.

33 (i) The superintendent shall separately estimate the per member annual
34 cost of total claims reimbursement from each stop loss fund for [quali-
35 fying individual health insurance contracts and for] qualifying group
36 health insurance contracts based upon available data and appropriate
37 actuarial assumptions. Upon request, each health maintenance organiza-
38 tion, corporation or insurer shall furnish to the superintendent claims
39 experience data for use in such estimations.

40 (j) The superintendent shall determine total eligible enrollment under
41 qualifying group health insurance contracts [and qualifying individual
42 health insurance contracts]. [For qualifying group health insurance
43 contracts, the] THE total eligible enrollment shall be determined by
44 dividing the total funds available for distribution from the small
45 employer stop loss fund by the estimated per member annual cost of total
46 claims reimbursement from the small employer stop loss fund. [For quali-
47 fying individual health insurance contracts, the total eligible enroll-
48 ment shall be determined by dividing the total funds available for
49 distribution from the qualifying individual stop loss fund by the esti-
50 mated per member annual cost of total claims reimbursement from the
51 qualifying individual stop loss fund.]

52 (k) The superintendent shall suspend the enrollment of new employers
53 under qualifying group health insurance contracts if [he] THE SUPER-
54 INTENDENT determines that the total enrollment reported by all health
55 maintenance organizations, corporations or insurers under such contracts
56 exceeds the total eligible enrollment, thereby resulting in anticipated

1 annual expenditures from the small employer stop loss fund in excess of
2 the total funds available for distribution from such stop loss fund.
3 [The superintendent shall suspend the enrollment of new individuals
4 under qualifying individual health insurance contracts if he determines
5 that the total enrollment reported by all health maintenance organiza-
6 tions, corporations or insurers under such contracts exceeds the total
7 eligible enrollment, thereby resulting in anticipated annual expendi-
8 tures from the qualifying individual stop loss fund in excess of the
9 total funds available for distribution from such stop loss fund.]

10 (l) The superintendent shall provide the health maintenance organiza-
11 tions, corporations or insurers with notification of any enrollment
12 suspensions as soon as practicable after receipt of all enrollment data.
13 [The superintendent's determination and notification shall be made sepa-
14 rately for the qualifying group health insurance contracts and for the
15 qualifying individual health insurance contracts.]

16 (m) If at any point during a suspension of enrollment of new qualify-
17 ing small employers [and/or qualifying individuals], the superintendent
18 determines that funds are sufficient to provide for the addition of new
19 enrollments, the superintendent shall be authorized to reactivate new
20 enrollments and to notify all health maintenance organizations, corpo-
21 rations or insurers that enrollment of new employers [and/or individ-
22 uals] may again commence. [The superintendent's determination and
23 notification shall be made separately for the qualifying group health
24 insurance contracts and for the qualifying individual health insurance
25 contracts.]

26 (m-1) In the event that the superintendent suspends the enrollment of
27 new individuals for qualifying group health insurance contracts [or
28 qualifying individual health insurance contracts], the superintendent
29 shall ensure that small employers [or sole proprietors] seeking to
30 enroll in a qualified group [or individual] health insurance contract
31 pursuant to section forty-three hundred twenty-six of this article are
32 provided information on and directed to [the family health plus employer
33 partnership program under section three hundred sixty-nine-ff of the
34 social services law] COVERAGE OPTIONS AVAILABLE THROUGH THE HEALTH BENE-
35 FIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE
36 ACT, 42 U.S.C. S 18031.

37 (n) The suspension of issuance of qualifying group health insurance
38 contracts to new qualifying small employers shall not preclude the addi-
39 tion of new employees of an employer already covered under such a
40 contract or new dependents of employees already covered under such
41 contracts.

42 (o) [The suspension of issuance of qualifying individual health insur-
43 ance contracts to new qualifying individuals shall not preclude the
44 addition of new dependents to an existing qualifying individual health
45 insurance contract.]

46 (p)] The premiums for qualifying group health insurance contracts must
47 factor in the availability of reimbursement from the small employer stop
48 loss fund. [The premiums for qualifying individual health insurance
49 contracts must factor in the availability of reimbursement from the
50 qualifying individual stop loss funds.]

51 (q)] (P) The superintendent may obtain the services of an organization
52 to administer the stop loss funds established by this section. [If the
53 superintendent deems it appropriate, he or she may utilize a separate
54 organization for administration of the small employer stop loss fund and
55 the qualifying individual stop loss fund.] The superintendent shall
56 establish guidelines for the submission of proposals by organizations

1 for the purposes of administering the funds. The superintendent shall
2 make a determination whether to approve, disapprove or recommend modifi-
3 cation to the proposal of an applicant to administer the funds. An
4 organization approved to administer the funds shall submit reports to
5 the superintendent in such form and at times as may be required by the
6 superintendent in order to facilitate evaluation and ensure orderly
7 operation of the funds, including[, but not limited to,] an annual
8 report of the affairs and operations of the fund, such report to be
9 delivered to the superintendent and to the chairs of the senate finance
10 committee and the assembly ways and means committee. An organization
11 approved to administer the funds shall maintain records in a form
12 prescribed by the superintendent and which shall be available for
13 inspection by or at the request of the superintendent. The superinten-
14 dent shall determine the amount of compensation to be allocated to an
15 approved organization as payment for fund administration. Compensation
16 shall be payable from the stop loss coverage funds. An organization
17 approved to administer the funds may be removed by the superintendent
18 and must cooperate in the orderly transition of services to another
19 approved organization or to the superintendent.

20 [(r)] (Q) If the superintendent deems it appropriate for the proper
21 administration of the small employer stop loss fund [and/or the qualify-
22 ing individual stop loss fund], the administrator of the fund, on behalf
23 of and with the prior approval of the superintendent, shall be author-
24 ized to purchase stop loss insurance and/or reinsurance from an insur-
25 ance company licensed to write such type of insurance in this state.
26 Such stop loss insurance and/or reinsurance may be purchased to the
27 extent of funds available therefor within such funds which are available
28 for purposes of the stop loss funds established by this section.

29 [(s)] (R) The superintendent may access funding from the small employ-
30 er stop loss fund [and/or the qualifying individual stop loss fund] for
31 the purposes of developing and implementing public education, outreach
32 and facilitated enrollment strategies targeted to small employers [and
33 working adults] without health insurance. The superintendent may
34 contract with marketing organizations to perform or provide assistance
35 with such education, outreach, and enrollment strategies. The super-
36 intendent shall determine the amount of funding available for the
37 purposes of this subsection which in no event shall exceed eight percent
38 of the annual funding amounts for the small employer stop loss fund [and
39 the qualifying individual stop loss fund].

40 [(t)] (S) Brooklyn healthworks pilot program and upstate healthworks
41 pilot program. Commencing on July first, two thousand six, the super-
42 intendent shall access funding from the small employer stop loss fund
43 [and the qualifying individual stop loss fund] for the purpose of
44 support and expansion of the existing pilot program Brooklyn healthworks
45 approved by the superintendent and for the establishment and operation
46 of a pilot program to be located in upstate New York. For the purpose of
47 this subsection, in no event shall the amount of funding available
48 exceed two percent of the annual funding [amounts] AMOUNT for the small
49 employer stop loss fund [and the qualifying individual stop loss fund].

50 S 59. Paragraph 1 of subsection (d) of section 4235 of the insurance
51 law is amended to read as follows:

52 (1) In this section, for the purpose of insurance OTHER THAN FOR GROUP
53 HOSPITAL, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF
54 EXPENSE REIMBURSED INSURANCE hereunder: "employees" includes the offi-
55 cers, managers, employees and retired employees of the employer and of
56 subsidiary or affiliated corporations of a corporate employer, and the

1 individual proprietors, partners, employees and retired employees of
2 affiliated individuals and firms controlled by the insured employer
3 through stock ownership, contract or otherwise; "employees" may be
4 deemed to include the individual proprietor or partners if the employer
5 is an individual proprietor or a partnership; and "employees" as used in
6 subparagraph (A) of paragraph one of subsection (c) hereof may also
7 include the directors of the employer and of subsidiary or affiliated
8 corporations of a corporate employer.

9 S 60. Subsection (d) of section 4235 of the insurance law is amended
10 by adding a new paragraph 3 to read as follows:

11 (3) IN THIS SECTION, FOR THE PURPOSE OF GROUP HOSPITAL, MEDICAL, MAJOR
12 MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF EXPENSE REIMBURSED INSURANCE
13 HEREUNDER:

14 (A) "EMPLOYEE" SHALL HAVE THE MEANING SET FORTH IN SECTION 2791 OF THE
15 PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-91(D)(5) OR ANY REGULATIONS
16 PROMULGATED THEREUNDER; AND

17 (B) "FULL-TIME EMPLOYEE" MEANS WITH RESPECT TO ANY MONTH, AN EMPLOYEE
18 WHO IS EMPLOYED ON AVERAGE FOR AT LEAST THIRTY HOURS OF SERVICE PER WEEK
19 AS SET FORTH IN SECTION 4980H(C)(4) OF THE INTERNAL REVENUE CODE, 26
20 U.S.C. S 4980H(C)(4), OR ANY REGULATIONS PROMULGATED THEREUNDER.

21 S 61. Subparagraph (B) of paragraph 1 of subsection (e) of section
22 3231 of the insurance law, as amended by chapter 107 of the laws of
23 2010, is amended to read as follows:

24 (B) The expected minimum loss ratio for a policy form subject to this
25 section, for which a rate filing or application is made pursuant to this
26 paragraph, other than a medicare supplemental insurance policy, or, with
27 the approval of the superintendent, an aggregation of policy forms that
28 are combined into one community rating experience pool and rated
29 consistent with community rating requirements, shall not be less than
30 eighty-two percent. In reviewing a rate filing or application, the
31 superintendent may modify the eighty-two percent expected minimum loss
32 ratio requirement if the superintendent determines the modification to
33 be in the interests of the people of this state or if the superintendent
34 determines that a modification is necessary to maintain insurer solven-
35 cy. No later than [June thirtieth] JULY THIRTY-FIRST of each year, every
36 insurer subject to this subparagraph shall annually report the actual
37 loss ratio for the previous calendar year in a format acceptable to the
38 superintendent. If an expected loss ratio is not met, the superintendent
39 may direct the insurer to take corrective action, which may include the
40 submission of a rate filing to reduce future premiums, or to issue divi-
41 dends, premium refunds or credits, or any combination of these.

42 S 62. Subparagraph (A) of paragraph 3 of subsection (c) of section
43 4308 of the insurance law, as added by chapter 107 of the laws of 2010,
44 is amended to read as follows:

45 (A) The expected minimum loss ratio for a contract form subject to
46 this subsection for which a rate filing or application is made pursuant
47 to this paragraph, other than a medicare supplemental insurance
48 contract, or, with the approval of the superintendent, an aggregation of
49 contract forms that are combined into one community rating experience
50 pool and rated consistent with community rating requirements, shall not
51 be less than eighty-two percent. In reviewing a rate filing or applica-
52 tion, the superintendent may modify the eighty-two percent expected
53 minimum loss ratio requirement if the superintendent determines the
54 modification to be in the interests of the people of this state or if
55 the superintendent determines that a modification is necessary to main-
56 tain insurer solvency. No later than [June thirtieth] JULY THIRTY-FIRST

1 of each year, every corporation subject to this subparagraph shall annu-
2 ally report the actual loss ratio for the previous calendar year in a
3 format acceptable to the superintendent. If an expected loss ratio is
4 not met, the superintendent may direct the corporation to take correc-
5 tive action, which may include the submission of a rate filing to reduce
6 future premiums, or to issue dividends, premium refunds or credits, or
7 any combination of these.

8 S 63. Section 3233 of the insurance law is amended by adding a new
9 subsection (d) to read as follows:

10 (D) NOTWITHSTANDING ANY PROVISION OF THIS CHAPTER OR ANY OTHER CHAP-
11 TER, THE SUPERINTENDENT MAY SUSPEND OR TERMINATE, BY REGULATION, THE
12 OPERATION, IN WHOLE OR IN PART, OF ANY MECHANISM ESTABLISHED AND OPERAT-
13 ING PURSUANT TO THE AUTHORITY OF THIS SECTION PROVIDED THAT THE SUPER-
14 INTENDENT DETERMINES THAT THE OBJECTIVES STATED IN SUBSECTION (A) OF
15 THIS SECTION ARE MET BY THE OPERATION OF A MECHANISM OR MECHANISMS
16 ESTABLISHED BY THE FEDERAL GOVERNMENT PURSUANT TO SECTION 1343 OF THE
17 AFFORDABLE CARE ACT, 42 U.S.C. S 18063. NOTWITHSTANDING SUBSECTION (B)
18 OF THIS SECTION, THE SUPERINTENDENT MAY EXERCISE THIS AUTHORITY WITHOUT
19 CONVENING A TECHNICAL ADVISORY COMMITTEE.

20 S 64. Subparagraph (D) of paragraph 2 of subsection (p) of section
21 3221 of the insurance law, as added by chapter 661 of the laws of 1997,
22 is amended to read as follows:

23 (D) The insurer is ceasing to offer group or blanket policies in a
24 market in accordance with paragraph three OR SEVEN of this subsection.

25 S 65. Subsection (p) of section 3221 of the insurance law is amended
26 by adding a new paragraph 7 to read as follows:

27 (7) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, AN INSURER MAY
28 DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET POLICY OF
29 HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL OR
30 LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET POLICY OF
31 HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE
32 REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42
33 U.S.C. 300GG-6 THAT BECOME APPLICABLE TO SUCH POLICY AS OF JANUARY
34 FIRST, TWO THOUSAND FOURTEEN, PROVIDED THAT THE INSURER:

35 (A) DISCONTINUES THE EXISTING CLASS OF POLICY IN SUCH MARKET AS OF
36 EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE POLICY
37 RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS
38 CHAPTER;

39 (B) PROVIDES WRITTEN NOTICE TO EACH POLICYHOLDER PROVIDED COVERAGE OF
40 THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS
41 COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS
42 PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE. THE WRITTEN NOTICE
43 SHALL BE IN A FORM SATISFACTORY TO THE SUPERINTENDENT;

44 (C) OFFERS TO EACH POLICYHOLDER PROVIDED COVERAGE OF THE CLASS IN THE
45 MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE GROUP
46 MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE THAT
47 COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH
48 SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE
49 AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY
50 THE INSURER TO A GROUP IN THAT MARKET;

51 (D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND
52 IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARA-
53 GRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE
54 POLICYHOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY
55 PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR
56 NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR

1 SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH
2 THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH
3 EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

4 (E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCON-
5 TINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT
6 OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR
7 OF THE INSURER THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE THE
8 COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF
9 SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42 U.S.C. 300GG-6 THAT
10 BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN. THE WRITTEN
11 NOTICE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION THE SUPER-
12 INTENDENT REQUIRES.

13 S 66. Item (iii) of subparagraph (C) of paragraph 2 of subsection (c)
14 of section 4304 of the insurance law, as amended by chapter 661 of the
15 laws of 1997, is amended to read as follows:

16 (iii) Discontinuance of all individual hospital, surgical or medical
17 expense insurance contracts for which the premiums are paid by a remit-
18 ting agent of a group, in the small group market, or the large group
19 market, or both markets, in this state, in conjunction with a withdrawal
20 from the small group market, or the large group market, or both markets,
21 in this state. Withdrawal from the small group market, or the large
22 group market, or both markets, shall be governed by the requirements of
23 subparagraphs [(B)] (E) and [(C)] (F) of paragraph three of subsection
24 (j) of section four thousand three hundred five of this article. For
25 purposes of this item, "withdrawal" from a market means that no coverage
26 is offered or maintained in such market under contracts issued pursuant
27 to this section or contracts issued pursuant to section four thousand
28 three hundred five of this article.

29 S 67. Subparagraph (D) of paragraph 2 of subsection (j) of section
30 4305 of the insurance law, as added by chapter 661 of the laws of 1997,
31 is amended to read as follows:

32 (D) The corporation is ceasing to offer group or blanket contracts in
33 a market in accordance with paragraph three OR PARAGRAPH SIX of this
34 subsection.

35 S 68. Subsection (j) of section 4305 of the insurance law is amended
36 by adding a new paragraph 6 to read as follows:

37 (6) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, A CORPORATION
38 MAY DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET CONTRACT
39 OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL
40 OR LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET CONTRACT OF
41 HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE
42 REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C.
43 S 300GG-6 THAT BECOME APPLICABLE TO SUCH CONTRACT AS OF JANUARY FIRST,
44 TWO THOUSAND FOURTEEN, PROVIDED THAT THE CORPORATION:

45 (A) DISCONTINUES THE EXISTING CLASS OF CONTRACT IN SUCH MARKET AS OF
46 EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE CONTRACT
47 RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS
48 CHAPTER;

49 (B) PROVIDES WRITTEN NOTICE TO EACH CONTRACT HOLDER PROVIDED COVERAGE
50 OF THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS
51 COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS
52 PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE. THE WRITTEN NOTICE
53 SHALL BE IN A FORM SATISFACTORY TO THE SUPERINTENDENT;

54 (C) OFFERS TO EACH CONTRACT HOLDER PROVIDED COVERAGE OF THE CLASS IN
55 THE MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE
56 GROUP MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE

1 THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH
2 SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE
3 AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY
4 THE CORPORATION TO A GROUP IN THAT MARKET;

5 (D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND
6 IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARA-
7 GRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE
8 CONTRACT HOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY
9 PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR
10 NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR
11 SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH
12 THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH
13 EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

14 (E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCON-
15 TINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT
16 OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR
17 OF THE CORPORATION THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE
18 THE COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF
19 SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT
20 BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN. THE WRITTEN
21 NOTICE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION THE SUPER-
22 INTENDENT REQUIRES.

23 S 69. Subsections (a), (b) and (c) of section 3231 of the insurance
24 law, subsection (a) as amended by chapter 661 of the laws of 1997,
25 subsection (b) as amended by chapter 557 of the laws of 2002, subsection
26 (c) as added by chapter 501 of the laws of 1992, are amended to read as
27 follows:

28 (a) (1) No individual health insurance policy and no group health
29 insurance policy covering between [two] ONE and fifty employees or
30 members of the group OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR MEMBERS
31 OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST,
32 TWO THOUSAND SIXTEEN exclusive of spouses and dependents, hereinafter
33 referred to as a small group, providing hospital and/or medical bene-
34 fits, including medicare supplemental insurance, shall be issued in this
35 state unless such policy is community rated and, notwithstanding any
36 other provisions of law, the underwriting of such policy involves no
37 more than the imposition of a pre-existing condition limitation [as] IF
38 OTHERWISE permitted by this article. (2) Any individual, and dependents
39 of such individual, and any small group, including all employees or
40 group members and dependents of employees or members, applying for indi-
41 vidual health insurance coverage, including medicare supplemental cover-
42 age, [or small group health insurance coverage, including medicare
43 supplemental insurance,] OR SMALL GROUP HEALTH INSURANCE COVERAGE,
44 INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVERAGE
45 ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, SPECIFIED IN
46 SUBSECTION (L) OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, OF THIS
47 ARTICLE must be accepted at all times throughout the year for any hospi-
48 tal and/or medical coverage offered by the insurer to individuals or
49 small groups in this state. (3) Once accepted for coverage, an individ-
50 ual or small group cannot be terminated by the insurer due to claims
51 experience. Termination of an individual or small group shall be based
52 only on one or more of the reasons set forth in subsection (g) of
53 section three thousand two hundred sixteen or subsection (p) of section
54 three thousand two hundred twenty-one of this article. Group hospital
55 and/or medical coverage, including medicare supplemental insurance,
56 obtained through an out-of-state trust covering a group of fifty or

1 fewer employees, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES FOR POLICIES
2 ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, or
3 participating persons who are residents of this state must be community
4 rated regardless of the situs of delivery of the policy. Notwithstanding
5 any other provisions of law, the underwriting of such policy may involve
6 no more than the imposition of a pre-existing condition limitation [as]
7 IF permitted by this article, and once accepted for coverage, an indi-
8 vidual or small group cannot be terminated due to claims experience.
9 Termination of an individual or small group shall be based only on one
10 or more of the reasons set forth in subsection (p) of section three
11 thousand two hundred twenty-one of this article. (4) For the purposes
12 of this section, "community rated" means a rating methodology in which
13 the premium for all persons covered by a policy [or contract] form is
14 the same based on the experience of the entire pool of risks [covered by
15 that policy or contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED
16 BY THE INSURER without regard to age, sex, health status, TOBACCO USAGE
17 or occupation, EXCLUDING THOSE INDIVIDUALS OR SMALL GROUPS COVERED BY
18 MEDICARE SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE
19 COVERAGE, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE
20 PREMIUMS FOR ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE
21 SAME BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT
22 POLICY OR CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS,
23 TOBACCO USAGE OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE POLICIES
24 ISSUED PURSUANT TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C.
25 S 18022(E), SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

26 (b) [Nothing herein shall prohibit the use of premium rate structures
27 to establish different premium rates for individuals as opposed to fami-
28 ly units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND
29 STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL POLICIES
30 SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY SET A STANDARD RELATIVI-
31 TY APPLICABLE TO CHILD-ONLY POLICIES ISSUED PURSUANT TO SECTION 1302(F)
32 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVITY FOR
33 CHILD-ONLY POLICIES SHALL BE ACTUARIALLY JUSTIFIABLE USING THE AGGREGATE
34 EXPERIENCE OF INSURERS TO PREVENT THE CHARGING OF UNJUSTIFIED PREMIUMS.
35 THE SUPERINTENDENT MAY ADJUST SUCH PREMIUM TIERS AND RELATIVITIES PERI-
36 ODICALLY BASED UPON THE AGGREGATE EXPERIENCE OF INSURERS. (2) AN INSUR-
37 ER SHALL ESTABLISH separate community rates for individuals as opposed
38 to small groups. (3) If an insurer is required to issue a [contract]
39 POLICY to individual proprietors pursuant to subsection (i) of this
40 section, such policy shall be subject to subsection (a) of this section.

41 (c) (1) The superintendent shall permit the use of separate community
42 rates for reasonable geographic regions, which may, in a given case,
43 include a single county. The regions shall be approved by the super-
44 intendent as part of the rate filing. The superintendent shall not
45 require the inclusion of any specific geographic regions within the
46 proposed community rated regions selected by the insurer in its rate
47 filing so long as the insurer's proposed regions do not contain config-
48 urations designed to avoid or segregate particular areas within a county
49 covered by the insurer's community rates. (2) BEGINNING ON JANUARY
50 FIRST, TWO THOUSAND FOURTEEN, FOR EVERY POLICY SUBJECT TO THIS SECTION
51 THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR SIMILAR
52 COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENT PLANS,
53 INSURERS SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTEN-
54 DENT.

55 S 70. Subsection (g) of section 3231 of the insurance law, as added by
56 chapter 501 of the laws of 1992, is amended to read as follows:

1 (g) (1) This section shall also apply to policies issued to a group
2 defined in subsection (c) of section four thousand two hundred thirty-
3 five, including but not limited to an association or trust of employers,
4 if the group includes one or more member employers or other member
5 groups which have fifty or fewer employees or members exclusive of
6 spouses and dependents. FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANU-
7 ARY FIRST, TWO THOUSAND FOURTEEN, IF THE GROUP INCLUDES ONE OR MORE
8 MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR COVERAGE SUBJECT TO THIS
9 SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE CLASSIFIED AS SMALL GROUPS
10 FOR RATING PURPOSES AND THE REMAINING MEMBERS SHALL BE RATED CONSISTENT
11 WITH THE RATING RULES APPLICABLE TO SUCH REMAINING MEMBERS PURSUANT TO
12 PARAGRAPH TWO OF THIS SUBSECTION.

13 (2) IF A POLICY IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF
14 SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, INCLUDING
15 AN ASSOCIATION GROUP, THAT INCLUDES ONE OR MORE INDIVIDUAL OR INDIVIDUAL
16 PROPRIETOR MEMBERS, FOR RATING PURPOSES THE INSURER SHALL INCLUDE SUCH
17 MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING PREMIUM RATES
18 FOR SUCH MEMBERS.

19 S 71. Paragraph 2 of subsection (i) of section 3231 of the insurance
20 law, as amended by chapter 183 of the laws of 2011, is amended to read
21 as follows:

22 (2) For coverage purchased pursuant to this subsection, THROUGH DECEM-
23 BER THIRTY-FIRST, TWO THOUSAND THIRTEEN, individual proprietors shall be
24 classified in their own community rating category, provided however, up
25 to and including December thirty-first, two thousand [fourteen]
26 THIRTEEN, the premium rate established for individual proprietors
27 purchased pursuant to paragraph one of this subsection shall not be
28 greater than one hundred fifteen percent of the rate established for the
29 same coverage issued to groups. COVERAGE PURCHASED OR RENEWED PURSUANT
30 TO THIS SUBSECTION ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN
31 SHALL BE CLASSIFIED IN THE INDIVIDUAL RATING CATEGORY.

32 S 72. Section 4317 of the insurance law, as added by chapter 501 of
33 the laws of 1992, subsection (a) as amended by chapter 661 of the laws
34 of 1997, subsection (b) as amended and subsection (f) as added by chap-
35 ter 557 of the laws of 2002, subsection (d) as amended by section 2 of
36 part A of chapter 494 of the laws of 2009, paragraph 2 of subsection (f)
37 as amended by chapter 183 of the laws of 2011, is amended to read as
38 follows:

39 S 4317. Rating of individual and small group health insurance
40 contracts. (a) (1) No individual health insurance contract and no group
41 health insurance contract covering between [two] ONE and fifty employees
42 or members of the group, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR
43 MEMBERS OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY
44 FIRST, TWO THOUSAND SIXTEEN exclusive of spouses and dependents, includ-
45 ing contracts for which the premiums are paid by a remitting agent for a
46 group, hereinafter referred to as a small group, providing hospital
47 and/or medical benefits, including Medicare supplemental insurance,
48 shall be issued in this state unless such contract is community rated
49 and, notwithstanding any other provisions of law, the underwriting of
50 such contract involves no more than the imposition of a pre-existing
51 condition limitation [as] IF OTHERWISE permitted by this article. (2)
52 Any individual, and dependents of such individual, and any small group,
53 including all employees or group members and dependents of employees or
54 members, applying for individual or small group health insurance cover-
55 age INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVER-
56 AGE ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SPECIFIED IN

1 SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR, AND SECTION
2 FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER, must be
3 accepted at all times throughout the year for any hospital and/or
4 medical coverage[, including Medicare supplemental insurance,] offered
5 by the corporation to individuals or small groups in this state. (3)
6 Once accepted for coverage, an individual or small group cannot be
7 terminated by the insurer due to claims experience. Termination of
8 coverage for individuals or small groups may be based only on one or
9 more of the reasons set forth in subsection (c) of section four thousand
10 three hundred four or subsection (j) of section four thousand three
11 hundred five of this article. (4) For the purposes of this section,
12 "community rated" means a rating methodology in which the premium for
13 all persons covered by a policy or contract form is the same, based on
14 the experience of the entire pool of risks [covered by that policy or
15 contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED BY THE CORPO-
16 RATION without regard to age, sex, health status, TOBACCO USAGE or occu-
17 pation EXCLUDING THOSE INDIVIDUALS OF SMALL GROUPS COVERED BY MEDICARE
18 SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE COVERAGE,
19 "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUMS FOR
20 ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE SAME BASED ON
21 THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT POLICY OR
22 CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE
23 OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE CONTRACTS ISSUED PURSUANT
24 TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E),
25 SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

26 (b) [Nothing herein shall prohibit the use of premium rate structures
27 to establish different premium rates for individuals as opposed to fami-
28 ly units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND
29 STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL CONTRACTS
30 SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY ALSO SET A STANDARD
31 RELATIVITY APPLICABLE TO CHILD-ONLY CONTRACTS ISSUED PURSUANT TO SECTION
32 1302(F) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVI-
33 TY FOR CHILD-ONLY CONTRACTS MUST BE ACTUARIALLY JUSTIFIABLE USING THE
34 AGGREGATE EXPERIENCE OF CORPORATIONS TO PREVENT THE CHARGING OF UNJUSTI-
35 FIED PREMIUMS. THE SUPERINTENDENT MAY ADJUST SUCH PREMIUM TIERS AND
36 RELATIVITIES PERIODICALLY BASED UPON THE AGGREGATE EXPERIENCE OF CORPO-
37 RATIONS ISSUING CONTRACT FORMS SUBJECT TO THIS SECTION. (2) A CORPO-
38 RATION SHALL ESTABLISH separate community rates for individuals as
39 opposed to small groups. (3) If a corporation is required to issue a
40 contract to individual proprietors pursuant to subsection (f) of this
41 section, such contract shall be subject to the requirements of
42 subsection (a) of this section.

43 (c) (1) The superintendent shall permit the use of separate community
44 rates for reasonable geographic regions, which may, in a given case,
45 include a single county. The regions shall be approved by the super-
46 intendent as part of the rate filing. The superintendent shall not
47 require the inclusion of any specific geographic regions within the
48 proposed community rated regions selected by the corporation in its rate
49 filing so long as the corporation's proposed regions do not contain
50 configurations designed to avoid or segregate particular areas within a
51 county covered by the corporation's community rates. (2) BEGINNING ON
52 JANUARY FIRST, TWO THOUSAND FOURTEEN, FOR EVERY CONTRACT SUBJECT TO THIS
53 SECTION THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR
54 SIMILAR COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENTAL
55 INSURANCE, CORPORATIONS SHALL USE STANDARDIZED REGIONS ESTABLISHED BY
56 THE SUPERINTENDENT.

1 (d) (1) This section shall also apply to [contracts] A CONTRACT issued
2 to a group defined in subsection (c) of section four thousand two
3 hundred thirty-five of this chapter, including but not limited to an
4 association or trust of employers, if the group includes one or more
5 member employers or other member groups which have fifty or fewer
6 employees or members exclusive of spouses and dependents. FOR CONTRACTS
7 ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, IF
8 THE GROUP INCLUDES ONE OR MORE MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR
9 COVERAGE SUBJECT TO THIS SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE
10 CLASSIFIED AS SMALL GROUPS FOR RATING PURPOSES AND THE REMAINING MEMBERS
11 SHALL BE RATED CONSISTENT WITH THE RATING RULES APPLICABLE TO SUCH
12 REMAINING MEMBERS PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION.

13 (2) IF A CONTRACT IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF
14 SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER INCLUDING
15 ASSOCIATION GROUPS, THAT INCLUDES ONE OR MORE INDIVIDUAL OR INDIVIDUAL
16 PROPRIETOR MEMBERS, THEN FOR RATING PURPOSES THE CORPORATION SHALL
17 INCLUDE SUCH MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING
18 PREMIUM RATES FOR SUCH MEMBERS.

19 (3) A corporation shall provide specific claims experience to a munic-
20 ipal corporation, as defined in subsection (f) of section four thousand
21 seven hundred two of this chapter, covered by the corporation under a
22 community rated contract when the municipal corporation requests its
23 claims experience for purposes of forming or joining a municipal cooper-
24 ative health benefit plan certified pursuant to article forty-seven of
25 this chapter. Notwithstanding the foregoing provisions, no corporation
26 shall be required to provide more than three years' claims experience to
27 a municipal corporation making this request.

28 (e) (1) Notwithstanding any other provision of this chapter, no insur-
29 er, subsidiary of an insurer, or controlled person of a holding company
30 system may act as an administrator or claims paying agent, as opposed to
31 an insurer, on behalf of small groups which, if they purchased insur-
32 ance, would be subject to this section. No insurer, subsidiary of an
33 insurer, or controlled person of a holding company may provide stop
34 loss, catastrophic or reinsurance coverage to small groups which, if
35 they purchased insurance, would be subject to this section.

36 (2) This subsection shall not apply to coverage insuring a plan
37 [which] THAT was in effect on or before December thirty-first, nineteen
38 hundred ninety-one and was issued to a group [which] THAT includes
39 member small employers or other member small groups, including but not
40 limited to association groups, provided that (A) acceptance of addi-
41 tional small member employers (or other member groups comprised of fifty
42 or fewer employees or members, exclusive of spouses and dependents) into
43 the group on or after June first, nineteen hundred ninety-two and before
44 April first, nineteen hundred ninety-four does not exceed an amount
45 equal to ten percent per year of the total number of persons covered
46 under the group as of June first, nineteen hundred ninety-two, but noth-
47 ing in this subparagraph shall limit the addition of larger member
48 employers; (B) (i) after April first, nineteen hundred ninety-four, the
49 group thereafter accepts member small employers and member small groups
50 without underwriting by any more than the imposition of a pre-existing
51 condition limitation as permitted by this article and the cost for
52 participation in the group for all persons covered shall be the same
53 based on the experience of the entire pool of risks covered under the
54 entire group, without regard to age, sex, health status or occupation;
55 and; (ii) once accepted for coverage, an individual or small group
56 cannot be terminated due to claims experience; (C) the [insurer] CORPO-

RATION 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. 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 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 seventeen, thirty-eight, thirty-nine, forty, forty-a, forty-one, forty-six-a, forty-six-b forty-seven, forty-eight, forty-nine, fifty, fifty-one, fifty-two, fifty-three, fifty-four and fifty-five 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-two, forty-three, 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;

b-1 paragraph 8 of subsection (b) of section 4328 of the insurance law, as added by section forty-six of this act shall expire and be deemed repealed on December 31, 2015;

c. section fifty-six of this act shall take effect January 1, 2014;

1 d. section fifty-seven of this act shall be deemed repealed January 1,
2 2014;

3 e. sections fifteen, fifty-eight, sixty-one and sixty-two of this act
4 shall take effect January 1, 2015;

5 e-1. section fifteen-a of this act shall take effect January 1, 2014;

6 f. sections fifty-nine and sixty of this act shall take effect January
7 1, 2016 and shall apply to all policies and contracts issued, renewed,
8 modified, altered, or amended on or after such date;

9 g. sections fourteen and fourteen-a of this act shall take effect
10 immediately and shall be deemed to have been in full force and effect on
11 and after April 1, 2013;

12 h. the amendments to paragraphs (e) and (f) of subdivision 2 of
13 section 2511 of the public health law made by sections nineteen and
14 twenty-six of this act shall take effect January 1, 2014 or a later date
15 to be determined by the commissioner of health contingent upon the
16 requirements of the Patient Protection and Affordable Care Act of 2010
17 being fully implemented by the state and as approved by the secretary of
18 the department of health and human services; provided that the commis-
19 sioner of health shall notify the legislative bill drafting commission
20 upon the occurrence of the enactment of the legislation provided for in
21 sections nineteen and twenty-six of this act in order that the commis-
22 sion may maintain an accurate and timely effective data base of the
23 official text of the laws of the state of New York in furtherance of
24 effectuating the provisions of section 44 of the legislative law and
25 section 70-b of the public officers law;

26 h-1. provided however, the amendments to subparagraph (ii) of para-
27 graph (f) of subdivision 2 of section 2511 of the public health law made
28 by section twenty-six of this act shall take effect April 1, 2014;

29 i. the amendments to subdivision 4 of section 2511 of the public
30 health law made by section twenty-one of this act shall not affect the
31 expiration and reversion of such subdivision and shall be deemed to
32 expire therewith;

33 j. the amendments to subparagraph (ii) of paragraph (g) of subdivision
34 2 of section 2511 of the public health law made by section twenty-seven
35 of this act shall not affect the expiration of such paragraph and shall
36 be deemed to expire therewith;

37 j-1. the amendments to subparagraph (iii) of paragraph (a) of subdivi-
38 sion 2 of section 2511 of the public health law made by section thirty
39 of this act shall not affect the expiration of such paragraph and shall
40 be deemed to expire therewith;

41 j-2. the amendments to subparagraph (iv) of paragraph (b) and para-
42 graph (d) of subdivision 9 of section 2511 of the public health law made
43 by section thirty-three of this act shall not affect the expiration of
44 such subdivision and shall be deemed to expire therewith;

45 j-3. the amendments to subdivision 5 of section 365-n of the social
46 services law made by section thirty-three-a of this act shall not affect
47 the repeal of such subdivision and shall be deemed repealed therewith;

48 k. any rules or regulations necessary to implement the provisions of
49 this act may be promulgated and any procedures, forms, or instructions
50 necessary for implementation may be adopted and issued on or after the
51 date this act shall have become a law;

52 l. this act shall not be construed to alter, change, affect, impair or
53 defeat any rights, obligations, duties or interests accrued, incurred or
54 conferred prior to the effective date of this act;

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

4 n. notwithstanding any inconsistent provision of the state administra-
5 tive procedure act or any other provision of law, rule or regulation,
6 the commissioner of health and the superintendent of financial services
7 and any appropriate council is authorized to adopt or amend or promul-
8 gate on an emergency basis any regulation he or she or such council
9 determines necessary to implement any provision of this act on its
10 effective date;

11 o. the provisions of this act shall become effective notwithstanding
12 the failure of the commissioner of health or the superintendent of
13 financial services or any council to adopt or amend or promulgate regu-
14 lations implementing this act; and

15 p. the amendments made to subparagraph (7) of paragraph (b) of subdi-
16 vision 1 of section 366 of the social services law made by section one
17 of this act shall expire and be deemed repealed October 1, 2019.

18 PART E

19 Section 1. Intentionally omitted.

20 S 2. Intentionally omitted.

21 S 3. Intentionally omitted.

22 S 4. Intentionally omitted.

23 S 5. Intentionally omitted.

24 S 6. Intentionally omitted.

25 S 7. Intentionally omitted.

26 S 8. Intentionally omitted.

27 S 9. Intentionally omitted.

28 S 10. Intentionally omitted.

29 S 11. Intentionally omitted.

30 S 12. Intentionally omitted.

31 S 13. Intentionally omitted.

32 S 14. Section 600 of the public health law, as added by chapter 901 of
33 the laws of 1986, is amended to read as follows:

34 S 600. State aid; general requirements. In order to be eligible for
35 state aid under this title, a municipality shall be required to do the
36 following in accordance with the provisions of this article:

37 1. submit an application to the department for state aid WHICH IS
38 APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH SECTION SIX HUNDRED ONE
39 OF THIS TITLE;

40 [2. submit a municipal public health services plan to the department
41 for approval;

42 3. implement and adhere to the municipal public health services plan,
43 as approved;

44 4. submit a detailed report to the department of all expenditures on
45 services funded by this title for the immediately preceding fiscal year
46 of such municipality;

47 5. employ a person to supervise the provision of public health
48 services in accordance with the provisions of section six hundred four
49 of this chapter; and

50 6.] 2. PROVIDE CORE PUBLIC HEALTH SERVICES, AS DEFINED IN SECTION SIX
51 HUNDRED TWO OF THIS TITLE, IN ACCORDANCE WITH AN APPLICATION FOR STATE
52 AID SUBMITTED BY THE MUNICIPALITY AND APPROVED BY THE COMMISSIONER;

53 3. SUBMIT A COMMUNITY HEALTH ASSESSMENT IN ACCORDANCE WITH SECTION SIX
54 HUNDRED TWO-A OF THIS TITLE;

1 4. ESTABLISH, COLLECT AND REPORT FEES AND REVENUE FOR SERVICES
2 PROVIDED BY THE MUNICIPALITY, IN ACCORDANCE WITH SECTION SIX HUNDRED SIX
3 OF THIS TITLE; AND

4 5. appropriate or otherwise make funds available to finance a
5 prescribed share of the cost of public health services.

6 S 15. Section 601 of the public health law, as added by chapter 901 of
7 the laws of 1986, is amended to read as follows:

8 S 601. Application for state aid. 1. The governing body of each muni-
9 cipality desiring to make application for state aid under this title
10 shall annually, on such dates as may be fixed by the commissioner,
11 submit an application for such aid.

12 2. The application shall be in such form as the commissioner shall
13 prescribe, and shall include, but not be limited to:

14 (a) an organizational chart of the municipal health agency, AND A
15 STATEMENT PROVIDING THE NUMBER OF EMPLOYEES, BY JOB TITLE, PROPOSED TO
16 PROVIDE PUBLIC HEALTH SERVICES FUNDED BY THIS TITLE;

17 (b) a [detailed] budget of proposed expenditures for services funded
18 by this title;

19 [(c) a description of proposed program activities for services funded
20 by this title;

21 (d) a copy of the municipal public health services plan prepared and
22 submitted pursuant to section six hundred two of this title;

23 (e) a certification by the chief executive officer of the munici-
24 pality, or in those municipalities with no chief executive officer the
25 chairman of the county legislature, that the proposed expenditures and
26 program activities are consistent with the public health services plan;
27 and

28 (f)] (C) A DESCRIPTION OF HOW THE MUNICIPALITY WILL PROVIDE PUBLIC
29 HEALTH SERVICES;

30 (D) AN ATTESTATION BY THE CHIEF EXECUTIVE OFFICER OF THE MUNICIPALITY
31 THAT SUFFICIENT FUNDS HAVE BEEN APPROPRIATED TO PROVIDE THE PUBLIC
32 HEALTH SERVICES FOR WHICH THE MUNICIPALITY IS SEEKING STATE AID;

33 (E) AN ATTESTATION BY THE MUNICIPAL OFFICER IN CHARGE OF ADMINISTERING
34 PUBLIC HEALTH THAT THE MUNICIPALITY HAS DILIGENTLY REVIEWED ITS STATE
35 AID APPLICATION AND THAT THE APPLICATION SEEKS STATE AID ONLY FOR ELIGI-
36 BLE PUBLIC HEALTH SERVICES;

37 (F) A LIST OF PUBLIC HEALTH SERVICES PROVIDED BY THE MUNICIPALITY THAT
38 ARE NOT ELIGIBLE FOR STATE AID, AND THE COST OF EACH SERVICE;

39 (G) A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR PUBLIC HEALTH
40 SERVICES ELIGIBLE FOR STATE AID, IN ACCORDANCE WITH SECTION SIX HUNDRED
41 SIX OF THIS TITLE; AND

42 (H) such other information as the commissioner may require.

43 3. THE COMMISSIONER SHALL APPROVE THE STATE AID APPLICATION TO THE
44 EXTENT THAT IT IS CONSISTENT WITH THIS SECTION AND ANY OTHER CONDITIONS
45 OR LIMITATIONS ESTABLISHED IN, OR REGULATIONS PROMULGATED PURSUANT TO,
46 THIS ARTICLE.

47 4. A MUNICIPALITY MAY AMEND ITS STATE AID APPLICATION WITH THE
48 APPROVAL OF THE COMMISSIONER, AND SUBJECT TO ANY RULES AND REGULATIONS
49 THAT THE COMMISSIONER MAY ADOPT.

50 S 16. Section 602 of the public health law is REPEALED and a new
51 section 602 is added to read as follows:

52 S 602. CORE PUBLIC HEALTH SERVICES. 1. TO BE ELIGIBLE FOR STATE AID,
53 A MUNICIPALITY MUST PROVIDE THE FOLLOWING CORE PUBLIC HEALTH SERVICES:

54 (A) FAMILY HEALTH, WHICH SHALL INCLUDE ACTIVITIES DESIGNED TO REDUCE
55 PERINATAL, INFANT AND MATERNAL MORTALITY AND MORBIDITY AND TO PROMOTE
56 THE HEALTH OF INFANTS, CHILDREN, ADOLESCENTS, AND PEOPLE OF CHILDBEARING

1 AGE. SUCH ACTIVITIES SHALL INCLUDE FAMILY CENTERED PERINATAL SERVICES
2 AND OTHER SERVICES APPROPRIATE TO PROMOTE THE BIRTH OF A HEALTHY BABY TO
3 A HEALTHY MOTHER, AND SERVICES TO ASSURE THAT INFANTS, YOUNG CHILDREN,
4 AND SCHOOL AGE CHILDREN ARE ENROLLED IN APPROPRIATE HEALTH INSURANCE
5 PROGRAMS AND OTHER HEALTH BENEFIT PROGRAMS FOR WHICH THEY ARE ELIGIBLE,
6 AND THAT THE PARENTS OR GUARDIANS OF SUCH CHILDREN ARE PROVIDED WITH
7 INFORMATION CONCERNING HEALTH CARE PROVIDERS IN THEIR AREA THAT ARE
8 WILLING AND ABLE TO PROVIDE HEALTH SERVICES TO SUCH CHILDREN. PROVISION
9 OF PRIMARY AND PREVENTIVE CLINICAL HEALTH CARE SERVICES SHALL BE ELIGI-
10 BLE FOR STATE AID FOR UNINSURED PERSONS UNDER THE AGE OF TWENTY-ONE,
11 PROVIDED THAT THE MUNICIPALITY MAKES GOOD FAITH EFFORTS TO ASSIST SUCH
12 PERSONS WITH INSURANCE ENROLLMENT AND ONLY UNTIL SUCH TIME AS ENROLLMENT
13 BECOMES EFFECTIVE.

14 (B) COMMUNICABLE DISEASE CONTROL, WHICH SHALL INCLUDE ACTIVITIES TO
15 CONTROL AND MITIGATE THE EXTENT OF INFECTIOUS DISEASES. SUCH ACTIVITIES
16 SHALL INCLUDE, BUT NOT BE LIMITED TO, SURVEILLANCE AND EPIDEMIOLOGICAL
17 PROGRAMS, PROGRAMS TO DETECT DISEASES IN THEIR EARLY STAGES, IMMUNIZA-
18 TIONS AGAINST INFECTIOUS DISEASES, INVESTIGATION OF DISEASES AND
19 PREVENTION OF TRANSMISSION, PREVENTION AND TREATMENT OF SEXUALLY TRAN-
20 SMISSIBLE DISEASES, AND ARTHROPOD VECTOR-BORNE DISEASE PREVENTION.

21 (C) CHRONIC DISEASE PREVENTION, WHICH SHALL INCLUDE PROMOTING PUBLIC,
22 HEALTH CARE PROVIDER AND OTHER COMMUNITY SERVICE PROVIDER ACTIVITIES
23 THAT ENCOURAGE CHRONIC DISEASE PREVENTION, EARLY DETECTION AND QUALITY
24 CARE DELIVERY. SUCH ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, THOSE
25 THAT PROMOTE HEALTHY COMMUNITIES AND REDUCE RISK FACTORS SUCH AS TOBACCO
26 USE, POOR NUTRITION AND PHYSICAL INACTIVITY. PROVISION OF CLINICAL
27 SERVICES SHALL NOT BE ELIGIBLE FOR STATE AID, SUBJECT TO SUCH EXCEPTIONS
28 AS THE COMMISSIONER MAY DEEM APPROPRIATE.

29 (D) COMMUNITY HEALTH ASSESSMENT, AS DESCRIBED IN SECTION SIX HUNDRED
30 TWO-A OF THIS ARTICLE.

31 (E) ENVIRONMENTAL HEALTH, WHICH SHALL INCLUDE ACTIVITIES THAT PROMOTE
32 HEALTH AND PREVENT ILLNESS AND INJURY BY ASSURING THAT SAFE AND SANITARY
33 CONDITIONS ARE MAINTAINED AT PUBLIC DRINKING WATER SUPPLIES, FOOD
34 SERVICE ESTABLISHMENTS, AND OTHER REGULATED FACILITIES; INVESTIGATING
35 PUBLIC HEALTH NUISANCES TO ASSURE ABATEMENT BY RESPONSIBLE PARTIES;
36 PROTECTING THE PUBLIC FROM UNNECESSARY EXPOSURE TO RADIATION, CHEMICALS,
37 AND OTHER HARMFUL CONTAMINANTS; AND CONDUCTING INVESTIGATIONS OF INCI-
38 DENTS THAT RESULT IN ILLNESS, INJURY OR DEATH IN ORDER TO IDENTIFY AND
39 MITIGATE THE ENVIRONMENTAL CAUSES TO PREVENT ADDITIONAL MORBIDITY AND
40 MORTALITY.

41 (F) PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE, INCLUDING PLAN-
42 NING, TRAINING, AND MAINTAINING READINESS FOR PUBLIC HEALTH EMERGENCIES.

43 2. THE MUNICIPALITY MUST INCORPORATE INTO EACH CORE PUBLIC HEALTH
44 SERVICE THE FOLLOWING GENERAL ACTIVITIES:

45 (A) ONGOING ASSESSMENT OF COMMUNITY HEALTH NEEDS;

46 (B) EDUCATION ON PUBLIC HEALTH ISSUES;

47 (C) DEVELOPMENT OF POLICIES AND PLANS TO ADDRESS HEALTH NEEDS; AND

48 (D) ACTIONS TO ASSURE THAT SERVICES NECESSARY TO ACHIEVE AGREED UPON
49 GOALS ARE PROVIDED.

50 3. THE COMMISSIONER MAY APPROVE A STATE AID APPLICATION IN WHICH THE
51 MUNICIPALITY ACTUALLY PROVIDES FEWER SERVICES THAN THOSE SET FORTH IN
52 SUBDIVISION ONE OF THIS SECTION AS LONG AS THE APPLICATION IDENTIFIES
53 THE AVAILABILITY OF OTHER SERVICES, WHO WILL PROVIDE THOSE SERVICES AND
54 THE MANNER IN WHICH THE SERVICES WILL BE PROVIDED AND FINANCED.

55 4. THE COMMISSIONER SHALL CONSULT WITH THE COUNTY HEALTH COMMISSION-
56 ERS, PUBLIC HEALTH DIRECTORS, AND BOARDS OF PUBLIC HEALTH WHEN PROMUL-

GATING RULES AND REGULATIONS TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTICLE. THE COMMISSIONER SHALL NOT HAVE THE POWER TO PRESCRIBE THE NUMBER OF PERSONS TO BE EMPLOYED BY ANY MUNICIPALITY.

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

1 NECESSARY OR RELEVANT TO VERIFY THAT THE CLAIMED EXPENDITURES ARE ELIGI-
2 BLE FOR STATE AID UNDER THIS ARTICLE.

3 S 19. Section 604 of the public health law, as added by chapter 901 of
4 the laws of 1986, is amended to read as follows:

5 S 604. Supervision of public health programs. In order to be eligible
6 for state aid, under this title, each municipality shall employ a full-
7 time local commissioner of health or public health director to supervise
8 the provision of public health services [and to implement the approved
9 public health services plan] for that municipality, SUBJECT TO THE
10 FOLLOWING EXCEPTIONS:

11 1. SUCH PERSON MAY SERVE AS THE HEAD OF A MERGED AGENCY OR MULTIPLE
12 AGENCIES, IF THE APPROVAL OF THE COMMISSIONER IS OBTAINED; AND

13 2. SUCH PERSON MAY SERVE AS THE LOCAL COMMISSIONER OF HEALTH OR PUBLIC
14 HEALTH DIRECTOR OF ADDITIONAL COUNTIES, WHEN AUTHORIZED PURSUANT TO
15 SECTION THREE HUNDRED FIFTY-ONE OF THIS CHAPTER.

16 S 20. Section 605 of the public health law, as added by chapter 901 of
17 the laws of 1986, subdivision 1 as amended by section 6 of part B of
18 chapter 57 of the laws of 2006, subdivision 2 as amended by section 13
19 of part A of chapter 59 of the laws of 2011, is amended to read as
20 follows:

21 S 605. State aid; amount of reimbursement. 1. A state aid base grant
22 shall be reimbursed to municipalities for the [base] CORE public health
23 services identified in [paragraph (b) of subdivision three of] section
24 six hundred two of this title, in an amount of the greater of [fifty-
25 five] SIXTY-FIVE cents per capita, for each person in the municipality,
26 or [five] SIX hundred fifty thousand dollars provided that the munici-
27 pality expends at least [five] SIX hundred fifty thousand dollars for
28 such [base] CORE public health services. A municipality must provide all
29 the [basic] CORE public health services identified in [paragraph (b) of
30 subdivision three of] section six hundred two of this title to qualify
31 for such base grant unless the municipality has the approval of the
32 commissioner to expend the base grant on a portion of such [base] CORE
33 public health services. If any services in such [paragraph (b)] SECTION
34 are not [approved in the plan or if no plan is submitted for such
35 services] PROVIDED, the commissioner may limit the municipality's per
36 capita or base grant to [that proportionate share which will fund those
37 services that are submitted in a plan and subsequently approved] REFLECT
38 THE SCOPE OF THE REDUCED SERVICES. The commissioner may use the [propor-
39 tionate share] AMOUNT that is not granted to contract with agencies,
40 associations, or organizations to provide such services; or the health
41 department may use such proportionate share to provide the services upon
42 approval of the director of the division of the budget.

43 2. State aid reimbursement for public health services provided by a
44 municipality under this title, shall be made if the municipality is
45 providing some or all of the [basic] CORE public health services identi-
46 fied in [paragraph (b) of subdivision three of] section six hundred two
47 of this title, pursuant to an approved [plan] APPLICATION FOR STATE AID,
48 at a rate of no less than thirty-six per centum of the difference
49 between the amount of moneys expended by the municipality for public
50 health services required by [paragraph (b) of subdivision three of]
51 section six hundred two of this title during the fiscal year and the
52 base grant provided pursuant to subdivision one of this section. No such
53 reimbursement shall be provided for services [if they are not approved
54 in a plan or if no plan is submitted for such services] THAT ARE NOT
55 ELIGIBLE FOR STATE AID PURSUANT TO THIS ARTICLE.

1 3. Municipalities shall make every reasonable effort to collect
2 payments for public health services provided. All such revenues shall be
3 reported to the commissioner PURSUANT TO SECTION SIX HUNDRED SIX OF THIS
4 TITLE and will be deducted from expenditures identified under subdivi-
5 sion two of this section to produce a net cost eligible for state aid.

6 S 21. Section 606 of the public health law, as added by chapter 901 of
7 the laws of 1986, is amended to read as follows:

8 S 606. Assessment of fees; THIRD-PARTY COVERAGE OR INDEMNIFICATION.

9 1. Assessment of fees by municipalities. [Each municipality shall
10 assess fees for services provided by such municipality in accordance
11 with a fee and revenue plan which shall include a schedule of fees that
12 the municipality proposes to charge for each service identified by the
13 commissioner and each additional service identified by the municipality
14 for which a fee is to be charged. In accordance with the provisions of
15 subdivision four of section six hundred two of this chapter, the commis-
16 sioner shall review each fee and revenue plan submitted to him and, on
17 the basis of such review, issue a notice of intent to disapprove the
18 plan or approve the plan, with or without conditions, within ninety days
19 of his receipt of the plan. In determining whether to approve or disap-
20 prove a plan, the commissioner shall consider the extent to which the
21 plan, once implemented, will satisfy standards which the commissioner
22 has promulgated through rules and regulations after consulting with the
23 public health council and county health commissioners, boards and public
24 health directors. Such standards shall include a list of those environ-
25 mental, personal health and other services for which fees shall be
26 charged, the calculation of cost by each municipality and the relation-
27 ship of cost to fees, and provisions for prohibiting the assessment of
28 fees which would impede the delivery of services deemed essential to the
29 protection of the health of the public.] EACH MUNICIPALITY SHALL ESTAB-
30 LISH A SCHEDULE OF FEES FOR PUBLIC HEALTH SERVICES PROVIDED BY THE MUNI-
31 CIPALITY AND SHALL MAKE EVERY REASONABLE EFFORT TO COLLECT SUCH FEES.
32 Fees for personal health services shall be reflective of an individual's
33 ability to pay and shall not be inconsistent with the reimbursement
34 guidelines of articles twenty-eight and thirty-six of this chapter and
35 applicable federal laws and regulations. To the extent possible revenues
36 generated shall be used to enhance or expand public health services. IN
37 ITS STATE AID APPLICATION, EACH MUNICIPALITY SHALL PROVIDE THE DEPART-
38 MENT WITH A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR THAT
39 YEAR. EACH MUNICIPALITY SHALL PERIODICALLY REPORT TO THE DEPARTMENT FEES
40 AND REVENUE ACTUALLY COLLECTED.

41 2. Assessment of fees by the commissioner. In each municipality, the
42 commissioner shall establish a fee and revenue plan for services
43 provided by the department in a manner consistent with the standards and
44 regulations established pursuant to subdivision one of this section.

45 3. THIRD PARTY COVERAGE OR INDEMNIFICATION. FOR ANY PUBLIC HEALTH
46 SERVICE FOR WHICH COVERAGE OR INDEMNIFICATION FROM A THIRD PARTY IS
47 AVAILABLE, THE MUNICIPALITY MUST SEEK SUCH COVERAGE OR INDEMNIFICATION
48 AND REPORT ANY ASSOCIATED REVENUE TO THE DEPARTMENT IN ITS STATE AID
49 APPLICATION.

50 S 22. Subdivisions 1 and 2 of section 609 of the public health law, as
51 amended by chapter 474 of the laws of 1996, are amended to read as
52 follows:

53 1. Where a laboratory shall have been or is hereafter established
54 pursuant to article five of this chapter, the state, through the legis-
55 lature and within the limits to be prescribed by the commissioner, shall
56 provide aid at a per centum, determined in accordance with the

1 provisions of [paragraph (b) of] subdivision two of section six hundred
2 five of this article, of the actual cost of [installation,] REPAIR,
3 RELOCATION, equipment and maintenance of the laboratory or laboratories
4 FOR SERVICES ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED
5 IN SECTION SIX HUNDRED TWO OF THIS TITLE. Such cost shall be the
6 excess, if any, of such expenditures over available revenues of all
7 types, including adequate and reasonable fees, derived from or attribut-
8 able to the performance of laboratory services.

9 2. Where a county or city provides or shall have provided for labora-
10 tory service by contracting with an established laboratory FOR SERVICES
11 ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED IN SUBDIVI-
12 SION THREE OF SECTION SIX HUNDRED TWO OF THIS TITLE, with the approval
13 of the commissioner, it shall be entitled to state aid at a per centum,
14 determined in accordance with the provisions of [paragraph (b) of]
15 subdivision two of section six hundred five of this article, of the cost
16 of the contracts. [State aid shall be available for a district laborato-
17 ry supply station maintained and operated in accordance with article
18 five of this chapter in the same manner and to the same extent as for
19 laboratory services.]

20 S 23. Sections 610 and 612 of the public health law are REPEALED.

21 S 24. Paragraphs (a) and (c) of subdivision 1 and subdivision 4 of
22 section 613 of the public health law, paragraphs (a) and (c) of subdivi-
23 sion 1 as amended by chapter 36 of the laws of 2010, subdivision 4 as
24 amended by chapter 207 of the laws of 2004, are amended to read as
25 follows:

26 (a) The commissioner shall develop and supervise the execution of a
27 program of immunization, surveillance and testing, to raise to the high-
28 est reasonable level the immunity of the children of the state against
29 communicable diseases including, but not limited to, influenza, poliomy-
30 elitis, measles, mumps, rubella, haemophilus influenzae type b (Hib),
31 diphtheria, pertussis, tetanus, varicella, hepatitis B, pneumococcal
32 disease, and the immunity of adults of the state against diseases iden-
33 tified by the commissioner, including but not limited to influenza,
34 smallpox, [and] hepatitis AND SUCH OTHER DISEASES AS THE COMMISSIONER
35 MAY DESIGNATE THROUGH REGULATION. [The commissioner shall encourage the
36 municipalities] MUNICIPALITIES in the state [to develop and] shall
37 [assist them in the development and the execution of] MAINTAIN local
38 programs of [inoculation] IMMUNIZATION to raise the immunity of the
39 children and adults of each municipality to the highest reasonable
40 level, IN ACCORDANCE WITH AN APPLICATION FOR STATE AID SUBMITTED BY THE
41 MUNICIPALITY AND APPROVED BY THE COMMISSIONER. Such programs shall
42 include ASSURANCE OF provision of vaccine, [surveillance of vaccine
43 effectiveness by means of laboratory tests,] serological testing of
44 individuals and educational efforts to inform health care providers and
45 target populations or their parents, if they are minors, of the facts
46 relative to these diseases and [inoculation] IMMUNIZATIONS to prevent
47 their occurrence.

48 (c) The commissioner shall invite and encourage the active assistance
49 and cooperation in such education activities of: the medical societies,
50 organizations of other licensed health personnel, hospitals, corpo-
51 rations subject to article forty-three of the insurance law, trade
52 unions, trade associations, parents and teachers and their associations,
53 organizations of child care resource and referral agencies, the media of
54 mass communication, and such other voluntary groups and organizations of
55 citizens as he or she shall deem appropriate. The public health AND
56 HEALTH PLANNING council, the department of education, the department of

1 family assistance, and the department of mental hygiene shall provide
2 the commissioner with such assistance in carrying out the program as he
3 or she shall request. All other state agencies shall also render such
4 assistance as the commissioner may reasonably require for this program.
5 Nothing in this subdivision shall authorize mandatory immunization of
6 adults or children, except as provided in sections twenty-one hundred
7 sixty-four and twenty-one hundred sixty-five of this chapter.

8 4. The commissioner shall expend such funds as the legislature shall
9 make available for the purchase of the vaccines described in subdivision
10 one of this section. [All immunization vaccines purchased with such
11 funds shall be purchased by sealed competitive state bids through the
12 office of general services. Immunization vaccine] VACCINES purchased
13 with funds made available under this section shall be made available
14 without charge to licensed private physicians, hospitals, clinics and
15 such others as the commissioner shall determine [in accordance with
16 regulations to be promulgated by the commissioner], and no charge shall
17 be made to any patient for such vaccines.

18 S 25. Subdivisions 5 and 7 of section 613 of the public health law are
19 REPEALED, and subdivision 6, as added by chapter 901 of the laws of
20 1986, is amended to read as follows:

21 [6.] 5. The commissioner shall submit to the governor and the legisla-
22 ture an annual report on the progress of the immunization program. Such
23 reports shall include specific information on the steps taken and
24 planned by the department [and by each participating municipality] to
25 carry out the program[, statistical information on immunization vaccine
26 purchased for each municipality, the number of inoculations administered
27 to children of various ages by municipal agencies, private clinics,
28 private physicians and others, the cost of the several vaccines
29 purchased, information on the results of the immunization program and
30 research on the effects of the vaccine, cooperative education efforts by
31 public and private agencies, special information and administrative
32 measures to reach parents and children in population groups which pres-
33 ent special educational problems, the actual and planned use of any
34 federal funds available to meet any part of the cost of the program, and
35 actual and planned expenditure by municipalities to meet costs not
36 provided for by state and federal funds].

37 S 26. Subdivision 2 of section 614 of the public health law, as added
38 by chapter 901 of the laws of 1986, is amended to read as follows:

39 2. "City", each city of the state having a population of [fifty thou-
40 sand] ONE MILLION or more, according to the last preceding federal
41 census[, but does not include any such city which is included as a part
42 of a county health district pursuant to this chapter].

43 S 27. Subdivision 1 of section 616 of the public health law, as
44 amended by section 9 of part B of chapter 57 of the laws of 2006, is
45 amended to read as follows:

46 1. The total amount of state aid provided pursuant to this article
47 shall be limited to the amount of the annual appropriation made by the
48 legislature. In no event, however, shall such state aid be less than an
49 amount to provide the full base grant and, as otherwise provided by
50 paragraph (a) of subdivision two of section six hundred five of this
51 article, at least thirty-six per centum of the difference between the
52 amount of moneys expended by the municipality for ELIGIBLE public health
53 services [required by paragraph (b) of subdivision three of section six
54 hundred two of this article] PURSUANT TO AN APPROVED APPLICATION FOR
55 STATE AID during the fiscal year and the base grant provided pursuant to
56 subdivision one of section six hundred five of this article. [A munici-

1 pality shall also receive not less than thirty-six per centum of the
2 moneys expended for other public health services pursuant to paragraph
3 (b) of subdivision two of section six hundred five of this article, and,
4 at least the minimum amount so required for the services identified in
5 title two of this article.]

6 S 28. Section 617 of the public health law, as added by chapter 901 of
7 the laws of 1986, is amended to read as follows:

8 S 617. Maintenance of effort. Such amount of state aid provided will
9 be used to support and to the extent practicable, to increase the level
10 of funds that would otherwise be made available for such purposes and
11 not to supplant the amount to be provided by the municipalities. If a
12 municipality that is provided state aid pursuant to title one of this
13 article reduces its expenditures beneath the amount expended in its base
14 year, which is [the greater of its expenditures in its fiscal year
15 ending in either nineteen hundred eighty-five or] the most recent fiscal
16 year for which the municipality has filed [an annual] ALL expenditure
17 [report] REPORTS to the department, state aid reimbursement provided
18 pursuant to subdivision one of section six hundred five of this article
19 will be reduced by the [difference between the reduction in local
20 expenditures between its base year and its current fiscal year and the
21 reduction in state aid between the base year and the current fiscal year
22 pursuant to paragraphs (a) and (b) of subdivision two of section six
23 hundred five of this article. A municipality may include revenue,
24 excluding third party reimbursement, raised by the municipality in
25 calculating its maintenance of effort] PERCENTAGE REDUCTION IN EXPENDI-
26 TURES BETWEEN ITS BASE YEAR AND ITS CURRENT FISCAL YEAR. FOR PURPOSES OF
27 THIS SECTION, REDUCTIONS IN EXPENDITURES SHALL BE ADJUSTED FOR: AN
28 ABSENCE OF EXTRAORDINARY EXPENDITURES OF A TEMPORARY NATURE, SUCH AS
29 DISASTER RELIEF; UNAVOIDABLE OR JUSTIFIABLE PROGRAM REDUCTIONS, SUCH AS
30 A PROGRAM BEING SUBSUMED BY ANOTHER AGENCY; OR IN CIRCUMSTANCES WHERE
31 THE MUNICIPALITY CAN DEMONSTRATE, TO THE DEPARTMENT'S SATISFACTION, THAT
32 THE NEED FOR THE EXPENDITURE NO LONGER EXISTS.

33 S 29. Section 618 of the public health law, as added by chapter 901 of
34 the laws of 1986, is amended to read as follows:

35 S 618. Performance and accountability. The commissioner shall estab-
36 lish, in consultation with the municipalities, uniform statewide
37 performance standards for the services funded pursuant to this article;
38 provided, however, the commissioner may modify a specific standard for a
39 municipality if such municipality demonstrates adequate justification.
40 The commissioner shall recognize the particular needs and capabilities
41 of the various municipalities. The commissioner shall monitor the
42 PERFORMANCE AND expenditures of each municipality to ensure that each
43 one satisfies the performance standards. Any municipality failing to
44 satisfy its standards may be subject to a reduction or loss of aid until
45 such municipality can demonstrate that it has the capacity to satisfy
46 such standards. The commissioner shall establish a uniform accounting
47 system for monitoring the expenditures for services of each municipality
48 to which aid is granted[, and for determining the appropriateness of the
49 costs of such services. The commissioner shall also establish a uniform
50 reporting system to determine the appropriateness of the amount and
51 types of services provided, and the number of people receiving such
52 services.] AND THE AMOUNT OF STATE AID RECEIVED INCLUDING ANY PERFORM-
53 ANCE PAYMENTS PURSUANT TO SECTION SIX HUNDRED NINETEEN-A OF THIS ARTI-
54 CLE. Such reporting system shall [also] require information on the
55 amount of public health moneys received from the federal government, the
56 private sector, grants, and fees. Each such municipality shall comply

1 with the regulations of such accounting and reporting systems. [The
2 commissioner shall determine the extent to which the services maintained
3 and improved the health status of a municipality's residents and main-
4 tained and improved the accessibility and quality of care, and
5 controlled costs of the health care system.]

6 S 30. Section 619 of the public health law, as added by chapter 901 of
7 the laws of 1986, is amended to read as follows:

8 S 619. Commissioner; regulatory powers. The commissioner shall adopt
9 regulations to effectuate the provisions and purposes of this article,
10 including, but not limited to:

11 1. setting standards of performance [and reasonable costs] for the
12 provision of [basic] CORE public health services which shall include
13 performance criteria to ensure that reimbursable health services are
14 delivered in an efficient and effective manner by a municipality; and

15 2. monitoring, COLLECTING DATA and evaluating the provision of [basic]
16 CORE public health services by the municipalities and the amounts
17 expended by the municipalities for such services.

18 S 31. The public health law is amended by adding a new section 619-a
19 to read as follows:

20 S 619-A. INCENTIVE STANDARDS OF PERFORMANCE. 1. THE COMMISSIONER MAY
21 ESTABLISH STATEWIDE INCENTIVE PERFORMANCE STANDARDS FOR THE DELIVERY OF
22 CORE PUBLIC HEALTH SERVICES.

23 2. WITHIN AMOUNTS APPROPRIATED, AND SUBJECT TO THE APPROVAL OF THE
24 DIRECTOR OF THE BUDGET, THE COMMISSIONER MAY INCREASE STATE AID TO ANY
25 MUNICIPALITY THAT MEETS OR EXCEEDS STATEWIDE INCENTIVE PERFORMANCE STAN-
26 DARDS ESTABLISHED UNDER THIS SECTION, PROVIDED THAT THE TOTAL OF SUCH
27 PAYMENTS TO ALL MUNICIPALITIES MAY NOT EXCEED ONE MILLION DOLLARS ANNU-
28 ALLY.

29 S 32. The article heading of article 23 of the public health law, as
30 amended by chapter 878 of the laws of 1980, is amended to read as
31 follows:

32 CONTROL OF SEXUALLY [TRANSMISSIBLE] TRANSMITTED DISEASES

33 S 33. Sections 2300, 2301, 2302 and 2303 of the public health law are
34 REPEALED.

35 S 34. The section heading and subdivisions 1 and 2 of section 2304 of
36 the public health law, as amended by chapter 878 of the laws of 1980,
37 are amended and two new subdivisions 4 and 5 are added to read as
38 follows:

39 Sexually [transmissible] TRANSMITTED diseases; treatment facilities;
40 administration. 1. It shall be the responsibility of each board of
41 health of a health district to provide adequate facilities for the
42 [free] diagnosis and treatment of persons living within its jurisdiction
43 who are suspected of being infected or are infected with a sexually
44 [transmissible] TRANSMITTED disease.

45 2. The health officer of said health district shall administer these
46 facilities DIRECTLY OR THROUGH CONTRACT and shall promptly examine or
47 arrange for the examination of persons suspected of being infected with
48 a sexually [transmissible] TRANSMITTED disease, and shall promptly
49 institute treatment or arrange for the treatment of those found or
50 otherwise known to be infected with a sexually [transmissible] TRANSMIT-
51 TED disease, provided that any person may, at his option, be treated at
52 his own expense by a licensed physician of his choice.

53 4. EACH BOARD OF HEALTH AND LOCAL HEALTH OFFICER SHALL ENSURE THAT
54 DIAGNOSIS AND TREATMENT SERVICES ARE AVAILABLE AND, TO THE GREATEST
55 EXTENT PRACTICABLE, SEEK THIRD PARTY COVERAGE OR INDEMNIFICATION FOR
56 SUCH SERVICES; PROVIDED, HOWEVER, THAT NO BOARD OF HEALTH, LOCAL HEALTH

1 OFFICER, OR OTHER MUNICIPAL OFFICER OR ENTITY SHALL REQUEST OR REQUIRE
2 THAT SUCH COVERAGE OR INDEMNIFICATION BE UTILIZED AS A CONDITION OF
3 PROVIDING DIAGNOSIS OR TREATMENT SERVICES.

4 5. THE TERM "HEALTH OFFICER" AS USED IN THIS ARTICLE SHALL MEAN A
5 COUNTY HEALTH OFFICER, A CITY HEALTH OFFICER, A TOWN HEALTH OFFICER, A
6 VILLAGE HEALTH OFFICER, THE HEALTH OFFICER OF A CONSOLIDATED HEALTH
7 DISTRICT OR A STATE DISTRICT HEALTH OFFICER.

8 S 35. The section heading and subdivisions 1 and 2 of section 2305 of
9 the public health law, as amended by chapter 878 of the laws of 1980,
10 are amended to read as follows:

11 Sexually [transmissible] TRANSMITTED diseases; treatment by licensed
12 physician or staff physician of a hospital; prescriptions. 1. No
13 person, other than a licensed physician, or, in a hospital, a staff
14 physician, shall diagnose, treat or prescribe for a person who is
15 infected with a sexually [transmissible] TRANSMITTED disease, or who has
16 been exposed to infection with a sexually [transmissible] TRANSMITTED
17 disease, or dispense or sell a drug, medicine or remedy for the treat-
18 ment of such person except on prescription of a duly licensed physician.

19 2. A licensed physician, or in a hospital, a staff physician, may
20 diagnose, treat or prescribe for a person under the age of twenty-one
21 years without the consent or knowledge of the parents or guardian of
22 said person, where such person is infected with a sexually [transmissi-
23 ble] TRANSMITTED disease, or has been exposed to infection with a sexu-
24 ally [transmissible] TRANSMITTED disease.

25 S 36. Section 2306 of the public health law, as amended by chapter 41
26 of the laws of 2010, is amended to read as follows:

27 S 2306. Sexually [transmissible] TRANSMITTED diseases; reports and
28 information, confidential. All reports or information secured by a board
29 of health or health officer under the provisions of this article shall
30 be confidential except in so far as is necessary to carry out the
31 purposes of this article. Such report or information may be disclosed by
32 court order in a criminal proceeding in which it is otherwise admissible
33 or in a proceeding pursuant to article ten of the family court act in
34 which it is otherwise admissible, to the prosecution and to the defense,
35 or in a proceeding pursuant to article ten of the family court act in
36 which it is otherwise admissible, to the petitioner, respondent and
37 attorney for the child, provided that the subject of the report or
38 information has waived the confidentiality provided for by this section
39 EXCEPT INsofar AS IS NECESSARY TO CARRY OUT THE PURPOSES OF THIS ARTI-
40 CLE. INFORMATION MAY BE DISCLOSED TO THIRD PARTY REIMBURSERS OR THEIR
41 AGENTS TO THE EXTENT NECESSARY TO REIMBURSE HEALTH CARE PROVIDERS FOR
42 HEALTH SERVICES; PROVIDED THAT, WHEN NECESSARY, AN OTHERWISE APPROPRIATE
43 AUTHORIZATION FOR SUCH DISCLOSURE HAS BEEN SECURED BY THE PROVIDER. A
44 person waives the confidentiality provided for by this section if such
45 person voluntarily discloses or consents to disclosure of such report or
46 information or a portion thereof. If such person lacks the capacity to
47 consent to such a waiver, his or her parent, guardian or attorney may so
48 consent. An order directing disclosure pursuant to this section shall
49 specify that no report or information shall be disclosed pursuant to
50 such order which identifies or relates to any person other than the
51 subject of the report or information. REPORTS AND INFORMATION MAY BE
52 USED IN THE AGGREGATE IN PROGRAMS APPROVED BY THE COMMISSIONER FOR THE
53 IMPROVEMENT OF THE QUALITY OF MEDICAL CARE PROVIDED TO PERSONS WITH
54 SEXUALLY TRANSMITTED DISEASES; OR WITH PATIENT IDENTIFIERS WHEN USED
55 WITHIN THE STATE OR LOCAL HEALTH DEPARTMENT BY PUBLIC HEALTH DISEASE
56 PROGRAMS TO ASSESS CO-MORBIDITY OR COMPLETENESS OF REPORTING AND TO

1 DIRECT PROGRAM NEEDS, IN WHICH CASE PATIENT IDENTIFIERS SHALL NOT BE
2 DISCLOSED OUTSIDE THE STATE OR LOCAL HEALTH DEPARTMENT EXCEPT AS OTHER-
3 WISE PROVIDED FOR IN THIS SECTION.

4 S 37. The section heading of section 2308 of the public health law is
5 amended to read as follows:

6 [Venereal] SEXUALLY TRANSMITTED disease; pregnant women; blood test
7 for syphilis.

8 S 38. Section 2308-a of the public health law, as amended by chapter
9 878 of the laws of 1980, is amended to read as follows:

10 S 2308-a. Sexually [transmissible] TRANSMITTED diseases; tests for
11 sexually [transmissible] TRANSMITTED diseases. 1. The administrative
12 officer or other person in charge of a clinic or other facility provid-
13 ing gynecological, obstetrical, genito-urolological, contraceptive, steri-
14 lization or termination of pregnancy services or treatment shall require
15 the staff of such clinic or facility to offer to administer to every
16 resident of the state of New York coming to such clinic or facility for
17 such services or treatment, appropriate examinations or tests for the
18 detection of sexually [transmissible] TRANSMITTED diseases.

19 2. Each physician providing gynecological, obstetrical, genito-urolog-
20 ical, contraceptive, sterilization, or termination of pregnancy services
21 or treatment shall offer to administer to every resident of the state of
22 New York coming to such physician for such services or treatment, appro-
23 priate examinations or tests for the detection of sexually [transmissi-
24 ble] TRANSMITTED diseases.

25 S 39. Sections 2309 and 2310 of the public health law are REPEALED.

26 S 40. Section 2311 of the public health law, as added by chapter 878
27 of the laws of 1980, is amended to read as follows:

28 S 2311. Sexually [transmissible] TRANSMITTED disease list. The commis-
29 sioner shall promulgate a list of sexually [transmissible] TRANSMITTED
30 diseases, such as gonorrhea and syphilis, for the purposes of this arti-
31 cle. The commissioner, in determining the diseases to be included in
32 such list, shall consider those conditions principally transmitted by
33 sexual contact, OTHER SECTIONS OF THIS CHAPTER ADDRESSING COMMUNICABLE
34 DISEASES and the impact of particular diseases on individual morbidity
35 and the health of newborns.

36 S 41. Section 2 of chapter 577 of the laws of 2008, amending the
37 public health law relating to expedited partner therapy for persons
38 infected with chlamydia trachomatis, is amended to read as follows:

39 S 2. This act shall take effect on the one hundred twentieth day after
40 it shall have become a law [and shall expire and be deemed repealed
41 January 1, 2014].

42 S 42. Intentionally omitted.

43 S 43. Intentionally omitted.

44 S 44. Intentionally omitted.

45 S 45. Intentionally omitted.

46 S 46. Intentionally omitted.

47 S 47. Intentionally omitted.

48 S 48. Intentionally omitted.

49 S 49. Intentionally omitted.

50 S 50. The public health law is amended by adding a new section 2806-a
51 to read as follows:

52 S 2806-A. TEMPORARY OPERATOR. 1. FOR THE PURPOSES OF THIS SECTION:

53 (A) "ADULT CARE FACILITY" SHALL MEAN AN ADULT HOME OR ENRICHED HOUSING
54 PROGRAM LICENSED PURSUANT TO ARTICLE SEVEN OF THE SOCIAL SERVICES LAW OR
55 AN ASSISTED LIVING RESIDENCE LICENSED PURSUANT TO ARTICLE FORTY-SIX-B OF
56 THIS CHAPTER;

1 (B) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF AN ADULT CARE
2 FACILITY, A GENERAL HOSPITAL OR A DIAGNOSTIC AND TREATMENT CENTER THAT
3 HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE AS SUCH PURSU-
4 ANT TO THIS ARTICLE;

5 (C) "FACILITY" SHALL MEAN (I) A GENERAL HOSPITAL OR A DIAGNOSTIC AND
6 TREATMENT CENTER THAT HAS BEEN ISSUED AN OPERATING CERTIFICATE AS SUCH
7 PURSUANT TO THIS ARTICLE; OR (II) AN ADULT CARE FACILITY;

8 (D) "TEMPORARY OPERATOR" SHALL MEAN ANY PERSON OR ENTITY THAT:

9 (I) AGREES TO OPERATE A FACILITY ON A TEMPORARY BASIS IN THE BEST
10 INTERESTS OF ITS RESIDENTS OR PATIENTS AND THE COMMUNITY SERVED BY THE
11 FACILITY; AND

12 (II) HAS DEMONSTRATED THAT HE OR SHE HAS THE CHARACTER, COMPETENCE AND
13 FINANCIAL ABILITY TO OPERATE THE FACILITY IN COMPLIANCE WITH APPLICABLE
14 STANDARDS;

15 (E) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED
16 TO DEFAULTING OR VIOLATING KEY COVENANTS OF LOANS, OR MISSED MORTGAGE
17 PAYMENTS, OR GENERAL UNTIMELY PAYMENT OF OBLIGATIONS, INCLUDING BUT NOT
18 LIMITED TO EMPLOYEE BENEFIT FUND, PAYROLL TAX, AND INSURANCE PREMIUM
19 OBLIGATIONS, OR FAILURE TO MAINTAIN REQUIRED DEBT SERVICE COVERAGE
20 RATIOS OR, AS APPLICABLE, FACTORS THAT HAVE TRIGGERED A WRITTEN EVENT OF
21 DEFAULT NOTICE TO THE DEPARTMENT BY THE DORMITORY AUTHORITY OF THE STATE
22 OF NEW YORK; AND

23 (F) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS
24 PROVIDED TO A FACILITY UPON SUCH FACILITY'S REQUEST FOR THE PURPOSE OF
25 ASSISTING THE FACILITY TO ADDRESS SERIOUS FINANCIAL INSTABILITY. SUCH
26 FUNDS MAY BE DERIVED FROM EXISTING PROGRAMS WITHIN THE DEPARTMENT,
27 SPECIAL APPROPRIATIONS, OR OTHER FUNDS.

28 2.(A) IN THE EVENT THAT: (I) A FACILITY SEEKS EXTRAORDINARY FINANCIAL
29 ASSISTANCE AND THE COMMISSIONER FINDS THAT THE FACILITY IS EXPERIENCING
30 SERIOUS FINANCIAL INSTABILITY THAT IS JEOPARDIZING EXISTING OR CONTINUED
31 ACCESS TO ESSENTIAL SERVICES WITHIN THE COMMUNITY, OR (II) THE COMMIS-
32 SIONER FINDS THAT THERE ARE CONDITIONS WITHIN THE FACILITY THAT SERIOUS-
33 LY ENDANGER THE LIFE, HEALTH OR SAFETY OF RESIDENTS OR PATIENTS, THE
34 COMMISSIONER MAY APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND
35 SOLE RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY. THE APPOINTMENT
36 OF THE TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO THIS SECTION
37 AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW.

38 (B) THE ESTABLISHED OPERATOR OF A FACILITY MAY AT ANY TIME REQUEST THE
39 COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A
40 REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN
41 ACTION IS NECESSARY TO RESTORE OR MAINTAIN THE PROVISION OF QUALITY CARE
42 TO THE RESIDENTS OR PATIENTS OR ALLEVIATE THE FACILITY'S FINANCIAL
43 INSTABILITY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR
44 THE APPOINTMENT OF A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND SOLE
45 RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY.

46 3. (A) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL,
47 PRIOR TO HIS OR HER APPOINTMENT AS TEMPORARY OPERATOR, PROVIDE THE
48 COMMISSIONER WITH A WORK PLAN SATISFACTORY TO THE COMMISSIONER TO
49 ADDRESS THE FACILITY'S DEFICIENCIES AND SERIOUS FINANCIAL INSTABILITY
50 AND A SCHEDULE FOR IMPLEMENTATION OF SUCH PLAN. A WORK PLAN SHALL NOT BE
51 REQUIRED PRIOR TO THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO
52 CLAUSE (II) OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE
53 COMMISSIONER HAS DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPO-
54 RARY OPERATOR IS NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMI-
55 NENT DANGER OR THERE EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING
56 PATTERN OF CONDITIONS OR PRACTICES WHICH POSES IMMINENT DANGER TO THE

1 HEALTH OR SAFETY OF ANY PATIENT OR RESIDENT OF THE FACILITY. WHERE SUCH
2 IMMEDIATE APPOINTMENT HAS BEEN FOUND TO BE NECESSARY, THE TEMPORARY
3 OPERATOR SHALL PROVIDE THE COMMISSIONER WITH A WORK PLAN SATISFACTORY TO
4 THE COMMISSIONER AS SOON AS PRACTICABLE.

5 (B) THE TEMPORARY OPERATOR SHALL USE HIS OR HER BEST EFFORTS TO IMPL-
6 MENT THE WORK PLAN PROVIDED TO THE COMMISSIONER, IF APPLICABLE, AND TO
7 CORRECT OR ELIMINATE ANY DEFICIENCIES OR FINANCIAL INSTABILITY IN THE
8 FACILITY AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF HEALTH CARE
9 SERVICES IN THE COMMUNITY SERVED BY THE FACILITY. SUCH CORRECTION OR
10 ELIMINATION OF DEFICIENCIES OR SERIOUS FINANCIAL INSTABILITY SHALL NOT
11 INCLUDE MAJOR ALTERATIONS OF THE PHYSICAL STRUCTURE OF THE FACILITY.
12 DURING THE TERM OF HIS OR HER APPOINTMENT, THE TEMPORARY OPERATOR SHALL
13 HAVE THE SOLE AUTHORITY TO DIRECT THE MANAGEMENT OF THE FACILITY IN ALL
14 ASPECTS OF OPERATION AND SHALL BE AFFORDED FULL ACCESS TO THE ACCOUNTS
15 AND RECORDS OF THE FACILITY. THE TEMPORARY OPERATOR SHALL, DURING THIS
16 PERIOD, OPERATE THE FACILITY IN SUCH A MANNER AS TO PROMOTE SAFETY AND
17 THE QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES OR RESIDENTIAL
18 CARE IN THE COMMUNITY SERVED BY THE FACILITY. THE TEMPORARY OPERATOR
19 SHALL HAVE THE POWER TO LET CONTRACTS THEREFOR OR INCUR EXPENSES ON
20 BEHALF OF THE FACILITY, PROVIDED THAT WHERE INDIVIDUAL ITEMS OF REPAIRS,
21 IMPROVEMENTS OR SUPPLIES EXCEED TEN THOUSAND DOLLARS, THE TEMPORARY
22 OPERATOR SHALL OBTAIN PRICE QUOTATIONS FROM AT LEAST THREE REPUTABLE
23 SOURCES. THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND.
24 NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE
25 FACILITY OR CONTAINED WITHIN THE FACILITY, OR IN ANY FIXTURE OF THE
26 FACILITY, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY
27 OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE DEPARTMENT SHALL ENGAGE
28 IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPERTY WITHOUT THE
29 PAYMENT OF FAIR COMPENSATION.

30 4. THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS
31 DETERMINED BY THE COMMISSIONER, AND NECESSARY EXPENSES INCURRED DURING
32 HIS OR HER PERFORMANCE AS TEMPORARY OPERATOR, TO BE PAID FROM THE REVEN-
33 UE OF THE FACILITY. THE TEMPORARY OPERATOR SHALL COLLECT INCOMING
34 PAYMENTS FROM ALL SOURCES AND APPLY THEM TO THE REASONABLE FEE AND TO
35 COSTS INCURRED IN THE PERFORMANCE OF HIS OR HER FUNCTIONS AS TEMPORARY
36 OPERATOR IN CORRECTING DEFICIENCIES AND CAUSES OF SERIOUS FINANCIAL
37 INSTABILITY. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN HIS OR HER
38 CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND PROPERTY BY
39 REASON OF CONDITIONS OF THE FACILITY IN A CASE WHERE AN ESTABLISHED
40 OPERATOR WOULD HAVE BEEN LIABLE; HE OR SHE SHALL NOT HAVE ANY LIABILITY
41 IN HIS OR HER PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTEN-
42 TIONAL ACTS.

43 5. (A) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR
44 SHALL NOT EXCEED ONE HUNDRED EIGHTY DAYS. AFTER ONE HUNDRED EIGHTY DAYS,
45 IF THE COMMISSIONER DETERMINES THAT TERMINATION OF THE TEMPORARY OPERA-
46 TOR WOULD CAUSE SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS
47 TO, HEALTH CARE OR RESIDENTIAL CARE IN THE COMMUNITY OR THAT REAPPOINT-
48 MENT IS NECESSARY TO CORRECT THE CONDITIONS WITHIN THE FACILITY THAT
49 SERIOUSLY ENDANGER THE LIFE, HEALTH OR SAFETY OF RESIDENTS OR PATIENTS,
50 OR THE FINANCIAL INSTABILITY THAT REQUIRED THE APPOINTMENT OF THE TEMPO-
51 RARY OPERATOR, THE COMMISSIONER MAY AUTHORIZE UP TO TWO ADDITIONAL NINE-
52 TY-DAY TERMS.

53 (B) UPON THE COMPLETION OF THE TWO NINETY-DAY TERMS REFERENCED IN
54 PARAGRAPH (A) OF THIS SUBDIVISION,

55 (I) IF THE ESTABLISHED OPERATOR IS THE DEBTOR IN A BANKRUPTCY PROCEED-
56 ING, AND THE COMMISSIONER DETERMINES THAT THE TEMPORARY OPERATOR

1 REQUIRES ADDITIONAL TERMS TO OPERATE THE FACILITY DURING THE PENDENCY OF
2 THE BANKRUPTCY PROCEEDING AND TO CARRY OUT ANY PLAN RESULTING FROM THE
3 PROCEEDING, THE COMMISSIONER MAY REAPPOINT THE TEMPORARY OPERATOR FOR
4 ADDITIONAL NINETY-DAY TERMS UNTIL THE TERMINATION OF THE BANKRUPTCY
5 PROCEEDING, PROVIDED THAT THE COMMISSIONER SHALL PROVIDE FOR NOTICE AND
6 A HEARING AS SET FORTH IN SUBDIVISION SIX OF THIS SECTION; OR

7 (II) IF THE ESTABLISHED OPERATOR REQUESTS THE REAPPOINTMENT OF THE
8 TEMPORARY OPERATOR, THE COMMISSIONER MAY REAPPOINT THE TEMPORARY OPERA-
9 TOR FOR ONE ADDITIONAL NINETY-DAY TERM, PURSUANT TO AN AGREEMENT BETWEEN
10 THE ESTABLISHED OPERATOR, THE TEMPORARY OPERATOR AND THE DEPARTMENT.

11 (C) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE
12 APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL
13 SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT
14 DESCRIBING:

15 (I) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS SUCH DEFICIEN-
16 CIES AND FINANCIAL INSTABILITY,

17 (II) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF
18 NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES,

19 (III) RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE FACILITY
20 SUBSEQUENT TO THE TERM OF THE TEMPORARY OPERATOR; AND

21 (IV) WITH RESPECT TO THE FIRST NINETY-DAY TERM REFERENCED IN PARAGRAPH
22 (A) OF THIS SUBDIVISION, A PLAN FOR SUSTAINABLE OPERATION TO AVOID
23 CLOSURE, OR TRANSFORMATION OF THE FACILITY WHICH MAY INCLUDE ANY OPTION
24 PERMISSIBLE UNDER THIS CHAPTER OR THE SOCIAL SERVICES LAW AND IMPLEMENT-
25 ING REGULATIONS THEREOF. THE REPORT SHALL REFLECT BEST EFFORTS TO
26 PRODUCE A FULL AND COMPLETE ACCOUNTING.

27 (D) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAP-
28 POINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED
29 TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN
30 OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

31 6. (A) THE COMMISSIONER, UPON MAKING A DETERMINATION TO APPOINT A
32 TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF SUBDIVISION TWO OF THIS
33 SECTION SHALL, PRIOR TO THE COMMENCEMENT OF THE APPOINTMENT, CAUSE THE
34 ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE DETERMINATION
35 BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE
36 ESTABLISHED OPERATOR. SUCH NOTIFICATION SHALL INCLUDE A DETAILED
37 DESCRIPTION OF THE FINDINGS UNDERLYING THE DETERMINATION TO APPOINT A
38 TEMPORARY OPERATOR, AND THE DATE AND TIME OF A REQUIRED MEETING WITH THE
39 COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN TEN BUSINESS DAYS OF THE
40 DATE OF SUCH NOTICE. AT SUCH MEETING, THE ESTABLISHED OPERATOR SHALL
41 HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS ALL RELEVANT FINDINGS. AT
42 SUCH MEETING OR WITHIN TEN ADDITIONAL BUSINESS DAYS, THE COMMISSIONER
43 AND THE ESTABLISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATIS-
44 FACTORY PLAN OF CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN THE EVENT
45 SUCH PLAN OF CORRECTION IS AGREED UPON, THE COMMISSIONER SHALL NOTIFY
46 THE ESTABLISHED OPERATOR THAT THE COMMISSIONER NO LONGER INTENDS TO
47 APPOINT A TEMPORARY OPERATOR. A MEETING SHALL NOT BE REQUIRED PRIOR TO
48 THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO CLAUSE (II) OF
49 PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE COMMISSIONER HAS
50 DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPORARY OPERATOR IS
51 NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMINENT DANGER OR THERE
52 EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS
53 OR PRACTICES WHICH POSES IMMINENT DANGER TO THE HEALTH OR SAFETY OF ANY
54 PATIENT OR RESIDENT OF THE FACILITY. WHERE SUCH IMMEDIATE APPOINTMENT
55 HAS BEEN FOUND TO BE NECESSARY, THE COMMISSIONER SHALL PROVIDE THE

1 ESTABLISHED OPERATOR WITH A NOTICE AS REQUIRED UNDER THIS PARAGRAPH ON
2 THE DATE OF THE APPOINTMENT OF THE TEMPORARY OPERATOR.

3 (B) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO
4 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH (A) OF THIS SUBDI-
5 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE
6 COMMISSIONER'S INITIAL NOTIFICATION, A TEMPORARY OPERATOR SHALL BE
7 APPOINTED AS SOON AS IS PRACTICABLE AND SHALL OPERATE PURSUANT TO THE
8 PROVISIONS OF THIS SECTION.

9 (C) THE ESTABLISHED OPERATOR SHALL BE AFFORDED AN OPPORTUNITY FOR AN
10 ADMINISTRATIVE HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A
11 TEMPORARY OPERATOR. SUCH ADMINISTRATIVE HEARING SHALL OCCUR PRIOR TO
12 SUCH APPOINTMENT, EXCEPT THAT THE HEARING SHALL NOT BE REQUIRED PRIOR TO
13 THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO CLAUSE (II) OF
14 PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE COMMISSIONER HAS
15 DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPORARY OPERATOR IS
16 NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMINENT DANGER OR THERE
17 EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS
18 OR PRACTICES WHICH POSES IMMINENT DANGER TO THE HEALTH OR SAFETY OF ANY
19 PATIENT OR RESIDENT OF THE FACILITY. AN ADMINISTRATIVE HEARING AS
20 PROVIDED FOR UNDER THIS PARAGRAPH SHALL BEGIN NO LATER THAN SIXTY DAYS
21 FROM THE DATE OF THE NOTICE TO THE ESTABLISHED OPERATOR AND SHALL NOT BE
22 EXTENDED WITHOUT THE CONSENT OF BOTH PARTIES. ANY SUCH HEARING SHALL BE
23 STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMINATION OF THE
24 COMMISSIONER TO APPOINT A TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL
25 EVIDENCE. A COPY OF THE DECISION SHALL BE SENT TO THE ESTABLISHED OPERA-
26 TOR.

27 (D) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION TO REAPPOINT A
28 TEMPORARY OPERATOR FOR THE FIRST OF AN ADDITIONAL NINETY-DAY TERM PURSU-
29 ANT TO PARAGRAPH (A) OF SUBDIVISION FIVE OF THIS SECTION, CAUSE THE
30 ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE DETERMINATION
31 BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE
32 ESTABLISHED OPERATOR. IF THE COMMISSIONER DETERMINES THAT ADDITIONAL
33 REAPPOINTMENTS PURSUANT TO SUBPARAGRAPH (I) OF PARAGRAPH (B) OF SUBDIVI-
34 SION FIVE OF THIS SECTION ARE REQUIRED, THE COMMISSIONER SHALL AGAIN
35 CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF SUCH
36 DETERMINATION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL
37 OFFICE OF THE ESTABLISHED OPERATOR AT THE COMMENCEMENT OF THE FIRST OF
38 EVERY TWO ADDITIONAL TERMS. UPON RECEIPT OF SUCH NOTIFICATION AT THE
39 PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR AND BEFORE THE EXPIRATION
40 OF TEN DAYS THEREAFTER, THE ESTABLISHED OPERATOR MAY REQUEST AN ADMINIS-
41 TRATIVE HEARING ON THE DETERMINATION TO BEGIN NO LATER THAN SIXTY DAYS
42 FROM THE DATE OF THE REAPPOINTMENT OF THE TEMPORARY OPERATOR. ANY SUCH
43 HEARING SHALL BE STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMI-
44 NATION OF THE COMMISSIONER TO REAPPOINT THE TEMPORARY OPERATOR IS
45 SUPPORTED BY SUBSTANTIAL EVIDENCE.

46 7. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE
47 THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL
48 LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR
49 OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE
50 APPOINTMENT OF ANY TEMPORARY OPERATOR HEREUNDER; NOR SHALL ANYTHING
51 CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING THE TERM OF THE
52 APPOINTMENT OF THE TEMPORARY OPERATOR ANY OBLIGATION OF THE ESTABLISHED
53 OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF TAXES OR OTHER OPERATING
54 AND MAINTENANCE EXPENSES OF THE FACILITY NOR OF THE ESTABLISHED OPERATOR
55 OR ANY OTHER PERSON FOR THE PAYMENT OF MORTGAGES OR LIENS.

1 S 51. The mental hygiene law is amended by adding a new section 32.20
2 to read as follows:

3 S 32.20 TEMPORARY OPERATOR. 1. FOR THE PURPOSES OF THIS SECTION:

4 (A) "CHEMICAL DEPENDENCE TREATMENT PROGRAM" SHALL MEAN A PROGRAM
5 CERTIFIED PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

6 (B) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF A CHEMICAL
7 DEPENDENCE TREATMENT PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN
8 OPERATING CERTIFICATE PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

9 (C) "TEMPORARY OPERATOR" SHALL MEAN ANY OASAS STAFF MEMBER, PERSON OR
10 ENTITY THAT:

11 (I) AGREES TO OPERATE A PROGRAM ON A TEMPORARY BASIS IN THE BEST
12 INTERESTS OF ITS PATIENTS AND THE COMMUNITY SERVED BY THE PROGRAM;

13 (II) HAS DEMONSTRATED THAT HE OR SHE HAS THE CHARACTER, COMPETENCE AND
14 ABILITY TO OPERATE AN OASAS-CERTIFIED PROGRAM IN COMPLIANCE WITH APPLI-
15 CABLE STANDARDS; AND

16 (III) PRIOR TO HIS OR HER APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS
17 WITH GUIDANCE FROM THE COMMISSIONER A SATISFACTORY PLAN TO ADDRESS THE
18 PROGRAM'S DEFICIENCIES;

19 (D) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED
20 TO DEFAULTING OR VIOLATING KEY COVENANTS OF BOND ISSUES, MISSED MORTGAGE
21 PAYMENTS, GENERAL UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOY-
22 EES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING
23 EXPENSES OF THE PROGRAM AND/OR FACILITY, FAILURE TO MAINTAIN REQUIRED
24 DEBT SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE
25 TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMI-
26 TORY AUTHORITY OF THE STATE OF NEW YORK; AND

27 (E) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS
28 PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF
29 PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS
30 PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

31 2. (A) IN THE EVENT THAT: (I) THE PROGRAM IS SEEKING EXTRAORDINARY
32 FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA INDICATES THAT THE
33 PROGRAM IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (III)
34 OFFICE COLLECTED DATA INDICATES THAT THE PROGRAM'S BOARD OF DIRECTORS OR
35 ADMINISTRATION ARE UNABLE OR UNWILLING TO ENSURE THE PROPER OPERATION OF
36 THE PROGRAM; OR (IV) OFFICE COLLECTED DATA INDICATES THERE ARE CONDI-
37 TIONS THAT SERIOUSLY ENDANGER OR JEOPARDIZE CONTINUED ACCESS TO NECES-
38 SARY CHEMICAL DEPENDENCE TREATMENT SERVICES WITHIN THE COMMUNITY, THE
39 COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR OF HIS OR HER INTEN-
40 TION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPONSIBILITY FOR
41 THE PROGRAM'S TREATMENT OPERATIONS OF THAT FACILITY FOR A LIMITED PERIOD
42 OF TIME. THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE EFFECTUATED
43 PURSUANT TO THIS SECTION, AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES
44 PROVIDED BY LAW.

45 (B) THE ESTABLISHED OPERATOR OF A PROGRAM MAY AT ANY TIME REQUEST THE
46 COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A
47 REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN
48 ACTION IS NECESSARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERA-
49 TOR FOR THE APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN
50 THE PROVISION OF QUALITY CARE TO THE PATIENTS UNTIL THE ESTABLISHED
51 OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD; THE
52 PATIENTS MAY BE TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS; OR THE
53 PROGRAM OPERATIONS OF THAT FACILITY SHOULD BE COMPLETELY DISCONTINUED.

54 3. (A) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL
55 USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEVELOPED WITH THE
56 GUIDANCE OF THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN

1 THE PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF CHEMICAL
2 DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY SERVED BY THE PROGRAM.

3 (B) IF THE IDENTIFIED PROGRAM DEFICIENCIES CANNOT BE ADDRESSED IN THE
4 TIME PERIOD DESIGNATED IN THE PLAN, THE PATIENTS SHALL BE TRANSFERRED TO
5 OTHER OASAS-CERTIFIED PROVIDERS.

6 (C) DURING THE TERM OF HIS OR HER APPOINTMENT, THE TEMPORARY OPERATOR
7 SHALL HAVE THE AUTHORITY TO DIRECT THE PROGRAM STAFF OF THE FACILITY IN
8 ALL ASPECTS NECESSARY TO APPROPRIATELY TREAT AND/OR TRANSFER THE
9 PATIENTS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE
10 PROGRAM IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCES-
11 SIBILITY OF CHEMICAL DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY
12 SERVED BY THE FACILITY UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME
13 PROGRAM OPERATIONS OR UNTIL THE PATIENTS ARE APPROPRIATELY TRANSFERRED
14 TO OTHER OASAS-CERTIFIED PROVIDERS.

15 (D) THE TEMPORARY OPERATOR SHALL ALSO BE AFFORDED ACCESS TO A
16 PROGRAM'S ACCOUNTS AND RECORDS IN ORDER TO ADDRESS ANY DEFICIENCIES
17 RELATED TO A PROGRAM EXPERIENCING SERIOUS FINANCIAL INSTABILITY OR A
18 PROGRAM REQUESTING FINANCIAL ASSISTANCE IN ACCORDANCE WITH THIS SECTION.
19 THE TEMPORARY OPERATOR SHALL APPROVE ANY FINANCIAL DECISION RELATED TO A
20 PROGRAM'S DAY TO DAY OPERATIONS OR PROGRAM'S ABILITY TO PROVIDE CHEMICAL
21 DEPENDENCE SERVICES.

22 (E) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO
23 SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE FACIL-
24 ITY OR CONTAINED WITHIN THE FACILITY OR IN ANY FIXTURE OF THE FACILITY,
25 SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY OPERATOR.
26 NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE SHALL ENGAGE IN ANY ACTIV-
27 ITY THAT CONSTITUTES A CONFISCATION OF PROPERTY.

28 4. THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS
29 DETERMINED BY THE COMMISSIONER, AND NECESSARY EXPENSES INCURRED DURING
30 HIS OR HER PERFORMANCE AS TEMPORARY OPERATOR. THE TEMPORARY OPERATOR
31 SHALL BE LIABLE ONLY IN HIS OR HER CAPACITY AS TEMPORARY OPERATOR OF THE
32 PROGRAM FOR INJURY TO PERSON AND PROPERTY BY REASON OF HIS OR HER OPERA-
33 TION OF SUCH PROGRAM; HE OR SHE SHALL NOT HAVE ANY LIABILITY IN HIS OR
34 HER PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

35 5. (A) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR
36 SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER
37 DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE
38 SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, HEALTH CARE
39 IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICI-
40 CIENCIES THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE
41 COMMISSIONER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH
42 AUTHORIZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLU-
43 SION OF THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL
44 TERM.

45 (B) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE
46 APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL
47 SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT
48 DESCRIBING:

49 (I) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS: THE IDENTI-
50 FIED PROGRAM DEFICIENCIES; THE RESUMPTION OF PROGRAM OPERATIONS BY THE
51 ESTABLISHED OPERATOR; OR THE TRANSFER OF THE PATIENTS TO OTHER
52 OASAS-CERTIFIED PROVIDERS;

53 (II) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF
54 NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

55 (III) IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING OPERATION
56 OF THE PROGRAM SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

1 (C) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAP-
2 POINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED
3 TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN
4 OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

5 6. (A) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN
6 INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF
7 SUBDIVISION TWO OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR OF THE
8 FACILITY TO BE NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL
9 ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH
10 NOTIFICATION SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDER-
11 LYING THE INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND
12 TIME OF A REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER
13 DESIGNEE WITHIN TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH
14 MEETING, THE ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW
15 AND DISCUSS ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND
16 THE ESTABLISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFAC-
17 TORY PLAN OF CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT,
18 THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMIS-
19 SIONER WILL ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON
20 THE ESTABLISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN
21 THE AGREED UPON TIMEFRAME.

22 (B) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO
23 ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH (A) OF THIS SUBDI-
24 VISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE
25 COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE
26 HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPER-
27 ATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO
28 THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO
29 THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A
30 TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE
31 DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

32 (C) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH
33 TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND
34 SHALL OPERATE THE PROGRAM PURSUANT TO THE PROVISIONS OF THIS SECTION.

35 7. NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTAB-
36 LISHED OPERATOR REMAINS OBLIGATED FOR THE CONTINUED OPERATION OF THE
37 FACILITY SO THAT THE PROGRAM CAN FUNCTION IN A NORMAL MANNER. NO
38 PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE THE
39 ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL
40 LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR
41 OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE
42 APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER; NOR
43 SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING
44 THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE PROGRAM ANY
45 OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE MAIN-
46 TENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY SERVICES,
47 PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES OF THE
48 FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE
49 PAYMENT OF MORTGAGES OR LIENS.

50 S 52. Intentionally omitted.

51 S 53. Intentionally omitted.

52 S 54. Intentionally omitted.

53 S 55. Intentionally omitted.

54 S 56. Intentionally omitted.

55 S 57. Intentionally omitted.

56 S 58. Intentionally omitted.

1 S 59. Intentionally omitted.
2 S 60. Intentionally omitted.
3 S 61. Intentionally omitted.
4 S 62. Intentionally omitted.
5 S 63. Intentionally omitted.
6 S 64. Intentionally omitted.
7 S 65. Intentionally omitted.
8 S 66. Intentionally omitted.
9 S 67. Intentionally omitted.
10 S 68. Intentionally omitted.
11 S 69. Intentionally omitted.
12 S 70. Intentionally omitted.
13 S 71. Intentionally omitted.
14 S 72. Intentionally omitted.
15 S 73. Intentionally omitted.
16 S 74. Intentionally omitted.
17 S 75. Intentionally omitted.
18 S 76. Intentionally omitted.
19 S 77. Intentionally omitted.
20 S 78. Intentionally omitted.
21 S 79. Intentionally omitted.
22 S 80. Intentionally omitted.
23 S 81. Intentionally omitted.
24 S 82. Intentionally omitted.
25 S 83. Intentionally omitted.
26 S 84. Intentionally omitted.
27 S 85. Intentionally omitted.
28 S 86. Intentionally omitted.
29 S 87. Intentionally omitted.
30 S 88. Intentionally omitted.
31 S 89. Intentionally omitted.
32 S 90. Intentionally omitted.
33 S 91. Intentionally omitted.
34 S 92. Intentionally omitted.
35 S 93. Intentionally omitted.
36 S 94. Intentionally omitted.
37 S 95. Intentionally omitted.
38 S 96. Intentionally omitted.

39 S 97. The opening paragraph, and paragraphs (k) and (l) of subdivision
40 1 of section 3510 of the public health law, as added by chapter 175 of
41 the laws of 2006, are amended and four new paragraphs (m), (n), (o) and
42 (p) are added to read as follows:

43 The license, registration or intravenous contrast administration
44 certificate of a [radiological] RADIOLOGIC technologist may be suspended
45 for a fixed period, revoked or annulled, or such licensee censured,
46 reprimanded, subject to a civil penalty not to exceed two thousand
47 dollars for every such violation, or otherwise disciplined, in accord-
48 ance with the provisions and procedures defined in this article,
49 PROVIDED THAT NO CIVIL PENALTY SHALL BE ASSESSED FOR ANY CRIME OR
50 MISCONDUCT THAT OCCURRED OUTSIDE THE JURISDICTION OF NEW YORK STATE upon
51 decision after due hearing that the individual is guilty of the follow-
52 ing misconduct:

53 (k) using the prefix "Dr.", the word "doctor" or any suffix or affix
54 to indicate or imply that the licensee is a duly licensed practitioner
55 as defined in this article when not so licensed; [or]

56 (l) incompetence or negligence[.];

(M) BEING CONVICTED OF A CRIME WHICH HAS A DIRECT RELATIONSHIP TO THE EMPLOYMENT OR LICENSURE AT ISSUE OR POSES AN UNREASONABLE RISK TO PUBLIC SAFETY PURSUANT TO ARTICLE TWENTY-THREE-A OF THE CORRECTION LAW AND IS A CONVICTION UNDER (I) NEW YORK STATE LAW; (II) FEDERAL LAW; OR (III) THE LAW OF ANOTHER JURISDICTION WHICH, IF COMMITTED WITHIN THIS STATE, WOULD HAVE CONSTITUTED PROFESSIONAL MISCONDUCT 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. Intentionally omitted.

S 102. Intentionally omitted.

S 103. Intentionally omitted.

S 104. Intentionally omitted.

S 105. Intentionally omitted.

S 105-a. Intentionally omitted.

S 106. Intentionally omitted.

S 107. Intentionally omitted.

S 108. 1. 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. For the coverage period beginning the first of July, two thousand thirteen, the superintendent of financial services and the commissioner of health, or their designee, shall purchase up to one thousand policies for excess coverage or equivalent excess coverage in addition to the

1 number of policies purchased for excess coverage or equivalent excess
2 coverage for the coverage period ending the thirtieth of June, two thou-
3 sand thirteen. A general hospital may certify additional eligible physi-
4 cians or dentists in a number equal to such general hospital's propor-
5 tional share of the total number of physicians or dentists for whom
6 excess coverage or equivalent excess coverage was purchased with funds
7 available in the hospital excess liability pool as of the thirtieth of
8 June, two thousand thirteen, as applied to the greater of one thousand
9 or the difference between the number of eligible physicians or dentists
10 for whom a policy for excess coverage or equivalent excess coverage was
11 purchased for the coverage period ending the thirtieth of June, two
12 thousand thirteen and the number of such eligible physicians or dentists
13 who have applied for excess coverage or equivalent excess coverage for
14 the coverage period beginning the first of July, two thousand thirteen
15 plus one thousand.

16 2. Notwithstanding any inconsistent provision of sections one hundred
17 twelve and one hundred sixty-three of the state finance law, or sections
18 one hundred forty-two and one hundred forty-three of the economic devel-
19 opment law, or any other contrary provision of law, the superintendent
20 of financial services may enter into a contract or contracts under this
21 subdivision for the purpose of retaining an entity to administer the
22 hospital excess liability pool without a competitive bid or request for
23 proposal process, provided, however, that:

24 (a) The department of financial services shall post on its website,
25 for a period of no less than thirty days:

26 (i) A description of the proposed services to be provided pursuant to
27 the contract or contracts;

28 (ii) The criteria for selection of a contractor or contractors;

29 (iii) The period of time during which a prospective contractor may
30 seek selection, which shall be no less than thirty days after such
31 information is first posted on the website; and

32 (iv) The manner by which a prospective contractor may seek such
33 selection, which may include submission by electronic means;

34 (b) All reasonable and responsive submissions that are received from
35 prospective contractors in timely fashion shall be reviewed by the
36 superintendent of financial services; and

37 (c) The superintendent of financial services shall select such
38 contractor or contractors that, in the superintendent of financial
39 services' discretion, are best suited to serve the purposes of this
40 subdivision.

41 S 109. Section 5-a of part C of chapter 58 of the laws of 2005, relat-
42 ing to authorizing reimbursements for expenditures made by or on behalf
43 of social services districts for medical assistance for needy persons
44 and the administration thereof, in relation to the use of Medicaid
45 recovery savings, as added by section 52-f of part H of chapter 59 of
46 the laws of 2011, is amended to read as follows:

47 S 5-a. Notwithstanding any provision of law to the contrary, the
48 commissioner of health is authorized to approve social services district
49 demonstration programs for the purpose of maximizing Medicaid recov-
50 eries. The commissioner shall evaluate the results of any such programs,
51 including any savings resulting therefrom. [Ten] TWENTY percent of any
52 such savings, after certification by the director of the division of the
53 budget, shall be shared with the applicable social services district in
54 a manner to be determined jointly by the commissioner of health and the
55 director of the division of the budget.

1 S 110. Subdivisions 5, 23 and 24 of section 32 of the public health
2 law, as added by chapter 442 of the laws of 2006, are amended and 2 new
3 subdivisions 25 and 26 are added to read as follows:

4 5. to keep the governor, attorney general, state comptroller, tempo-
5 rary president and minority leader of the senate, the speaker and the
6 minority leader of the assembly, and the heads of agencies with respon-
7 sibility for the administration of the medical assistance program
8 apprised of efforts to prevent, detect, investigate, and prosecute fraud
9 and abuse within the medical assistance program, AND TO PROVIDE A QUAR-
10 TERLY BRIEFING TO THE LEGISLATURE ON ACTIVITIES OF THE OFFICE;

11 23. to annually submit a budget request, for the ensuing state fiscal
12 year, to the division of THE budget, provided that the office's budget
13 request shall not be subject to review, alteration or modification by
14 the commissioner or any other entity or person prior to its submission
15 to the division of THE budget; [and]

16 24. TO MEET QUARTERLY WITH REPRESENTATIVES OF SOCIAL SERVICES
17 DISTRICTS TO DISCUSS THE STATUS OF ONGOING COOPERATIVE EFFORTS BETWEEN
18 THE OFFICE OF MEDICAID INSPECTOR GENERAL AND DISTRICTS, INCLUDING DEMON-
19 STRATION PROGRAMS AUTHORIZED PURSUANT TO SECTION FIVE-A OF PART C OF
20 CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, THE POTENTIAL FOR
21 ADDITIONAL COLLABORATION AND/OR FOR IMPROVED OR INNOVATIVE TECHNIQUES TO
22 BE EMPLOYED, AND ANY ISSUES OF CONCERN TO SUCH DISTRICTS WITH RESPECT TO
23 THE PREVENTION AND DETECTION OF FRAUD AND ABUSE IN THE MEDICAL ASSIST-
24 ANCE PROGRAM;

25 25. TO REQUEST SUBMISSION OF SOCIAL SERVICES DISTRICTS ANNUAL BUDGET
26 AND AUDIT WORKPLANS FOR PURPOSES OF PLANNING FOR AND EXECUTING THE COUN-
27 TY DEMONSTRATION PROGRAM AND FOR THE CREATION OF THE OFFICE'S ANNUAL
28 WORKPLAN AND TO INCLUDE IN THE OFFICE'S ANNUAL WORKPLAN A DESCRIPTION OF
29 ACTIVITIES THAT WILL BE CONDUCTED IN COLLABORATION WITH SOCIAL SERVICES
30 DISTRICTS;

31 26. TO DEVELOP TRAINING MATERIALS WITH RESPECT TO THE OFFICE'S AUDIT
32 STANDARDS AND CRITERIA FOR IDENTIFYING FRAUD OR WASTE, FOR USE BY SOCIAL
33 SERVICES DISTRICTS WHO ARE ENGAGED WITH THE OFFICE IN DEMONSTRATION
34 PROGRAMS OR OTHER COLLABORATIVE EFFORTS; AND

35 27. to perform any other functions that are necessary or appropriate
36 to fulfill the duties and responsibilities of the office in accordance
37 with federal and state law.

38 S 111. Paragraphs (e) and (f) of subdivision 1 of section 35 of the
39 public health law, as added by chapter 442 of the laws of 2006, are
40 amended and a new paragraph (g) is added to read as follows:

41 (e) the number, subject and other relevant characteristics of civil
42 actions initiated by the office related to improper payments, the
43 resulting civil settlements entered and overpayments identified and the
44 total dollar value both identified and collected; [and]

45 (f) a narrative that evaluates the office's performance, describes any
46 specific problems and connection with the procedures and agreements
47 required under this section, discusses any other matters that may have
48 impaired its effectiveness and summarizes the total savings to the
49 state's medical assistance program[.]; AND

50 (G) A NARRATIVE, PROVIDED BY THE DEPARTMENT IN ITS ANNUAL REPORT
51 PURSUANT TO PARAGRAPH (T) OF SUBDIVISION ONE OF SECTION TWO HUNDRED SIX
52 OF THIS CHAPTER THAT SUMMARIZES THE DEPARTMENT'S ACTIVITIES TO MITIGATE
53 FRAUD, WASTE AND ABUSE DURING THE PRECEDING CALENDAR YEAR.

54 S 112. Subdivision 1 of section 206 of the public health law is
55 amended by adding a new paragraph (t) to read as follows:

(T) THE DEPARTMENT SHALL SUBMIT AS PART OF ITS ANNUAL REPORT PREPARED PURSUANT TO SECTION ONE HUNDRED SIXTY-FOUR OF THE EXECUTIVE LAW, WHICH MAY BE SUBMITTED IN ELECTRONIC FORMAT, COMPREHENSIVE INFORMATION INCLUDING, BUT NOT LIMITED TO, A DETAILED DESCRIPTION OF THE DEPARTMENT'S MISSION, PRIORITIES AND GOALS FOR THE UPCOMING YEAR, ACHIEVEMENTS OF THE PAST YEAR, AND ANY RELEVANT DATA AND STATISTICS.

S 113. Section 2500-a of the public health law is amended by adding a new subdivision (c) to read as follows:

(C) BY REGULATION, THE COMMISSIONER SHALL ADD ADRENOLEUKODYSTROPHY ("ALD") TO THE LIST OF DISEASES AND CONDITIONS FOR WHICH TESTING SHALL BE PERFORMED PURSUANT TO SUBDIVISION (A) OF THIS SECTION UPON VALIDATION BY THE WADSWORTH CENTER OF A TEST FOR ALD. THE WADSWORTH CENTER SHALL UNDERTAKE THE PROCESS FOR VALIDATION UPON THE DEVELOPMENT OF A TEST. THIS SUBDIVISION SHALL BE KNOWN AND MAY BE CITED AS "AIDAN'S LAW."

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. 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 122. 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 provisions of this act shall apply only to actions and proceedings commenced on or after such effective date; provided, further, that:

(a) sections thirty-two, thirty-three, thirty-four, thirty-five, thirty-six, thirty-seven, thirty-nine, forty, forty-one, and one hundred eight of this act shall take effect immediately;

(b) sections fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-three, twenty-four, twenty-six, twenty-seven, twenty-eight, twenty-nine, thirty, one hundred twelve, and one hundred thirteen of this act shall take effect January 1, 2014;

(c) section fifty of this act shall take effect immediately and shall expire three years after it becomes law;

(d) 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;

(e) 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;

(f) 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;

(g) 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; and

(h) 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.

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.

S 2. The office of alcoholism and substance abuse services shall ensure that accurate dosage delivery and facilitating disaster management shall not result in any new material expenditures by methadone programs.

S 3. 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.]

1 "LOCAL GOVERNMENTAL UNIT" SHALL HAVE THE SAME MEANING AS THAT CONTAINED
2 IN ARTICLE FORTY-ONE OF THIS CHAPTER.

3 2. "Operating [costs] EXPENSES" shall mean expenditures[, excluding
4 capital costs and debt service, subject to the approval of the office,]
5 APPROVED BY THE OFFICE AND incurred for the maintenance and operation of
6 substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING programs,
7 including but not limited to expenditures for treatment, administration,
8 personnel, AND contractual services[, rental, depreciation and interest
9 expenses incurred, in connection with the design, construction, acquisi-
10 tion, reconstruction, rehabilitation or improvement of a substance abuse
11 program facility, and payments made to the facilities development corpo-
12 ration for substance abuse program facilities; provided that where the].
13 OPERATING EXPENSES DO NOT INCLUDE CAPITAL COSTS AND DEBT SERVICE UNLESS
14 SUCH EXPENSES ARE RELATED TO THE rent, financing or refinancing of the
15 design, construction, acquisition, reconstruction, rehabilitation or
16 improvement of a substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBL-
17 ING program facility [is through the facilities development corporation,
18 operating costs shall include the debt service to be paid to amortize
19 obligations, including principal and interest, issued by the New York
20 State medical care facilities finance agency to finance or refinance the
21 capital costs of such facilities] PURSUANT TO THE MENTAL HYGIENE FACILI-
22 TIES FINANCE PROGRAM THROUGH THE DORMITORY AUTHORITY OF THE STATE OF NEW
23 YORK (DASNY; SUCCESSOR TO THE FACILITIES DEVELOPMENT CORPORATION), OR
24 OTHERWISE APPROVED BY THE OFFICE.

25 3. "Debt service" shall mean amounts, subject to the approval of the
26 office, [as shall be] required to be paid to amortize obligations
27 including principal and interest [issued by the New York state housing
28 finance agency, the New York State medical care facilities finance agen-
29 cy or], ASSUMED by or on behalf of a [substance abuse program] VOLUNTARY
30 AGENCY or a PROGRAM OPERATED BY A local [agency to finance capital costs
31 for substance abuse program facilities] GOVERNMENTAL UNIT.

32 4. "Capital costs" shall mean [expenditures, subject to the approval
33 of the office, as shall be obligated to acquire, construct, reconstruct,
34 rehabilitate or improve a substance abuse program facility.] THE COSTS
35 OF A PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR A VOLUNTARY AGENCY
36 WITH RESPECT TO THE ACQUISITION OF REAL PROPERTY ESTATES, INTERESTS, AND
37 COOPERATIVE INTERESTS IN REALTY, THEIR DESIGN, CONSTRUCTION, RECON-
38 STRUCTION, REHABILITATION AND IMPROVEMENT, ORIGINAL FURNISHINGS AND
39 EQUIPMENT, SITE DEVELOPMENT, AND APPURTENANCES OF A FACILITY.

40 5. "STATE AID" SHALL MEAN FINANCIAL SUPPORT PROVIDED THROUGH APPROPRI-
41 ATIONS OF THE OFFICE TO SUPPORT THE PROVISION OF SUBSTANCE USE DISORDER
42 TREATMENT, COMPULSIVE GAMBLING, PREVENTION OR OTHER AUTHORIZED SERVICES,
43 WITH THE EXCLUSION OF APPROPRIATIONS FOR THE PURPOSE OF MEDICAL ASSIST-
44 ANCE.

45 6. "VOLUNTARY AGENCY CONTRIBUTIONS" SHALL MEAN REVENUE SOURCES OF
46 VOLUNTARY AGENCIES EXCLUSIVE OF STATE AID AND LOCAL TAX LEVY.

47 7. "APPROVED NET OPERATING COST" SHALL MEAN THE REMAINDER OF TOTAL
48 OPERATING EXPENSES APPROVED BY THE OFFICE, LESS ALL SOURCES OF REVENUE,
49 INCLUDING VOLUNTARY AGENCY CONTRIBUTIONS AND LOCAL TAX LEVY.

50 8. "VOLUNTARY AGENCY" SHALL MEAN A CORPORATION ORGANIZED OR EXISTING
51 PURSUANT TO THE NOT-FOR-PROFIT CORPORATION LAW FOR THE PURPOSE OF
52 PROVIDING SUBSTANCE USE DISORDER, TREATMENT, COMPULSIVE GAMBLING,
53 PREVENTION OR OTHER AUTHORIZED SERVICES.

54 S 4. Subdivisions (a) and (b) of section 25.03 of the mental hygiene
55 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 GOVERNMENTAL UNITS 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 UP TO THE SAME PERCENTAGE AS THE REDUCTION IN LOCAL TAX LEVY.

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 AND/OR COMPULSIVE GAMBLING 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 AND/OR COMPULSIVE GAMBLING 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

1 or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT for the
2 administration of a [substance abuse] program.

3 S 9. Section 25.11 of the mental hygiene law, as added by chapter 471
4 of the laws of 1980, subdivision (a) as amended by chapter 223 of the
5 laws of 1992, is amended to read as follows:

6 S 25.11 [Comprehensive plan] DISTRIBUTION OF STATE AID TO A LOCAL
7 GOVERNMENTAL UNIT.

8 [(a) A local agency intending to seek financial support from the
9 office shall no later than July first of each year submit to the office
10 a comprehensive substance abuse services plan, which shall describe the
11 programs and activities planned for its ensuing fiscal year. Such plan
12 shall indicate to the extent possible, the nature of the services to be
13 provided, whether such services are to be provided directly, through
14 subcontract, or through the utilization of existing public resources,
15 the area or areas to be served, and an estimate of the cost of such
16 services, including amounts to be provided other than by office finan-
17 cial support, specifically identifying the amount of local governmental
18 funds committed to substance abuse programs during its current fiscal
19 year, and a commitment that no less than such an amount will be used
20 from such funds for the operation of such programs during the next
21 fiscal year. Such plan shall make provisions for all needed substance
22 abuse services and for the evaluation of the effectiveness of such
23 services.

24 (b) When a comprehensive plan includes a local school district based
25 substance abuse program such plan shall include the details of an
26 adequate distribution of in-school and community-wide preventive educa-
27 tion services, including, but not limited to, services to be provided by
28 local drug abuse prevention councils, and shall emphasize the use of
29 other volunteer agency services as may be available. The description of
30 the program and activities thereunder shall be separately stated, and
31 the data and information required to be provided shall conform to the
32 provisions of subdivision (a) of this section except that the period to
33 be covered may, notwithstanding the fiscal year of the local agency,
34 conform to the school year.] NOTWITHSTANDING SECTION ONE HUNDRED TWELVE
35 OF THE STATE FINANCE LAW, THE OFFICE IS AUTHORIZED TO GRANT STATE AID
36 ANNUALLY TO LOCAL GOVERNMENTAL UNITS IN THE FOLLOWING MANNER:

37 (A) LOCAL GOVERNMENTAL UNITS SHALL BE GRANTED STATE AID BY A STATE AID
38 FUNDING AUTHORIZATION LETTER ISSUED BY THE OFFICE FOR APPROVED NET OPER-
39 ATING COSTS FOR VOLUNTARY AGENCIES TO SUPPORT THE BASE AMOUNT OF STATE
40 AID PROVIDED TO SUCH VOLUNTARY AGENCIES FOR THE PRIOR YEAR PROVIDED THAT
41 THE LOCAL GOVERNMENTAL UNIT HAS APPROVED AND SUBMITTED BUDGETS FOR THE
42 VOLUNTARY AGENCIES TO THE OFFICE. THE VOLUNTARY AGENCY BUDGETS SHALL
43 IDENTIFY THE NATURE OF THE SERVICES TO BE PROVIDED WHICH MUST BE
44 CONSISTENT WITH THE LOCAL SERVICES PLAN SUBMITTED BY THE LOCAL GOVERN-
45 MENTAL UNIT PURSUANT TO ARTICLE FORTY-ONE OF THIS CHAPTER, THE AREAS TO
46 BE SERVED AND INCLUDE A DESCRIPTION OF THE VOLUNTARY AGENCY CONTRIB-
47 UTIONS AND LOCAL GOVERNMENTAL UNIT FUNDING PROVIDED. THE LOCAL GOVERN-
48 MENTAL UNIT SHALL ENTER INTO CONTRACTS WITH THE VOLUNTARY AGENCIES
49 RECEIVING SUCH STATE AID. SUCH CONTRACTS SHALL INCLUDE FUNDING REQUIRE-
50 MENTS SET BY THE OFFICE INCLUDING BUT NOT LIMITED TO RESPONSIBILITIES OF
51 VOLUNTARY AGENCIES RELATING TO WORK SCOPES, PROGRAM PERFORMANCE AND
52 OPERATIONS, APPLICATION OF PROGRAM INCOME, PROHIBITED USE OF FUNDS,
53 RECORDKEEPING AND AUDIT OBLIGATIONS. UPON DESIGNATION BY THE OFFICE,
54 LOCAL GOVERNMENTAL UNITS SHALL NOTIFY VOLUNTARY AGENCIES AS TO THE
55 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 PROGRAM OPERATED BY A VOLUNTARY AGENCY OR A LOCAL GOVERNMENTAL UNIT 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 PROVIDED HOWEVER, THAT UPON DETERMINATION THAT THE PROGRAM IS NOT MEETING THE MINIMUM STANDARDS AND REQUIREMENTS, THE OFFICE SHALL NOTIFY SUCH PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY OF THEIR DEFICIENCIES, AND IF APPROPRIATE, A CORRECTIVE ACTION PLAN THAT INCLUDES SPECIFIC ACTIONS TO ADDRESS ANY DEFICIENCIES AND A TIMETABLE FOR IMPLEMENTATION SHALL BE DEVELOPED. STATE AID MAY BE REDUCED IF A CORRECTIVE ACTION PLAN IS NOT APPROVED BY THE OFFICE OR IS NOT IMPLEMENTED IN A TIMELY AND SATISFACTORY MANNER;

(2) THAT THE VOLUNTARY AGENCY HAS HAD AN INCREASE IN VOLUNTARY AGENCY CONTRIBUTIONS THAT REDUCES THE APPROVED NET OPERATING COSTS NECESSARY, EXCEPT WHERE THE OFFICE HAS APPROVED AN ALTERNATIVE USE OF SUCH VOLUNTARY AGENCY CONTRIBUTIONS OR SUCH VOLUNTARY AGENCY CONTRIBUTIONS ARE NECESSARY TO ENSURE FINANCIAL VIABILITY.

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 AND/OR COMPULSIVE GAMBLING 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 AND/OR COMPULSIVE GAMBLING 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 AND/OR COMPULSIVE GAMBLING 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 OPERATED 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 AND/OR COMPULSIVE GAMBLING 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 AND/OR COMPULSIVE GAMBLING 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 AND/OR COMPULSIVE GAMBLING 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. Subdivision (b) of section 7.17 of the mental hygiene law, as amended by section 1 of part O of chapter 56 of the laws of 2012, is amended to read as follows:

(b) There shall be in the office the hospitals named below for the care, treatment and rehabilitation of persons with mental illness and for research and teaching in the science and skills required for the care, treatment and rehabilitation of such persons with mental illness.

Greater Binghamton Health Center

Bronx Psychiatric Center

Buffalo Psychiatric Center

Capital District Psychiatric Center

Central New York Psychiatric Center

1 Creedmoor Psychiatric Center
2 Elmira Psychiatric Center
3 Kingsboro Psychiatric Center
4 Kirby Forensic Psychiatric Center
5 Manhattan Psychiatric Center
6 Mid-Hudson Forensic Psychiatric Center
7 Mohawk Valley Psychiatric Center
8 Nathan S. Kline Institute for Psychiatric Research
9 New York State Psychiatric Institute
10 Pilgrim Psychiatric Center
11 Richard H. Hutchings Psychiatric Center
12 Rochester Psychiatric Center
13 Rockland Psychiatric Center
14 St. Lawrence Psychiatric Center
15 South Beach Psychiatric Center
16 New York City Children's Center
17 Rockland Children's Psychiatric Center
18 Sagamore Children's Psychiatric Center
19 Western New York Children's Psychiatric Center
20 The New York State Psychiatric Institute and The Nathan S. Kline
21 Institute for Psychiatric Research are designated as institutes for the
22 conduct of medical research and other scientific investigation directed
23 towards furthering knowledge of the etiology, diagnosis, treatment and
24 prevention of mental illness. [Whenever the term Bronx Children's
25 Psychiatric Center, Brooklyn Children's Psychiatric Center and Queens
26 Children's Psychiatric Center is referred to or designated in any regu-
27 lation, contract or document pertaining to the functions, powers, obli-
28 gations and duties hereby transferred and assigned, such reference or
29 designation shall be deemed to refer to the New York City Children's
30 Center.]

31 S 2. Section 4 of part 0 of chapter 56 of the laws of 2012, amending
32 the mental hygiene law relating to the closure and the reduction in size
33 of certain facilities serving persons with mental illness, is amended
34 and a new section 1-a is added to read as follows:

35 S 1-A. WHENEVER THE TERM BRONX CHILDREN'S PSYCHIATRIC CENTER, BROOKLYN
36 CHILDREN'S PSYCHIATRIC CENTER OR QUEENS CHILDREN'S PSYCHIATRIC CENTER IS
37 REFERRED TO OR DESIGNATED IN ANY REGULATION, CONTRACT OR DOCUMENT
38 PERTAINING TO THE FUNCTIONS, POWERS, OBLIGATIONS AND DUTIES HEREBY
39 TRANSFERRED AND ASSIGNED PURSUANT TO THIS ACT, SUCH REFERENCE OR DESIG-
40 NATION SHALL BE DEEMED TO REFER TO THE NEW YORK CITY CHILDREN'S CENTER.

41 S 4. This act shall take effect immediately and shall be deemed to
42 have been in full force and effect on and after April 1, 2012; provided
43 that the date for any closure or consolidation pursuant to this act
44 shall be on a date certified by the commissioner of mental health; and
45 provided further, however, that SECTION TWO OF this act shall expire and
46 be deemed repealed March 31, 2013.

47 S 3. Section 7 of part R2 of chapter 62 of the laws of 2003, amending
48 the mental hygiene law and the state finance law relating to the commu-
49 nity mental health support and workforce reinvestment program, the
50 membership of subcommittees for mental health of community services
51 boards and the duties of such subcommittees and creating the community
52 mental health and workforce reinvestment account, as amended by section
53 2 of part C of chapter 111 of the laws of 2010, is amended to read as
54 follows:

1 S 7. This act shall take effect immediately and shall expire March 31,
2 [2013] 2015 when upon such date the provisions of this act shall be
3 deemed repealed.

4 S 4. Severability clause. If any clause, sentence, paragraph, subdivi-
5 sion, section or part of this act shall be adjudged by any court of
6 competent jurisdiction to be invalid, such judgment shall not affect,
7 impair, or invalidate the remainder thereof, but shall be confined in
8 its operation to the clause, sentence, paragraph, subdivision, section
9 or part thereof directly involved in the controversy in which such judg-
10 ment shall have been rendered. It is hereby declared to be the intent of
11 the legislature that this act would have been enacted even if such
12 invalid provisions had not been included herein.

13 S 5. This act shall take effect April 1, 2013; provided, however that
14 if this act shall become a law after April 1, 2013, this act shall take
15 effect immediately and shall be deemed to have been in full force and
16 effect on and after April 1, 2013.

17 PART I

18 Section 1. Section 1 of part D of chapter 111 of the laws of 2010
19 relating to the recovery of exempt income by the office of mental health
20 for community residences and family-based treatment programs as amended
21 by section 1 of part R of chapter 56 of the laws of 2012, is amended to
22 read as follows:

23 Section 1. The office of mental health is authorized to recover fund-
24 ing from community residences and family-based treatment providers
25 licensed by the office of mental health, consistent with contractual
26 obligations of such providers, and notwithstanding any other inconsis-
27 tent provision of law to the contrary, in an amount equal to 50 percent
28 of the income received by such providers which exceeds the fixed amount
29 of annual Medicaid revenue limitations, as established by the commis-
30 sioner of mental health. Recovery of such excess income shall be for the
31 following fiscal periods: for programs in counties located outside of
32 the city of New York, the applicable fiscal periods shall be January 1,
33 2003 through December 31, 2009 and January 1, 2011 through December 31,
34 [2013] 2014; and for programs located within the city of New York, the
35 applicable fiscal periods shall be July 1, 2003 through June 30, 2010
36 and July 1, 2011 through June 30, [2013] 2014.

37 S 2. This act shall take effect immediately.

38 PART J

39 Section 1. Subdivision (a) of section 7.19 of the mental hygiene law,
40 as amended by chapter 307 of the laws of 1979, is amended to read as
41 follows:

42 (a) The commissioner OR HIS OR HER DESIGNEE may, within the amounts
43 appropriated therefor, appoint and remove in accordance with law and
44 applicable rules of the state civil service commission, such officers
45 and employees of the office of mental health [and facility officers and
46 employees who are designated managerial or confidential pursuant to
47 article fourteen of the civil service law] as are necessary for effi-
48 cient administration AND SHALL ADMINISTER THE OFFICE'S PERSONNEL SYSTEM
49 IN ACCORDANCE WITH SUCH LAW AND RULES. IN EXERCISING THE APPOINTING
50 AUTHORITY, THE COMMISSIONER SHALL TAKE ALL REASONABLE AND NECESSARY
51 STEPS, CONSISTENT WITH ARTICLE TWENTY-THREE-A OF THE CORRECTION LAW, TO
52 ENSURE THAT ANY SUCH PERSON SO APPOINTED HAS NOT PREVIOUSLY ENGAGED IN

1 ANY ACT IN VIOLATION OF ANY LAW WHICH COULD COMPROMISE THE HEALTH AND
2 SAFETY OF PATIENTS.

3 S 2. Subdivision (a) of section 7.21 of the mental hygiene law, as
4 amended by chapter 434 of the laws of 1980, is amended to read as
5 follows:

6 (a) The director of a facility under the jurisdiction of the office of
7 mental health shall be its chief executive officer. Each such director
8 shall be in the noncompetitive class and designated as confidential as
9 defined by subdivision two-a of section forty-two of the civil service
10 law and shall be appointed by and serve at the pleasure of the commis-
11 sioner. [Except for facility officers and employees for which subdivi-
12 sion (a) of section 7.19 of this article makes the commissioner the
13 appointing and removing authority, the director of a facility shall have
14 the power, within amounts appropriated therefor, to appoint and remove
15 in accordance with law and applicable rules of the state civil service
16 commission such officers and employees of the facility of which he is
17 director as are necessary for its efficient administration. He shall in
18 exercising this appointing authority take, consistent with article twen-
19 ty-three-A of the correction law, all reasonable and necessary steps to
20 insure that any such person so appointed has not previously engaged in
21 any act in violation of any law which could compromise the health and
22 safety of patients in the facility of which he is director.] He OR SHE
23 shall manage the facility [and administer its personnel system] subject
24 to applicable law and the regulations of the commissioner of mental
25 health [and the rules of the state civil service commission]. Before
26 the commissioner shall issue any such regulation or any amendment or
27 revision thereof, he OR SHE shall consult with the FACILITY directors
28 [of the office's hospitals] regarding its suitability. The director
29 shall maintain effective supervision of all parts of the facility and
30 over all persons employed therein or coming thereon and shall generally
31 direct the care and treatment of patients. Directors presently serving
32 at office of mental health facilities shall continue to serve under the
33 terms of their original appointment.

34 S 3. The amendments to sections 7.19 and 7.21 of the mental hygiene
35 law pursuant to Part J of a chapter of the laws of two thousand thirteen
36 shall not authorize the commissioner of mental health to make any deci-
37 sions with respect to employees in contradiction of the civil service
38 law and regulations, and applicable collective bargaining agreements,
39 nor otherwise alter any geographically discrete layoff unit structures.

40 S 4. This act shall take effect April 1, 2013.

41 PART K

42 Intentionally omitted

43 PART L

44 Section 1. The mental hygiene law is amended by adding a new section
45 31.37 to read as follows:

46 S 31.37 MENTAL HEALTH INCIDENT REVIEW PANELS.

47 (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH, ON HIS OR HER OWN
48 ACCORD OR PURSUANT TO A REQUEST BY A LOCAL GOVERNMENTAL UNIT, A MENTAL
49 HEALTH INCIDENT REVIEW PANEL FOR THE PURPOSES OF REVIEWING IN CONJUNC-
50 TION WITH LOCAL REPRESENTATION, THE CIRCUMSTANCES AND EVENTS RELATED TO
51 A SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL ILLNESS. FOR PURPOSES
52 OF THIS SECTION, A "SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL

1 ILLNESS" MEANS AN INCIDENT OCCURRING IN THE COMMUNITY IN WHICH A PERSON
2 WITH A SERIOUS MENTAL ILLNESS SUFFERS PHYSICAL INJURY AS DEFINED IN
3 SUBDIVISION NINE OF SECTION 10.00 OF THE PENAL LAW OR CAUSES SUCH PHYS-
4 ICAL INJURY TO ANOTHER PERSON, OR SUFFERS A SERIOUS AND PREVENTABLE
5 MEDICAL COMPLICATION OR BECOMES INVOLVED IN A CRIMINAL INCIDENT INVOLV-
6 ING VIOLENCE. A PANEL SHALL BE AUTHORIZED TO CONDUCT A REVIEW OF SUCH
7 SERIOUS INCIDENT IN AN ATTEMPT TO IDENTIFY PROBLEMS OR GAPS IN MENTAL
8 HEALTH DELIVERY SYSTEMS AND TO MAKE RECOMMENDATIONS FOR CORRECTIVE
9 ACTIONS TO IMPROVE THE PROVISION OF MENTAL HEALTH OR RELATED SERVICES,
10 TO IMPROVE THE COORDINATION, INTEGRATION AND ACCOUNTABILITY OF CARE IN
11 THE MENTAL HEALTH SERVICE SYSTEM, AND TO ENHANCE INDIVIDUAL AND PUBLIC
12 SAFETY.

13 (B) A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL INCLUDE REPRESENT-
14 TATIVES FROM THE OFFICE OF MENTAL HEALTH AND THE CHIEF EXECUTIVE OFFICER
15 OR DESIGNEE OF THE LOCAL GOVERNMENTAL UNIT WHERE THE SERIOUS INCIDENT
16 INVOLVING A PERSON WITH A MENTAL ILLNESS OCCURRED. A MENTAL HEALTH INCI-
17 DENT REVIEW PANEL MAY ALSO INCLUDE, IF DEEMED APPROPRIATE BY THE COMMIS-
18 SIONER BASED ON THE NATURE OF THE SERIOUS INCIDENT BEING REVIEWED, ONE
19 OR MORE REPRESENTATIVES FROM MENTAL HEALTH PROVIDERS, LOCAL DEPARTMENTS
20 OF SOCIAL SERVICES, HUMAN SERVICES PROGRAMS, HOSPITALS, LOCAL SCHOOLS,
21 EMERGENCY MEDICAL OR MENTAL HEALTH SERVICES, THE OFFICE OF THE COUNTY
22 ATTORNEY, STATE OR LOCAL POLICE AGENCIES, THE OFFICE OF THE MEDICAL
23 EXAMINER OR THE OFFICE OF THE CORONER, THE JUDICIARY, OR OTHER APPROPRI-
24 ATE STATE OR LOCAL OFFICIALS; PROVIDED, HOWEVER, THAT A LOCAL LAW
25 ENFORCEMENT OFFICIAL MAY NOT SERVE AS A MEMBER OF SUCH A REVIEW PANEL IF
26 HIS OR HER OFFICE OR AGENCY IS DIRECTLY INVOLVED IN ANY ONGOING INVESTI-
27 GATION OR PROSECUTION OF A CRIME UNDER REVIEW BY THE PANEL, OR ANY
28 APPEAL OF A CRIMINAL CONVICTION FOR SUCH CRIME.

29 (C) (I) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY AND
30 TO THE EXTENT CONSISTENT WITH FEDERAL LAW, A MENTAL HEALTH INCIDENT
31 REVIEW PANEL SHALL HAVE ACCESS TO THOSE RELEVANT CLIENT-IDENTIFIABLE
32 MENTAL HEALTH RECORDS, AS WELL AS ALL RECORDS, DOCUMENTATION AND REPORTS
33 RELATING TO THE INVESTIGATION OF AN INCIDENT BY THE JUSTICE CENTER,
34 PURSUANT TO ARTICLE TWENTY OF THE EXECUTIVE LAW AND AN INCIDENT BY A
35 FACILITY IN ACCORDANCE WITH REGULATIONS OF THE COMMISSIONER, WHICH ARE
36 NECESSARY FOR THE INVESTIGATION OF THE SERIOUS INCIDENT INVOLVING A
37 PERSON WITH MENTAL ILLNESS AND THE PREPARATION OF A REPORT OF SUCH INCI-
38 DENT, AS PROVIDED IN SUBDIVISION (E) OF THIS SECTION. A MENTAL HEALTH
39 INCIDENT REVIEW PANEL INVESTIGATING A SERIOUS INCIDENT INVOLVING A
40 PERSON WITH A MENTAL ILLNESS PURSUANT TO THIS SECTION SHALL BE PROVIDED
41 WITH ACCESS TO ALL RELEVANT, NON-PRIVILEGED RECORDS IN THE POSSESSION OF
42 STATE OR LOCAL OFFICIALS OR AGENCIES, WITHIN TWENTY-ONE DAYS OF RECEIPT
43 OF A REQUEST, EXCEPT: (A) THOSE RECORDS PROTECTED BY SECTION 190.25 OF
44 THE CRIMINAL PROCEDURE LAW; (B) WHERE PROVIDING LAW ENFORCEMENT RECORDS
45 WOULD INTERFERE WITH AN ONGOING LAW ENFORCEMENT INVESTIGATION OR JUDI-
46 CIAL PROCEEDING, IDENTIFY A CONFIDENTIAL SOURCE OR DISCLOSE CONFIDENTIAL
47 INFORMATION RELATING TO AN ONGOING CRIMINAL INVESTIGATION, HIGHLY SENSI-
48 TIVE CRIMINAL INVESTIGATIVE TECHNIQUES OR PROCEDURES, OR ENDANGER THE
49 SAFETY OR WELFARE OF AN INDIVIDUAL; (C) WITH RESPECT TO ANY SUCH RECORD
50 THAT IS PRIVILEGED, WHERE THE PRIVILEGE IS HELD BY THE OFFICIAL OR AGEN-
51 CY AND NO SEPARATE PRIVILEGE HELD BY AN INDIVIDUAL APPLIES, SUCH OFFI-
52 CIAL OR AGENCY SHALL BE AUTHORIZED TO WAIVE SUCH OFFICIAL'S OR AGENCY'S
53 PRIVILEGE, AS APPLICABLE, AND PROVIDE SUCH RECORD; AND (D) WHENEVER AN
54 AGENCY, DIRECTOR OR UNIT BELIEVES PURSUANT TO SUBPARAGRAPH (B) OF THIS
55 PARAGRAPH THAT RELEASE OF RECORDS WOULD INTERFERE WITH A JUDICIAL
56 PROCEEDING, IT SHALL IDENTIFY THAT PROCEEDING, AND THE MENTAL HEALTH

1 INCIDENT REVIEW PANEL SHALL BE AUTHORIZED, UPON NOTICE TO SUCH AGENCY,
2 DIRECTOR OR UNIT, TO REQUEST IN WRITING TO THE JUDGE BEFORE WHOM SUCH
3 JUDICIAL PROCEEDING IS PENDING, THAT SUCH JUDGE DETERMINE WHETHER ACCESS
4 TO SUCH RECORDS SHOULD BE DENIED ON THE GROUND THAT RELEASE OF SUCH
5 RECORDS WOULD INTERFERE WITH THE PENDING PROCEEDING. UPON RECEIPT OF
6 SUCH A REQUEST, THE JUDGE SHALL OFFER THE AGENCY, DIRECTOR OR UNIT AND
7 THE PANEL A REASONABLE OPPORTUNITY TO BE HEARD, AND MAY REVIEW THE
8 DISPUTED RECORDS IN CAMERA. THE JUDGE SHALL SUBMIT ITS DETERMINATION TO
9 THE AGENCY, DIRECTOR OR UNIT AND THE MENTAL HEALTH INCIDENT REVIEW
10 PANEL, AND THE AGENCY, DIRECTOR OR UNIT SHALL THEN PROCEED IN ACCORDANCE
11 WITH THE JUDGE'S DETERMINATION.

12 (II) IN ANY CASE IN WHICH ACCESS TO RECORDS IS DENIED PURSUANT TO THIS
13 SUBDIVISION, THE APPROPRIATE AGENCY SHALL INFORM THE PANEL IN WRITING OF
14 THE REASONING FOR SUCH DENIAL.

15 (D) MENTAL HEALTH INCIDENT REVIEW PANELS AND MEMBERS OF THE REVIEW
16 PANELS SHALL HAVE IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR ALL
17 REASONABLE AND GOOD FAITH ACTIONS TAKEN PURSUANT TO THIS SECTION, AND
18 SHALL NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING
19 ANY DISCUSSIONS, DELIBERATIONS OR FINDINGS RELATING TO THE OFFICIAL
20 DUTIES OF SUCH REVIEW PANEL. NOTHING IN THIS SECTION SHALL BE CONSTRUED
21 TO PREVENT A PERSON FROM TESTIFYING AS TO INFORMATION OBTAINED INDEPEND-
22 ENTLY OF A MENTAL HEALTH INCIDENT REVIEW PANEL, OR INFORMATION WHICH IS
23 PUBLIC.

24 (D-1) PERSONS WHO PRESENT INFORMATION TO THE PANEL SHALL HAVE IMMUNITY
25 FROM CIVIL AND CRIMINAL LIABILITY FOR ALL REASONABLE AND GOOD FAITH
26 ACTIONS TAKEN PURSUANT TO THIS SECTION, AND SHALL NOT BE QUESTIONED IN
27 ANY CIVIL OR CRIMINAL PROCEEDING REGARDING THEIR AUTHORIZED PARTIC-
28 IPATION AT A MEETING OF THE PANEL. NEITHER INFORMATION NOR RECORDS
29 RELATING TO THE PERFORMANCE OF A REVIEW PANEL FUNCTION, NOR A PERSON'S
30 PARTICIPATION IN A REVIEW PANEL SHALL BE SUBJECT TO DISCLOSURE PURSUANT
31 TO ARTICLE THIRTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. NOTHING IN
32 THIS SECTION SHALL BE CONSTRUED TO PREVENT THE DISCLOSURE OF, OR TESTI-
33 MONY REGARDING, INFORMATION THAT EXISTS OR IS OBTAINED INDEPENDENTLY OF
34 THE PANEL OR INFORMATION THAT IS PUBLIC.

35 (E) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ALL
36 MEETINGS CONDUCTED, ALL REPORTS AND RECORDS MADE AND MAINTAINED AND ALL
37 BOOKS AND PAPERS OBTAINED BY A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL
38 BE CONFIDENTIAL, AND SHALL NOT BE OPEN OR MADE AVAILABLE, EXCEPT BY
39 COURT ORDER FOR GOOD CAUSE SHOWN OR AS SET FORTH IN SUBDIVISION (G) OF
40 THIS SECTION. EACH MENTAL HEALTH INCIDENT REVIEW PANEL SHALL DEVELOP A
41 REPORT OF THE INCIDENT INVESTIGATED. SUCH REPORT SHALL NOT CONTAIN ANY
42 INDIVIDUALLY IDENTIFIABLE INFORMATION AND SHALL BE PROVIDED TO THE
43 OFFICE OF MENTAL HEALTH UPON COMPLETION. RECORDS, REPORTS, INFORMATION
44 REGARDING TESTIMONY AND OTHER INFORMATION GATHERED BY THE PANEL SHALL
45 NOT BE FURTHER DISSEMINATED BY A PANEL MEMBER.

46 (F) IF QUALITY PROBLEMS OF PARTICULAR MENTAL HEALTH PROGRAMS ARE IDEN-
47 TIFIED BASED ON SUCH REVIEWS, THE COMMISSIONER IS AUTHORIZED, PURSUANT
48 TO THE RELEVANT PROVISIONS OF THIS CHAPTER, TO TAKE APPROPRIATE ACTIONS
49 REGARDING THE LICENSURE OF PARTICULAR PROVIDERS, TO REFER THE ISSUE TO
50 OTHER RESPONSIBLE PARTIES FOR INVESTIGATION, OR TO TAKE OTHER APPROPRI-
51 ATE ACTION WITHIN THE SCOPE OF HIS OR HER AUTHORITY.

52 (G) IN HIS OR HER DISCRETION, THE COMMISSIONER SHALL BE AUTHORIZED TO
53 PROVIDE THE FINAL REPORT OF A REVIEW PANEL OR PORTIONS THEREOF TO ANY
54 INDIVIDUAL OR ENTITY FOR WHOM THE REPORT MAKES RECOMMENDATIONS FOR
55 CORRECTIVE OR OTHER APPROPRIATE ACTIONS THAT SHOULD BE TAKEN. ANY FINAL
56 REPORT OR PORTION THEREOF SHALL NOT BE FURTHER DISSEMINATED BY THE INDI-

VIDUAL OR ENTITY RECEIVING SUCH REPORT. FURTHER, THE COMMISSIONER SHALL SUBMIT THE FINAL REPORT OF A REVIEW PANEL TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY, CONSISTENT WITH FEDERAL AND STATE CONFIDENTIALITY PROTECTIONS.

(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 AND, TO THE EXTENT PRACTICABLE, ANY RECOMMENDATIONS THAT HAVE BEEN IMPLEMENTED, INCLUDING RECOMMENDATIONS FROM PRIOR YEAR REPORTS, AND THE IMPACT OF SUCH IMPLEMENTATIONS. THE ANNUAL CUMULATIVE REPORTS SHALL THEREAFTER BE MADE AVAILABLE TO THE PUBLIC CONSISTENT WITH FEDERAL AND STATE CONFIDENTIALITY PROTECTIONS.

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. 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 to read 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

1 not include a COLA for the purpose of establishing rates of payments,
2 contracts or any other form of reimbursement.

3 3-c. Notwithstanding any inconsistent provision of law, beginning
4 April 1, [2013] 2014 and ending March 31, [2016] 2017, the commissioners
5 shall develop the COLA under this section using the actual U.S. consumer
6 price index for all urban consumers (CPI-U) published by the United
7 States department of labor, bureau of labor statistics for the twelve
8 month period ending in July of the budget year prior to such state
9 fiscal year, for the purpose of establishing rates of payments,
10 contracts or any other form of reimbursement.

11 S 4. This act shall take effect immediately and shall be deemed to
12 have been in full force and effect on and after April 1, 2006; provided
13 section one of this act shall expire and be deemed repealed April 1,
14 [2016] 2017; provided, further, that sections two and three of this act
15 shall expire and be deemed repealed December 31, 2009.

16 S 2. This act shall take effect immediately and shall be deemed to
17 have been in full force and effect on and after April 1, 2013; provided,
18 however, that the amendments to section 1 of part C of chapter 57 of the
19 laws of 2006 made by section one of this act shall not affect the repeal
20 of such section and shall be deemed repealed therewith.

21 PART O

22 Section 1. Legislative findings and purpose. Recent actions by the
23 United States Center for Medicare and Medicaid Services impact the
24 stability of New York state's mental hygiene system. While the state
25 must embark on a deliberate path to replace the existing, long-standing
26 financing system for developmental disability services, replacement of
27 the sudden loss of \$1.1 billion in federal revenue is too significant to
28 be solved solely by actions within the mental hygiene system. A partner-
29 ship with the entire health care community is needed to manage this loss
30 over time. Accordingly, this part authorizes the actions necessary and
31 creates the Mental Hygiene Stabilization Fund that will be supported by
32 department of health medicaid resources under the Global Cap in annual
33 amounts not to exceed \$730,000,000 in state fiscal year 2013-14,
34 \$445,000,000 in 2014-15, \$267,000,000 in 2015-16, and \$267,000,000 in
35 2016-17.

36 S 2. Notwithstanding any contrary provision of law, the commissioner
37 of health may, in consultation with the director of the budget, annul
38 implementation of the reimbursement reductions authorized by section one
39 of part A of this act with regard to any period between April 1, 2013
40 and March 31, 2015 if it is determined by the commissioner of health, in
41 consultation with the director of the budget, that such annulment may be
42 accomplished consistent with the implementation of the provisions of
43 section 92 of part H of chapter 59 of the laws of 2011, as amended.

44 S 3. Notwithstanding any contrary provision of law, implementation of
45 the provisions of sections twenty-two, twenty-three, and/or twenty-four
46 of part A of this act shall be delayed to the state fiscal year begin-
47 ning April 1, 2014, provided, however, that the commissioner of health
48 may, in consultation with the director of the budget, implement one or
49 more of such provisions during the 2013-14 state fiscal year if it is
50 determined that such implementation may be accomplished consistent with
51 the implementation of the provisions of section 92 of part H of chapter
52 59 of the laws of 2011, as amended.

53 S 4. Notwithstanding any inconsistent provision of law, rule or regu-
54 lation, for purposes of implementing the provisions of the public health

1 law and the social services law, references to titles XIX and XXI of the
2 federal social security act in the public health law and the social
3 services law shall be deemed to include and also to mean any successor
4 titles thereto under the federal social security act.

5 S 5. Notwithstanding any inconsistent provision of law, rule or regu-
6 lation, the effectiveness of the provisions of sections 2807 and 3614 of
7 the public health law, section 18 of chapter 2 of the laws of 1988, as
8 amended, and 18 NYCRR 505.14(h), as they relate to time frames for
9 notice, approval or certification of rates of payment, are hereby
10 suspended and without force or effect for purposes of implementing the
11 provisions of this act.

12 S 6. Severability clause. If any clause, sentence, paragraph, subdivi-
13 sion, section or part of this act shall be adjudged by any court of
14 competent jurisdiction to be invalid, such judgment shall not affect,
15 impair or invalidate the remainder thereof, but shall be confined in its
16 operation to the clause, sentence, paragraph, subdivision, section or
17 part thereof directly involved in the controversy in which such judgment
18 shall have been rendered. It is hereby declared to be the intent of the
19 legislature that this act would have been enacted even if such invalid
20 provisions had not been included herein.

21 S 7. This act shall take effect immediately and shall be deemed to
22 have been in full force and effect on and after April 1, 2013.

23

PART P

24 Section 1. Notwithstanding any other provision of law, for state
25 fiscal year 2013-14, and for each state fiscal year thereafter, up to
26 five million dollars shall be available annually to provide medical
27 assistance for individuals who reside in New York state and are retirees
28 of the New York city off-track betting corporation or were active
29 employees of such corporation with vested pension time or credit as of
30 December 7, 2010, and for the dependents of such individuals, in accord-
31 ance with the provisions of this section. Such individuals who are Medi-
32 care beneficiaries under title XVIII of the federal social security act
33 shall be eligible for assistance under title 11 of article 5 of the
34 social services law with the cost of Medicare premiums and/or cost shar-
35 ing obligations, as determined in accordance with guidelines established
36 by the commissioner of health. For the period from April 1, 2013 to
37 December 31, 2013, such individuals who are not Medicare beneficiaries
38 under title XVIII of the federal social security act shall be eligible
39 for standard fee-for-service coverage under title 11 of article 5 of the
40 social services law, as determined in accordance with guidelines estab-
41 lished by the commissioner of health. Prior to October 1, 2013, the
42 state enrollment center shall provide a written notice of program
43 discontinuance that will become effective as of December 31, 2013, to
44 each individual eligible by a Medicaid fee-for-service plan established
45 pursuant to this section. The notice shall be in such form and contain
46 such information as the commissioner of health may require. In addition
47 to any other information required by such commissioner, the written
48 notice shall include a conspicuous explanation, in plain language,
49 informing such individual of available health insurance options, includ-
50 ing coverage through the health benefit exchange established pursuant to
51 section 1311 of the federal affordable care act, (42 USC S 18031) and
52 information on the process by which application therefore may be made
53 through the state enrollment center in order to effectuate health cover-
54 age under the health benefit exchange for such individuals beginning on

January 1, 2014. Such commissioner shall direct the state enrollment center to facilitate the enrollment of such individuals into the health benefit 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). Upon notice to participating individuals, the size and scope of program benefits in a given fiscal year may be reduced by the commissioner of health to remain within program funding levels.

S 2. This act shall take effect immediately.

PART Q

Section 1. Legislative findings. The legislature hereby finds and declares that it is necessary to restructure University Hospital of Brooklyn ("Downstate Hospital") in order to achieve its continued fiscal viability.

S 2. On or before June 1, 2013, the chancellor of the state university of New York shall submit to the governor, the chair of the assembly ways and means committee, the chair of the senate finance committee, the chair of the senate health committee, the chair of the assembly health committee, the chair of the senate higher education committee and the chair of the assembly higher education committee, a sustainability plan achieving the fiscal viability of Downstate Hospital.

S 3. Such sustainability plan shall be subject to the approval of the commissioner of health and the director of the division of the budget and shall set forth recommendations for accomplishing the restructuring of Downstate Hospital for the purpose of achieving fiscal viability while preserving its status as a teaching hospital. Such sustainability plan shall include the elimination and/or reduction of acute, ambulatory and support services that are not necessary or financially sustainable and any additional measures necessary to achieve such restructuring and achieve financial stability.

S 4. In the development of the sustainability plan, the chancellor shall consult with labor representatives, community representatives, and other regional stakeholders. The chancellor shall, to the maximum extent practicable, allow for public comment and input from consumers of health care services in the development of the plan.

S 5. Notwithstanding any contrary provision of law, the approved sustainability plan for Downstate Hospital shall be deemed final and the chancellor shall initiate implementation of such sustainability plan by June 15, 2013.

S 6. Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, section 355 of the education law, or section 142 of the economic development law, or any other law, in academic fiscal year 2013-14 the chancellor, for the purpose of implementing a sustainability plan for Downstate Hospital is hereby authorized to enter into a contract or contracts under this section without a competitive bid or request for proposal process and provided further that such contract or contracts shall not be subject to the requirements set forth in subdivisions 2 and 3 of section 112 of the state finance law, provided, however, that:

(a) (i) such contracts are limited to the purchase of goods and supplies where exigencies require an expedited process, and may also be authorized for restructuring consultant services, revenue collection and billing services, electronic and medical health records, and insurance eligibility and verification services; and (ii) due to the unique

1 circumstances facing Downstate Hospital, such contracts may also include
2 clinical services pursuant to the sustainability plan, provided, howev-
3 er, that such contracts shall not be of such scope or nature as to alter
4 the character of Downstate Hospital as a public hospital, and shall be
5 limited to fifteen percent of clinical services unless the commissioner
6 of health determines that additional actions are necessary for the full
7 implementation of the sustainability plan, in which case, up to twenty
8 percent of such clinical services may be authorized; and

9 (b) Downstate Hospital shall post on its website, for a period of no
10 less than fifteen days:

11 (i) a description of the proposed goods or services to be provided
12 pursuant to the contract or contracts;

13 (ii) the criteria for contractor selection;

14 (iii) the period of time during which a prospective contractor may
15 seek selection, which shall be no less than fifteen days after such
16 information is first posted on the website; and

17 (iv) the manner by which a prospective contractor may seek such
18 selection, which may include submission by electronic means; and

19 (c) all reasonable and responsive submissions that are received from
20 prospective contractors in a timely fashion shall be reviewed by the
21 chancellor or his or her designee.

22 S 7. Paragraph a of subdivision 16 of section 355 of the education
23 law, as added by chapter 363 of the laws of 1998, is amended to read as
24 follows:

25 a. Notwithstanding section one hundred sixty-three of the state
26 finance law, authorize contracts for a state university health care
27 facility for participation in managed care networks and other joint and
28 cooperative arrangements with public, non-profit or business entities
29 including entering into a maximum of twenty network arrangements per
30 year, as partners, JOINT VENTURES, SOLE MEMBER OR members of non-profit
31 OR FOR-PROFIT corporations, SOLE MEMBER OR MEMBERS OF NON-PROFIT OR
32 FOR-PROFIT LIMITED LIABILITY COMPANIES, AS LESSOR OR LESSEE, AS PARTIC-
33 IPANTS IN JOINT OPERATING AGREEMENTS, and shareholders of business
34 corporations, and the provision of management and administrative
35 services by or for state university; PROVIDED, HOWEVER, THAT ANY SUCH
36 CONTRACTS WITH FOR-PROFIT ENTITIES SHALL BE AUTHORIZED ONLY UPON
37 APPROVAL BY THE COMMISSIONER OF HEALTH AND THE DIRECTOR OF THE DIVISION
38 OF THE BUDGET OF A REQUEST BY THE CHANCELLOR DEMONSTRATING FINANCIAL
39 NEED OF A STATE UNIVERSITY HEALTH CARE FACILITY. Any contract for the
40 provision of management services shall be subject to any provision of
41 the public health law and health regulations applicable to the state
42 university as a health care provider, including any review by the
43 commissioner of health pursuant to 10 NYCRR section 405.3(f). In addi-
44 tion, the commissioner of health shall provide for public comment within
45 thirty days of a submission of any management contract required to be
46 reviewed pursuant to regulation. The trustees may also authorize
47 contracts, including capitation contracts, for a state university health
48 care facility for the provision of general comprehensive and specialty
49 health care services, directly or through contract with other service
50 providers or entities, including state university employees or entities
51 comprised thereof. Contracts authorized hereunder shall be:

52 (1) consistent with trustee guidelines respecting all terms and condi-
53 tions necessary and appropriate for managed care and other network,
54 joint or cooperative arrangements, including guidelines for comparative
55 review where appropriate;

1 (2) subject to laws and regulations applicable to the state university
2 as a health care provider, including with respect to rates and certif-
3 icates of need; and

4 (3) subject to article fourteen of the civil service law and the
5 applicable provisions of agreements between the state and employee
6 organizations pursuant to article fourteen of the civil service law.

7 S 8. Subdivision 8-a of section 355 of the education law, as added by
8 chapter 363 of the laws of 1998, is amended to read as follows:

9 8-a. All monies received by state university health care facilities
10 from fees, charges, and reimbursement and from all other sources shall
11 be credited to a state university health care account in a fund to be
12 designated by the state comptroller. NOTWITHSTANDING THE PROVISION OF
13 ANY LAW, RULE OR REGULATION TO THE CONTRARY, A PORTION OF SUCH MONIES
14 CREDITED MAY BE TRANSFERRED TO A STATE UNIVERSITY ACCOUNT AS REQUESTED
15 BY THE STATE UNIVERSITY CHANCELLOR OR HIS OR HER DESIGNEE. Monies to
16 establish reserves for long-term expenses of state university health
17 care facilities and to fulfill obligations required for any contract for
18 health care services authorized pursuant to subdivision sixteen of this
19 section may be designated by the state university as a reserve and
20 transferred to a separate contractual reserve account. The amounts in
21 such accounts shall be available for use in accordance with paragraph b
22 of subdivision four and subdivision eight of this section. Monies shall
23 only be expended from the state university health care account and the
24 contractual reserve account pursuant to appropriation. Notwithstanding
25 any provision of this chapter, the state finance law or any other law to
26 the contrary, such appropriations shall remain in full force and effect
27 for two years from the effective date of the appropriation act making
28 the appropriation. Monies so transferred may be returned to the state
29 university health care account; provided, however, that funds in such
30 contractual reserve account must be sufficient to meet the obligations
31 of all such contracts.

32 S 9. Section 2807 of the public health law is amended by adding a new
33 subdivision 20 to read as follows:

34 20. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE
35 RECEIPT OF ALL NECESSARY FEDERAL APPROVALS AND THE AVAILABILITY OF
36 FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO ENTER
37 INTO AGREEMENTS WITH SUNY DOWNSTATE MEDICAL CENTER, OTHER PUBLIC GENERAL
38 HOSPITALS, AND/OR WITH THE SPONSORING LOCAL GOVERNMENTS OF SUCH OTHER
39 PUBLIC GENERAL HOSPITALS, UNDER WHICH SUCH FACILITIES AND/OR SUCH LOCAL
40 GOVERNMENT SHALL, BY INTERGOVERNMENTAL TRANSFER, FUND THE NON-FEDERAL
41 SHARE OF MEDICAID FUNDS MADE AVAILABLE FOR DELIVERY SYSTEM REFORM INCEN-
42 TIVE PAYMENTS ("DSRIPS") TO SUCH FACILITIES. SUCH NON-FEDERAL SHARE
43 PAYMENTS SHALL BE DEEMED VOLUNTARY AND, FURTHER, SUCH PAYMENTS SHALL BE
44 EXCLUDED FROM COMPUTATIONS MADE PURSUANT TO SECTION ONE OF PART C OF
45 CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, AS AMENDED. IN
46 ADDITION, THE FACILITIES, AND/OR THE SPONSORING LOCAL GOVERNMENTS OF
47 SUCH FACILITIES OR THE STATE MAY, BY WRITTEN NOTIFICATION TO THE OTHER
48 PARTIES TO THE AGREEMENT, CANCEL SUCH AGREEMENT AT ANY TIME PRIOR TO THE
49 PAYMENT OF THE DSRIP FUNDS.

50 S 10. Section 2807 of the public health law is amended by adding a new
51 subdivision 21 to read as follows:

52 21. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE
53 RECEIPT OF ALL NECESSARY FEDERAL APPROVALS AND THE AVAILABILITY OF
54 FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO ENTER
55 INTO AGREEMENTS WITH SUNY DOWNSTATE MEDICAL CENTER, OTHER PUBLIC GENERAL
56 HOSPITALS, AND/OR WITH THE SPONSORING LOCAL GOVERNMENTS OF SUCH OTHER

1 PUBLIC GENERAL HOSPITALS, UNDER WHICH SUCH FACILITIES AND/OR SUCH LOCAL
2 GOVERNMENT SHALL, BY INTERGOVERNMENTAL TRANSFER, FUND THE NON-FEDERAL
3 SHARE OF MEDICAID FUNDS MADE AVAILABLE FOR IMPLEMENTATION OF MEDICAID
4 REDESIGN TEAM INITIATIVES. SUCH NON-FEDERAL SHARE PAYMENTS SHALL BE
5 DEEMED VOLUNTARY AND, FURTHER, SUCH PAYMENTS SHALL BE EXCLUDED FROM
6 COMPUTATIONS MADE PURSUANT TO SECTION ONE OF PART C OF CHAPTER
7 FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, AS AMENDED. IN ADDITION,
8 THE FACILITIES, AND/OR THE SPONSORING LOCAL GOVERNMENTS OF SUCH FACILI-
9 TIES OR THE STATE MAY, BY WRITTEN NOTIFICATION TO THE OTHER PARTIES TO
10 THE AGREEMENT, CANCEL SUCH AGREEMENT AT ANY TIME PRIOR TO THE PAYMENT OF
11 THE MEDICAID REDESIGN TEAM INITIATIVES FUNDS.

12 S 11. This act shall take effect immediately.

13 S 2. Severability clause. If any clause, sentence, paragraph, subdivi-
14 sion, section or part of this act shall be adjudged by any court of
15 competent jurisdiction to be invalid, such judgment shall not affect,
16 impair, or invalidate the remainder thereof, but shall be confined in
17 its operation to the clause, sentence, paragraph, subdivision, section
18 or part thereof directly involved in the controversy in which such judg-
19 ment shall have been rendered. It is hereby declared to be the intent of
20 the legislature that this act would have been enacted even if such
21 invalid provisions had not been included herein.

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