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

S. 58 A. 158

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

(PREFILED)

January 7, 2009

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

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

AN ACT to amend the public health law, the state finance law, the education law and the insurance law, in relation to the early intervention program for infants and toddlers with disabilities and their families; to repeal certain provisions of the public health law, the education law, the insurance law and the elder law relating thereto (Part A); to amend the public health law and the social services law, in relation to long term home health care programs; to amend the public health law, in relation to the office of the Medicaid inspector general; to amend part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to the effectiveness of certain provisions of such chapter; to amend the public health law, in relation to payments under the medical assistance program; to amend the public health law and chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to reimbursements; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend chapter 639 of the laws of 1996, amending the public health law and other laws relating to welfare reform, in relation to reimbursements; to amend the public health law and 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

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

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year, in relation to rates of payment by state governmental agencies; to amend chapter 629 of the laws of 1986, amending the social services law relating to establishing a demonstration program for the delivery of long term home health care services to certain persons, in relation to extending the provisions thereof; 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 chapter 55 of the laws of 1992, amending the tax law and other laws relating to taxes, surcharges, fees and funding, in relation to the effectiveness thereof; to amend chapter 942 of the laws of 1983 and chapter 541 of the laws of 1984, relating to foster family care demonstration programs, and to amend chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, in relation to extending the expirations thereof; to amend chapter 693 of the laws of 1996, amending the social services law relating to authorizing patient discharge to hospices and residential health care facilities, under the medical assistance presumptive eligibility program, in relation to extending the provisions of such chapter; to amend chapter 631 of the laws of 1997, amending the social services law relating to authorizing medical assistance payments to certain clinics or diagnostic and treatment centers, in relation to extending the effectiveness thereof; to amend chapter 119 of the laws of 1997 relating to authorizing the department of health to establish certain payments to general hospitals, in relation to making such authorization permanent; and to repeal section 74 of the executive law relating to the office of the welfare inspector general (Part B); to amend the public health law, in relation to payment by governmental agencies for general hospital inpatient services, inpatient medical assistance rates for non-public general hospitals, grants to public general hospitals, tobacco control and insurance initiatives pool distributions, health care initiatives pool distributions and payments made on behalf of persons enrolled in Medicaid managed care or family health plus; to direct the commissioners of health and mental health to enhance funding of the ambulatory patient group methodology and expand certain programs; to direct the commissioners of health, and mental retardation and developmental disabilities to enhance funding of the ambulatory patient group methodology; to amend the social services law, in relation to establishing the statewide health care home program; to amend the public health law, in relation to establishing the Adirondack health care home multipayor demonstration program; to amend the social services law, in relation to medicaid coverage of smoking cessation, cardiac rehabilitation services and substance abuse intervention; to amend the social services law, in relation to the provision and reimbursement of transportation costs and the primary care case management program; to amend the public authorities law, in relation to the authorization of the dormitory authority to issue bonds for health care; to amend the social services law, in relation to directing the commissioner of health to negotiate pharmaceutical rebates, retrospective and prospective drug utilization review, and the duration of drug therapy, the development of clinical prescribing guidelines, drug coverage for persons who are beneficiaries under Part D; to amend the public health law and the social services law, in relation to the clinical drug review program; to amend the social services law, in relation to electronic transmission of prescriptions; to amend the public health law

and the education law, in relation to prohibiting certain payments to prescribers and requiring the disclosure of other payments, prohibiting the presentation of information at continuing professional education programs that is false or misleading and requiring disclosure of certain potential conflicts of interest in connection with such programs, providing for transparency in the business relationships between pharmacy benefit managers and health plans, and requiring pharmacy benefit managers to provide certain information to health plan participants and their prescribers; to amend the social services law, in relation to eligibility for medical assistance and the family health plus program; to amend the welfare reform act of 1997, in relation to applicants for public assistance; to amend the public health law, in relation to child insurance plans; to amend the social services law, in relation to monthly premiums for medical assistance and liens for public assistance care; to amend the public health law, in relation to fees for the establishment of hospitals, approval of the construction of hospitals, licensure of home care services agencies, the establishment of certified home health agencies, changes in the ownership of a home health agency hospice construction, distribution of the professional education pools, the general hospital indigent care pool and the comprehensive diagnostic and treatment centers indigent care program; to amend the elder law, in relation to the program for elderly pharmaceutical insurance coverage; to amend the public health law, in relation to patient services payments; to amend the insurance law, in relation to examinations and appraisals of authorized insurers and employee welfare funds, independent adjusters, establishing a fee on insurance claims processed by independent adjusters; to amend the tax law and the state finance law, in relation to the sales of cigarettes and tobacco products and the health care reform act (HCRA) resources fund; to repeal certain provisions of the public health law relating to the preferred drug program and the telemedicine demonstration program; to repeal certain provisions of chapter 62 of the laws of 2003, amending the social services law and the public health law relating to expanding Medicaid coverage and rates of payment for residential health care facilities, relating thereto; to repeal certain provisions of the social services law relating to specialized HIV pharmacies, the family health plus program, eligibility for medical assistance; to repeal certain provisions of the elder law relating to the program for elderly pharmaceutical insurance coverage; and providing for the repeal of certain provisions upon the expiration thereof (Part C); to amend the public health law, in relation to reimbursement to residential health care facilities, to community service plans, to payments for certified home health agency services, to establishing the long-term care nursing initiative demonstration project; to amend the social services law, in relation to assisted living programs, to payment for AIDS home care programs, to regional long-term care assessment centers, to establishing the cash and counseling demonstration program, to Medicaid extended coverage for the partnership for long-term care program; to amend chapter 1 of the laws of 1999, amending the public health law and other laws, relating to enacting the New York Health Care Reform Act of 2000, in relation to adult day health care services; to amend the education law and the public health law, in relation to establishing long-term care nursing initiative demonstration projects; and providing for the repeal of certain provisions upon expiration thereof (Part D); to amend part E of chapter 58 of the laws of 1998, relating to the deter-

mination of state aid for the long-term sheltered employment program, in relation to availability of funding as certified by the director of the budget (Part E); in relation to the establishment of the authority of the office of mental health to close wards in hospitals operated by such office and to develop transitional placement programs for persons discharged from such hospitals, notwithstanding certain provisions of the mental hygiene law (Part F); to amend chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, and chapter 676 of the laws of 2002 amending the education law relating to defining the practice of psychology, in relation to the professions of social work and mental health practitioners (Part G); to amend the mental hygiene law, in relation to civil commitment of sex offenders (Part H); to amend the mental hygiene law, in relation to the receipt of federal and state benefits received by patients receiving care in facilities operated by an office of the department of mental hygiene (Part I); to amend the mental hygiene law in relation to the consolidation of certain developmental disabilities services offices (Part J); to amend the mental hygiene law, in relation to the closure of the Manhattan Addiction Treatment Center (Part K); to amend chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services programs, in relation to foregoing such adjustment during the 2009--2010 state fiscal year (Part L); to amend the mental hygiene law, in relation to the requirement for the commissioner of mental health to annually report on child and adult non-geriatric inpatient bed closures; to amend chapter 119 of the laws of 2007 relating to directing the commissioner of mental health to study, evaluate and report on the unmet mental health service needs of traditionally underserved populations, in relation to such study; to repeal subdivisions (h) and (l) of section 41.55 of the mental hygiene law relating to reports on the community mental health support and workforce reinvestment program; to repeal 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, relating to reports thereon; and to repeal subdivision (c) of section 7.15 of the mental hygiene law relating to reports on the delivery of care and services in family care homes and other community residences (Part M); to amend chapter 119 of the laws of 1997 authorizing the department of health to establish certain payments to general hospitals, in relation to extending the authorization for the department of health to continue certain payments to general hospitals (Part N); to amend the administrative code of the city of New York, in relation to extending the authorization of the city of New York to lease to the state of New York certain real property on Ward's Island (Part O); and to amend the mental hygiene law and the vehicle and traffic law, in relation to transfer of the alcohol and drug rehabilitation program from the department of motor vehicles to the office of alcoholism and substance abuse services (Part P)

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

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2008-2009 state fiscal year. Each component is wholly contained within a Part

identified as Parts A through P. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Section 2541 of the public health law, as added by chapter 428 of the laws of 1992, paragraph (a) of subdivision 8 as amended by section 1 of part B-3 of chapter 62 of the laws of 2003 and subdivision 13-a as added by chapter 231 of the laws of 1993, is amended to read as follows:

S 2541. Definitions. As used in this title the following terms shall have the following meanings, unless the context clearly requires otherwise:

1. "AGENCY" MEANS AN ENTITY WHICH EMPLOYS QUALIFIED PERSONNEL, OR CONTRACTS WITH QUALIFIED PERSONNEL WHO ARE APPROVED BY THE DEPARTMENT, FOR THE PROVISION OF EARLY INTERVENTION PROGRAM EVALUATIONS, SERVICE COORDINATION OR EARLY INTERVENTION SERVICES, AND MEETS THE REQUIREMENTS SET FORTH IN PARAGRAPH (E) OF SUBDIVISION 5 OF SECTION TWENTY-FIVE HUNDRED FIFTY-A OF THIS TITLE.

2. "Children at risk" means children who may experience a disability because of medical, biological or environmental factors which may produce developmental delay, as determined by the commissioner through regulation.

[2. "Coordinated standards and procedures" means standards and procedures developed by state early intervention service agencies pursuant to section twenty-five hundred fifty-one of this title.]

3. "Council" means the early intervention coordinating council established under section twenty-five hundred fifty-three of this title.

4. "Developmental delay" means that a child has not attained developmental milestones expected for the child's chronological age, as measured by qualified professionals using appropriate diagnostic instruments and/or procedures and informed clinical opinion, in one or more of the following areas of development: cognitive, physical, communication, social or emotional, or adaptive; EXCEPT THAT FOR CHILDREN WHO HAVE BEEN FOUND, AFTER A MULTIDISCIPLINARY EVALUATION BASED ON INFORMED CLINICAL OPINION AND CONDUCTED IN ACCORDANCE WITH THE REQUIREMENTS OF THIS TITLE, TO HAVE A DELAY SOLELY IN THE AREA OF COMMUNICATION, DEVELOPMENTAL DELAY FOR PROGRAM ELIGIBILITY SHALL BE DEFINED AS A SCORE OF TWO STANDARD DEVIATIONS BELOW THE MEAN IN THE AREA OF COMMUNICATION AS MEASURED BY A STANDARDIZED, NORM-REFERENCED TEST DESIGNED TO ASSESS COMMUNICATION DEVELOPMENT, INCLUDING EXPRESSIVE AND RECEPTIVE LANGUAGE DEVELOPMENT; OR IF NO STANDARDIZED TEST IS AVAILABLE OR APPROPRIATE FOR THE CHILD, A DEVELOPMENTAL DELAY IN THE AREA OF COMMUNICATION SHALL BE A SEVERE DELAY OR MARKED REGRESSION IN COMMUNICATION DEVELOPMENT AS DETERMINED BY SPECIFIC QUALITATIVE EVIDENCE BASED CRITERIA AS SET FORTH BY THE DEPARTMENT IN REGULATION.

5. "Disability" means:

(a) a developmental delay; or

(b) a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, such as Down syndrome or other

chromosomal abnormalities, sensory impairments, inborn errors of metabolism or fetal alcohol syndrome.

6. "Early intervention official" means an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official.

7. "Early intervention services" means developmental services that:

(a) are provided under public supervision;

(b) are selected in collaboration with the parents;

(c) are designed to meet a child's developmental needs in any one or more of the following areas:

(i) physical development, including vision and hearing,

(ii) cognitive development,

(iii) communication development,

(iv) social or emotional development, or

(v) adaptive development;

(d) meet [the coordinated standards and procedures] STANDARDS DEVELOPED BY THE LEAD AGENCY;

(e) are provided by qualified personnel;

(f) are provided in conformity with an IFSP;

(g) are, to the maximum extent appropriate, provided in natural environments, including the home and community settings where children without disabilities would participate;

(h) include, as appropriate:

(i) family training, counseling, home visits and parent support groups,

(ii) special instruction,

(iii) speech pathology and audiology,

(iv) occupational therapy,

(v) physical therapy,

(vi) psychological services,

(vii) case management services, hereafter referred to as service coordination services,

(viii) medical services for diagnostic or evaluation purposes, subject to reasonable prior approval requirements for exceptionally expensive services, as prescribed by the commissioner,

(ix) early identification, screening, and assessment services,

(x) health services necessary to enable the infant or toddler to benefit from the other early intervention services,

(xi) nursing services,

(xii) nutrition services,

(xiii) social work services,

(xiv) vision services,

(xv) assistive technology devices and assistive technology services,

(xvi) transportation and related costs that are necessary to enable a child and the child's family to receive early intervention services, and

(xvii) other appropriate services approved by the commissioner[.];

(i) are cost-effective.

8. (a) "Eligible child" means an infant or toddler from birth through age two who has a disability; provided, however, that any toddler with a disability who has been determined to be eligible for program services under section forty-four hundred ten of the education law and:

(i) who turns three years of age on or before the thirty-first day of August shall, if requested by the parent, be eligible to receive early intervention services contained in an IFSP until the first day of September of that calendar year; or

(ii) who turns three years of age on or after the first day of September shall, if requested by the parent and if already receiving services pursuant to this title, be eligible to continue receiving such services until the second day of January of the following calendar year.

(b) Notwithstanding the provisions of paragraph (a) of this subdivision, a child who receives services pursuant to section forty-four hundred ten of the education law shall not be an eligible child.

9. "Evaluation" means a multidisciplinary professional, objective assessment conducted by appropriately qualified personnel and conducted pursuant to section twenty-five hundred forty-four of this title to determine a child's eligibility under this title.

10. "Evaluator" means a team of two or more professionals approved pursuant to section twenty-five hundred fifty-one of this title to conduct screenings and evaluations.

11. "IFSP" means the individualized family service plan adopted in accordance with section twenty-five hundred forty-five of this title.

12. "INDIVIDUAL" SHALL MEAN A PERSON WHO HOLDS A STATE APPROVED OR RECOGNIZED CERTIFICATE, LICENSE OR REGISTRATION IN ONE OF THE DISCIPLINES SET FORTH IN SUBDIVISION FIFTEEN OF THIS SECTION.

13 "Lead agency" means the department of health, the public agency responsible for the administration of the early intervention system [in collaboration with the state early intervention service agencies].

[13.] 13-A. "Municipality" means a county outside the city of New York or the city of New York in the case of a county contained within the city of New York.

[13-a.] 13-B. Subject to federal law and regulations, "natural environment" or "natural setting" means a setting that is natural or normal for the child's age peers who have no disability.

14. "Parent" means parent or person in parental relation to the child. With respect to a child who has no parent or person in a parental relation, "parent" shall mean the person designated to serve in parental relation for the purposes of this title, pursuant to regulations of the commissioner promulgated in consultation with the commissioner of social services for children in foster care.

15. "Qualified personnel" means:

(a) persons holding a state approved or recognized certificate, license or registration in one of the following fields:

(i) special education teachers;

(ii) speech and language pathologists and audiologists;

(iii) occupational therapists;

(iv) physical therapists;

(v) social workers;

(vi) nurses;

(vii) dieticians or nutritionists;

(viii) other persons designated by the commissioner who meet requirements that apply to the area in which the person is providing early intervention services, where not in conflict with existing professional licensing, certification and/or registration requirements.

(b) persons holding a state approved license in one of the following fields:

(i) psychologists; or

(ii) physicians.

16. "Service coordinator" means a person who:

(a) meets the qualifications established in federal law and regulation and demonstrates knowledge and understanding of:

(i) infants and toddlers who may be eligible for services under this title;
(ii) principles of family-centered services;
(iii) part H of the federal individuals with disabilities education act and its corresponding regulations;
(iv) the nature and scope of services available under this title; and
(v) the requirements for authorizing and paying for such services and other pertinent information;
(b) is responsible for:
(i) assisting eligible children and their families in gaining access to services listed on the IFSP;
(ii) coordinating early intervention services with other services such as medical and health services provided to the child;
(iii) coordinating the performance of evaluations and assessments;
(iv) participating in the development, monitoring and evaluation of the IFSP;
(v) assisting the parent in identifying available service providers;
(vi) coordinating service delivery;
(vii) informing the family of advocacy services;
(viii) where appropriate, facilitating the transition of the child to other appropriate services; and
(ix) assisting in resolving any disputes which may arise between the family and service providers, as necessary and appropriate; and
(c) meets such other standards as are specified pursuant to section twenty-five hundred fifty-one of this title.
17. ["State early intervention service agencies" means the departments of health, education and social services and the offices of mental health, mental retardation and developmental disabilities and office of alcoholism and substance abuse services.
18.] "Year" shall mean the twelve-month period commencing July first unless otherwise specified.

S 2. Paragraph (b) of subdivision 3 and subdivision 6 of section 2544 of the public health law, as added by chapter 428 of the laws of 1992, are amended, and a new subdivision 4-a is added to read as follows:

(b) If, based upon the screening, a child is believed to be eligible, or if otherwise elected by the parent, the child shall, with the consent of a parent, receive a multidisciplinary evaluation. All evaluations shall be conducted in accordance with [the coordinated standards and procedures and with regulations promulgated by] THIS SECTION AND WITH STANDARDS AND GUIDELINES ESTABLISHED BY the commissioner IN REGULATIONS OR OTHERWISE.

4-A. THE DEPARTMENT SHALL DEVELOP A LIST OF EVALUATION INSTRUMENTS TO BE USED BY EVALUATORS, IN CONJUNCTION WITH INFORMED CLINICAL OPINION, IN CONDUCTING THE MULTIDISCIPLINARY EVALUATIONS OF CHILDREN THOUGHT TO BE ELIGIBLE FOR THE EARLY INTERVENTION PROGRAM. THE EVALUATOR SHALL PROVIDE WRITTEN JUSTIFICATION WHY SUCH INSTRUMENT OR INSTRUMENTS ARE NOT APPROPRIATE IF THE EVALUATOR DOES NOT UTILIZE AN INSTRUMENT ON THE DEPARTMENT'S LIST AS PART OF THE MULTIDISCIPLINARY EVALUATION OF A CHILD. EVALUATORS SHALL SET FORTH IN DETAIL HOW THE CHILD MEETS ELIGIBILITY CRITERIA FOR THE PROGRAM.

6. Nothing in this section shall restrict an evaluator from utilizing, in addition to findings from his or her personal examination, other examinations, evaluations or assessments conducted for such child, including those conducted prior to the evaluation under this section, if such examinations, evaluations or assessments are consistent with the [coordinated standards and procedures] REQUIREMENTS SET FORTH IN THIS

SECTION AND WITH STANDARDS AND GUIDELINES ESTABLISHED BY THE COMMISSIONER IN REGULATION OR OTHERWISE, PROVIDED, HOWEVER, THAT SUCH EXAMINATIONS, EVALUATIONS OR ASSESSMENTS ARE USED TO AUGMENT AND NOT REPLACE THE MULTIDISCIPLINARY EVALUATION TO DETERMINE ELIGIBILITY.

S 3. Subdivision 5 and paragraph (b) of subdivision 8 of section 2549 of the public health law, as added by chapter 428 of the laws of 1992, are amended to read as follows:

5. The impartial hearing shall be conducted by the hearing officer in accordance with the regulations of the commissioner. The hearing shall be held, and a decision rendered, within thirty days after the department receives the request for an impartial hearing except to the extent that the parent consents, in writing, to an extension. The decision shall be in writing and shall state the reasons for the decision and shall be final unless appealed by a party to the proceeding. A copy of the decision reached by the hearing officer shall be mailed to the parent, any public or private agency that was a party to the hearing, the service coordinator, AND the department [and any state early intervention service agency with an interest in the decision]. Where ordered by the hearing officer, the service coordinator shall modify the IFSP in accordance with the decision within five days after such decision.

(b) Providers of service to eligible children and families shall maintain the confidentiality of all personally identifiable information regarding children and families receiving their services. The provider shall ensure that no information regarding the condition, services, needs, or any other individual information regarding a child and family is released to any party other than the early intervention official without the express written consent of the parent, except as specifically permitted in [the coordinated standards and procedures,] STANDARDS OR GUIDELINES DEVELOPED BY THE DEPARTMENT which shall additionally ensure that the requirements of federal or state law which pertain to the early intervention services [of the state early intervention service agencies] have been maintained.

S 4. Paragraph (d) of subdivision 2 of section 2550 of the public health law, as amended by section 5 of part B3 of chapter 62 of the laws of 2003, is amended to read as follows:

(d) monitoring of INDIVIDUALS, agencies, institutions and organizations APPROVED under this title [and agencies, institutions and organizations providing early intervention services which are under the jurisdiction of a state early intervention service agency] TO PROVIDE EARLY INTERVENTION SERVICES AND EVALUATIONS;

S 5. The public health law is amended by adding a new section 2550-a to read as follows:

S 2550-A. PROVIDERS OF EVALUATIONS, SERVICE COORDINATION SERVICES OR EARLY INTERVENTION SERVICES. 1. INDIVIDUALS AND AGENCIES SHALL APPLY TO THE DEPARTMENT FOR APPROVAL TO PROVIDE EVALUATIONS, SERVICE COORDINATION SERVICES OR EARLY INTERVENTION SERVICES. SUCH APPROVAL SHALL BE VALID FOR A PERIOD OF TIME AS DETERMINED BY THE DEPARTMENT, NOT TO EXCEED FIVE YEARS. INDIVIDUALS AND AGENCIES SHALL THEREAFTER APPLY FOR REAPPROVAL TO PROVIDE SUCH SERVICES.

2. ALL INDIVIDUALS SHALL PAY A FEE OF TWO HUNDRED SEVENTY DOLLARS TO THE DEPARTMENT UPON SUBMISSION OF THE INDIVIDUAL'S APPLICATION FOR APPROVAL OR REAPPROVAL. ALL AGENCY APPLICANTS SHALL PAY A FEE OF THREE HUNDRED FORTY-FIVE DOLLARS TO THE DEPARTMENT UPON SUBMISSION OF THE APPLICATION FOR APPROVAL OR REAPPROVAL. THE COMPTROLLER IS HEREBY AUTHORIZED AND DIRECTED TO DEPOSIT THE FEE FOR EACH APPLICATION AND

REAPPROVAL APPLICATION INTO THE EARLY INTERVENTION PROGRAM ACCOUNT ESTABLISHED IN SECTION NINETY-NINE-Q OF THE STATE FINANCE LAW.

3. ALL AGENCIES AND INDIVIDUALS APPROVED TO PROVIDE EVALUATIONS, SERVICE COORDINATION SERVICES OR EARLY INTERVENTION SERVICES SHALL BE ENROLLED AS PROVIDERS IN THE MEDICAL ASSISTANCE PROGRAM IN ACCORDANCE WITH THE PROCEDURES FOR SUCH ENROLLMENT ESTABLISHED BY THE DEPARTMENT.

4. THE DEPARTMENT IS HEREBY AUTHORIZED TO REVIEW PROVIDER CAPACITY AND DETERMINE PROVIDER SERVICE NEED BY MUNICIPALITY. THE DEPARTMENT MAY DENY APPROVAL TO AN APPLICANT WHO SEEKS TO PROVIDE SERVICES IN A MUNICIPALITY WHERE THE DEPARTMENT HAS DETERMINED THAT SUFFICIENT PROVIDER CAPACITY EXISTS.

5. APPROVAL AND REAPPROVAL OF INDIVIDUALS AND AGENCIES SHALL BE BASED ON THE FOLLOWING CRITERIA:

(A) THE CHARACTER AND COMPETENCE OF THE INDIVIDUAL PERSON, OR IN THE CASE OF AGENCIES, THE OWNERS, OFFICERS, INCLUDING THE CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER, MEMBERS, SHAREHOLDERS WHO OWN TEN PERCENT OR MORE OF THE VOTING SHARES IN THE AGENCY, DIRECTORS OR SPONSORS, THE PROGRAM DIRECTOR AND OTHER KEY EMPLOYEES, AND THE BOARD OF DIRECTORS OF A NOT-FOR-PROFIT ENTITY AS DETERMINED BY THE DEPARTMENT;

(B) DOCUMENTED FISCAL VIABILITY;

(C) DOCUMENTED ABILITY TO PROVIDE EVALUATIONS, SERVICE COORDINATION SERVICES, OR EARLY INTERVENTION SERVICES IN CONFORMANCE WITH LAWS AND REGULATIONS APPLICABLE TO THE PRACTICE OF THE PROFESSIONS. FOR INDIVIDUALS, PROOF OF CURRENT LICENSURE, CERTIFICATION OR REGISTRATION IF REQUIRED FOR THE SERVICE PROVIDED. FOR AGENCIES:

(I) IDENTIFICATION OF ALL EMPLOYEES WHO WILL PROVIDE EARLY INTERVENTION PROGRAM SERVICES, AND WHERE APPLICABLE, THE EMPLOYEES' LICENSES, REGISTRATIONS, CERTIFICATIONS OR NATIONAL PROVIDER IDENTIFICATION NUMBERS AND EXPIRATION DATES; AND

(II) IDENTIFICATION OF ALL STATE-APPROVED AGENCY AND INDIVIDUAL CONTRACTORS WHO WILL BE UTILIZED TO PROVIDE SUCH SERVICES AND WHERE APPLICABLE, THE PERSONS' LICENSES, REGISTRATIONS, CERTIFICATIONS OR NATIONAL PROVIDER IDENTIFICATION NUMBERS AND EXPIRATION DATES;

(D) FOR AGENCY PROVIDERS, A QUALITY ASSURANCE PLAN THAT IS APPROVED BY THE DEPARTMENT FOR EACH TYPE OF PROFESSIONAL SERVICE OFFERED BY THE AGENCY, INCLUDING EVALUATIONS AND SERVICE COORDINATION, TO ENSURE THAT EVALUATIONS, SERVICE COORDINATION AND EARLY INTERVENTION PROGRAM SERVICES ARE PROVIDED IN A MANNER THAT COMPLIES WITH FEDERAL AND STATE LAWS AND REGULATIONS. THE PLAN SHALL INCLUDE A PROVISION FOR THE EMPLOYMENT OF A PROFESSIONAL OR PROFESSIONALS TO MONITOR AND OVERSEE IMPLEMENTATION OF THE PLAN AS REQUIRED BY SUBPARAGRAPH (II) OF PARAGRAPH (E) OF THIS SUBDIVISION;

(E) FOR AGENCY PROVIDERS, DOCUMENTATION THAT THE AGENCY HAS IN ITS EMPLOYMENT, OR IN ACCORDANCE WITH THIS PARAGRAPH, WILL HAVE IN ITS EMPLOYMENT, THE FOLLOWING PERSONNEL:

(I) A FULL-TIME EQUIVALENT EARLY INTERVENTION PROGRAM DIRECTOR WITH A MINIMUM OF TWO YEARS OF FULL-TIME EQUIVALENT EXPERIENCE IN AN EARLY INTERVENTION, CLINICAL PEDIATRIC, OR EARLY CHILDHOOD EDUCATION PROGRAM SERVING CHILDREN AGES BIRTH TO FIVE YEARS OF AGE, PROVIDED THAT:

(A) SUCH EXPERIENCE MUST HAVE INCLUDED DIRECT EXPERIENCE IN DELIVERING SERVICES TO CHILDREN WITH DISABILITIES AND THEIR FAMILIES; AND

(B) AT LEAST ONE YEAR OF SUCH EXPERIENCE MUST HAVE BEEN IN THE DELIVERY OF SERVICES TO CHILDREN LESS THAN THREE YEARS OF AGE AND THEIR FAMILIES; AND

(II) AT LEAST ONE LICENSED PROFESSIONAL FOR EACH TYPE OF SERVICE BEING OFFERED BY THE AGENCY, INCLUDING EVALUATIONS, WHO HOLDS A LICENSE,

CERTIFICATION OR REGISTRATION IN AN OCCUPATION AUTHORIZED TO PROVIDE THAT TYPE OF SERVICE, AND WHOSE RESPONSIBILITIES INCLUDE MONITORING THE QUALITY ASSURANCE PLAN DEVELOPED BY THE AGENCY FOR THE SERVICE BEING RENDERED, TO THE EXTENT AUTHORIZED BY THE PROFESSIONAL'S LICENSURE, CERTIFICATION OR REGISTRATION; AND

(III) A MINIMUM OF TWO QUALIFIED PERSONNEL, IN ADDITION TO THE EARLY INTERVENTION PROGRAM DIRECTOR, EACH OF WHOM PROVIDES EVALUATIONS, SERVICE COORDINATION OR EARLY INTERVENTION SERVICES FOR A MINIMUM OF TWENTY HOURS PER WEEK.

(IV) FOR PURPOSES OF THIS SUBDIVISION, IF THE AGENCY APPLYING FOR INITIAL APPROVAL HAS NOT, AT THE TIME OF APPLICATION, EMPLOYED THE PERSONNEL REQUIRED IN SUBPARAGRAPHS (I), (II) AND (III) OF THIS PARAGRAPH, THE AGENCY MAY VERIFY THAT IT WILL EMPLOY SUCH PERSONNEL WITHIN THREE MONTHS OF APPROVAL. IF APPROVED BY THE DEPARTMENT, AT THE END OF THE THREE MONTH PERIOD, THE AGENCY SHALL SUBMIT DOCUMENTATION OF THE EMPLOYMENT OF SUCH PERSONNEL IN ACCORDANCE WITH SAID REQUIREMENTS.

(V) AN AGENCY APPLYING FOR REAPPROVAL SHALL, AT THE TIME OF APPLICATION, SUBMIT DOCUMENTATION THAT IT HAS IN ITS EMPLOYMENT THE PERSONNEL REQUIRED IN SUBPARAGRAPHS (I), (II) AND (III) OF THIS PARAGRAPH;

(F) ADHERENCE TO, AND FOR PURPOSES OF REAPPROVAL, EVIDENCE OF DEMONSTRATED COMPLIANCE WITH ALL APPLICABLE FEDERAL AND STATE LAWS, REGULATIONS, STANDARDS AND GUIDELINES;

(G) DELIVERY OF SERVICES ON A TWELVE-MONTH BASIS AND FLEXIBILITY IN THE HOURS OF SERVICE DELIVERY, INCLUDING WEEKEND AND EVENING HOURS IN ACCORDANCE WITH ELIGIBLE CHILDREN'S IFSPS;

(H) AGREEMENT TO PARTICIPATE AND, FOR PURPOSES OF REAPPROVAL, EVIDENCE OF PARTICIPATION IN CONTINUING PROFESSIONAL AND CLINICAL EDUCATION RELEVANT TO EARLY INTERVENTION SERVICES AND IN-SERVICE TRAINING ON STATE AND LOCAL POLICIES AND PROCEDURES ON THE EARLY INTERVENTION PROGRAM, INCLUDING DEPARTMENT-SPONSORED TRAINING;

(I) ADHERENCE TO, AND FOR PURPOSES OF REAPPROVAL, DEMONSTRATED COMPLIANCE WITH THE CONFIDENTIALITY REQUIREMENTS APPLICABLE TO THE EARLY INTERVENTION PROGRAM AS SET FORTH IN FEDERAL AND STATE LAW AND REGULATIONS;

(J) PROVISION OF COPIES OF ALL ORGANIZATIONAL DOCUMENTS AS REQUESTED BY THE DEPARTMENT AND DOCUMENTATION OF LICENSURE OR APPROVAL GRANTED TO THE INDIVIDUAL OR AGENCY BY OTHER REGULATORY AGENCIES;

(K) FOR THE PURPOSES OF REAPPROVAL, DOCUMENTATION THAT CORRECTIVE ACTIONS REQUIRED BY THE DEPARTMENT HAVE BEEN IMPLEMENTED AND NON-COMPLIANCE CORRECTED TO THE SATISFACTION OF THE DEPARTMENT;

(L) PROVISION OF CONSOLIDATED FISCAL REPORTS TO THE DEPARTMENT OR ANY OTHER SUCH COMPARABLE INFORMATION ON REVENUES AND EXPENSES, AS REQUESTED AND IN A FORM DEVELOPED BY THE DEPARTMENT;

(M) FOR PURPOSES OF REAPPROVAL OF INDIVIDUAL PROVIDERS, DOCUMENTATION THAT THE PROVIDER HAS SERVED A MINIMUM OF TEN CHILDREN ANNUALLY IN THE PROGRAM ON AVERAGE OVER THE PRIOR APPROVAL PERIOD; PROVIDED HOWEVER THAT THE DEPARTMENT MAY WAIVE THIS REQUIREMENT IF THE INDIVIDUAL PROVIDES SERVICES IN A GEOGRAPHIC AREA WHERE THERE IS INSUFFICIENT CAPACITY OR OTHERWISE MEETS A NEED FOR WHICH SUFFICIENT CAPACITY DOES NOT EXIST AS EITHER DETERMINED BY THE DEPARTMENT, OR IDENTIFIED BY A MUNICIPALITY AND APPROVED BY THE DEPARTMENT;

(N) DOCUMENTATION FROM A MUNICIPALITY INDICATING THE MUNICIPALITY INTENDS TO CONTRACT WITH THE APPLICANT UPON THE APPLICANT'S RECEIPT OF DEPARTMENT APPROVAL; AND

(O) PROVISION OF SUCH ADDITIONAL PERTINENT INFORMATION OR DOCUMENTS NECESSARY FOR APPROVAL OR REAPPROVAL, AS REQUESTED BY THE DEPARTMENT.

6. PROVIDERS APPROVED AND REAPPROVED TO DELIVER EARLY INTERVENTION EVALUATIONS, SERVICE COORDINATION SERVICES AND EARLY INTERVENTION PROGRAM SERVICES SHALL MEET WITH OR OTHERWISE COMMUNICATE WITH PARENTS AND OTHER SERVICE PROVIDERS, INCLUDING PARTICIPATION IN CASE CONFERENCING AND CONSULTATION. AN AGENCY MUST FURTHER REQUIRE THAT ITS EMPLOYEES COMPLY WITH THE PROVISIONS OF THIS SECTION.

7. AN AGENCY'S APPROVAL TO PROVIDE SERVICES IN THE EARLY INTERVENTION PROGRAM SHALL TERMINATE UPON THE TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF TEN PERCENT OR MORE OF AN INTEREST OR VOTING RIGHTS IN THE APPROVED AGENCY. IF THERE IS A TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF LESS THAN TEN PERCENT OF AN INTEREST OR VOTING RIGHTS IN THE APPROVED AGENCY, BUT THE TRANSFER, ASSIGNMENT OR OTHER DISPOSITION TOGETHER WITH ALL PRIOR TRANSFERS, ASSIGNMENTS OR OTHER DISPOSITIONS WITHIN THE LAST FIVE YEARS WOULD, IN THE AGGREGATE INVOLVE TEN PERCENT OR MORE OF AN INTEREST IN THE APPROVED AGENCY, THE AGENCY'S APPROVAL TO PROVIDE SERVICES IN THE EARLY INTERVENTION PROGRAM SHALL TERMINATE UPON SUCH TRANSFER, ASSIGNMENT OR DISPOSITION. IF THE AGENCY'S APPROVAL TERMINATES AS SET FORTH IN THIS SUBDIVISION, THE AGENCY MUST APPLY FOR APPROVAL IN ACCORDANCE WITH THIS SECTION TO PROVIDE SERVICES IN THE EARLY INTERVENTION PROGRAM AND, IF APPROVED, SAID AGENCY SHALL BE DEEMED IN EXISTENCE AFTER THE EFFECTIVE DATE OF THIS SECTION.

8. APPROVED PROVIDERS SHALL NOT DISSEMINATE, OR CAUSE TO BE DISSEMINATED ON THEIR BEHALF, MARKETING MATERIALS THAT ARE FALSE, DECEPTIVE, OR MISLEADING. THE DEPARTMENT IS AUTHORIZED TO REQUIRE THAT PROVIDERS PERIODICALLY SUBMIT COPIES OF MARKETING MATERIALS FOR REVIEW. MARKETING MATERIALS THAT DO NOT COMPLY WITH THE PROVISIONS OF THIS SUBDIVISION MAY BE A BASIS FOR ACTION AGAINST THE PROVIDER'S APPROVAL IN ACCORDANCE WITH THE PROVISIONS OF SECTION TWENTY-FIVE HUNDRED FIFTY-B OF THIS TITLE. THE DEPARTMENT SHALL DEVELOP STANDARDS ON APPROPRIATE MARKETING MATERIALS.

9. AN INDIVIDUAL PROVIDER SHALL NOTIFY THE DEPARTMENT WITHIN TWO BUSINESS DAYS IF HIS OR HER LICENSE IS SUSPENDED, REVOKED, LIMITED OR ANNULLED OR IF A CONTRACT THE PROVIDER HOLDS WITH A MUNICIPALITY OR AGENCY PROVIDER IS TERMINATED. AGENCY PROVIDERS SHALL ENSURE THAT SERVICES ARE DELIVERED BY THOSE AUTHORIZED TO DO SO AND SHALL ONLY EMPLOY OR CONTRACT WITH QUALIFIED PERSONNEL WHO ARE LICENSED, REGISTERED OR CERTIFIED IN COMPLIANCE WITH APPLICABLE PROVISIONS OF LAW, IF SUCH LICENSE, REGISTRATION OR CERTIFICATION IS REQUIRED FOR THE SERVICE THAT IS BEING PROVIDED.

10. INDIVIDUAL AND AGENCY PROVIDERS SHALL VERIFY THE ACCURACY OF ALL BILLING RECORDS PRIOR TO SUBMISSION OF SUCH BILLING FOR PAYMENT.

11. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, THE APPROVAL OF INDIVIDUALS AND AGENCIES THAT ARE IN EXISTENCE ON OR BEFORE THE EFFECTIVE DATE OF THIS SECTION THAT WERE APPROVED TO DELIVER EARLY INTERVENTION SERVICES BY THE DEPARTMENT OF EDUCATION SHALL REMAIN IN EFFECT; PROVIDED, HOWEVER THAT SUCH INDIVIDUALS OR AGENCIES SHALL BE SUBJECT TO THE REQUIREMENTS OF THIS SECTION AND SHALL, WHEN REQUESTED BY THE DEPARTMENT, APPLY FOR AND OBTAIN REAPPROVAL BY THE DEPARTMENT TO CONTINUE PROVIDING SERVICES IN THE EARLY INTERVENTION PROGRAM.

S 6. The public health law is amended by adding a new section 2550-b to read as follows:

S 2550-B. PROCEEDINGS INVOLVING THE APPROVAL OF AN INDIVIDUAL OR AGENCY. 1. AN AGENCY'S OR INDIVIDUAL'S APPROVAL TO DELIVER EVALUATIONS, SERVICE COORDINATION SERVICES AND EARLY INTERVENTION PROGRAM SERVICES MAY BE REVOKED, SUSPENDED, LIMITED OR ANNULLED BY THE COMMISSIONER UPON A FINDING THAT THE AGENCY OR INDIVIDUAL PROVIDER:

(A) HAS FAILED TO COMPLY WITH THE PROVISIONS OF THIS ARTICLE OR RULES AND REGULATIONS PROMULGATED THEREUNDER;

(B) NO LONGER MEETS ONE OF THE CRITERIA FOR APPROVAL OR REAPPROVAL AS SET FORTH IN SUBDIVISION FIVE OF SECTION TWENTY-FIVE HUNDRED FIFTY-A OF THIS TITLE;

(C) DOES NOT HAVE CURRENT LICENSURE, REGISTRATION OR CERTIFICATION TO DELIVER SERVICES IN THE EARLY INTERVENTION PROGRAM; OR

(D) FOR AGENCY PROVIDERS, USED PERSONNEL, WHETHER BY CONTRACT OR UNDER EMPLOYMENT, TO PROVIDE AN EARLY INTERVENTION PROGRAM SERVICE WHO DID NOT HOLD A LICENSE, REGISTRATION OR CERTIFICATION TO PROVIDE SUCH SERVICE.

2. NO APPROVAL SHALL BE REVOKED, SUSPENDED, LIMITED OR ANNULLED WITHOUT FIRST PROVIDING THE INDIVIDUAL OR AGENCY AN OPPORTUNITY TO BE HEARD. THE DEPARTMENT SHALL NOTIFY THE INDIVIDUAL OR AGENCY IN WRITING OF THE PROPOSED ACTION AND SHALL AFFORD THE INDIVIDUAL OR AGENCY AN OPPORTUNITY TO BE HEARD IN PERSON OR BY COUNSEL. SUCH NOTICE MAY BE SERVED BY PERSONAL DELIVERY TO THE INDIVIDUAL OR AGENCY OR BY MAILING IT BY CERTIFIED MAIL TO THE LAST KNOWN ADDRESS ON FILE WITH THE DEPARTMENT OR BY ANY METHOD AUTHORIZED BY THE CIVIL PRACTICE LAW AND RULES FOR THE SERVICE OF A SUMMONS. THE HEARING SHALL BE AT SUCH TIME AND PLACE AS THE DEPARTMENT SHALL PRESCRIBE.

3. APPROVAL MAY BE TEMPORARILY SUSPENDED OR LIMITED WITHOUT A HEARING FOR A PERIOD NOT EXCEEDING ONE HUNDRED TWENTY DAYS UPON WRITTEN NOTICE TO THE PROVIDER AND AN OPPORTUNITY FOR A HEARING FOLLOWING A FINDING BY THE DEPARTMENT THAT THE HEALTH OR SAFETY OF A CHILD, PARENTS OR STAFF OF THE MUNICIPALITY IN WHICH THE PROVIDER IS UNDER CONTRACT IS IN IMMINENT RISK OF DANGER OR THERE EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS OR PRACTICES WHICH POSES IMMINENT DANGER TO THE HEALTH OR SAFETY OF SUCH CHILDREN, PARENTS OR STAFF OF THE MUNICIPALITY IN WHICH THE PROVIDER IS UNDER CONTRACT. UPON SUCH A FINDING AND NOTICE, THE DEPARTMENT MAY ALSO:

(A) PROHIBIT OR LIMIT THE ASSIGNMENT OF CHILDREN TO THE PROVIDER;

(B) REMOVE OR CAUSE TO BE REMOVED SOME OR ALL OF THE CHILDREN THE PROVIDER CURRENTLY SERVES; AND

(C) SUSPEND OR LIMIT OR CAUSE TO BE SUSPENDED OR LIMITED PAYMENT FOR SERVICES TO THE PROVIDER.

S 7. Section 2551 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

S 2551. [Coordinated standards] STANDARDS and procedures. 1. The [state early intervention service agencies shall jointly establish coordinated] DEPARTMENT MAY DEVELOP standards and procedures for:

(a) early intervention services and evaluations;

(b) child find system and public awareness program; and

(c) [programs and services, operating under the approval authority of any state early intervention service agency, which include any early intervention services or evaluations] APPROVAL AND REAPPROVAL OF INDIVIDUALS AND AGENCIES PROVIDING SERVICES UNDER THIS TITLE.

2. Such [coordinated] standards and procedures shall be designed to:

(a) enhance the objectives of this title, including the provision of services in natural environments to the maximum extent possible;

(b) minimize duplicative and inconsistent regulations and practices among [the] state [early intervention service] agencies;

(c) [conform, to the extent appropriate, to existing standards and procedures of state early intervention service agencies] ENSURE THAT SERVICES ARE PROVIDED IN A MANNER CONSISTENT WITH THE REQUIREMENTS OF THIS TITLE BY QUALIFIED INDIVIDUALS AND AGENCIES WHO MEET DEPARTMENT CRITERIA; and

(d) ensure that persons who provide early intervention services are trained, or can demonstrate proficiency in principles of early childhood development.

3. [Coordinated standards] STANDARDS and procedures may include guidelines suggesting appropriate early intervention services for enumerated disabilities that are most frequently found in eligible children.

4. [Coordinated standards] STANDARDS and procedures may encompass or allow for agreements among two or more [such] STATE agencies.

5. [Any standards promulgated by regulation or otherwise by any state early intervention service agency governing early intervention services or evaluations shall be consistent with the coordinated standards and procedures.

6. In the event of an inability to agree upon any coordinated standard or procedure, any state early intervention service agency may refer the issue to the early intervention coordinating council for its advice with respect to the standard or procedure which the council shall provide to the early intervention service agencies affected by the issue. The commissioner, after obtaining such advice, shall adopt an appropriate standard or procedure,] THE COMMISSIONER SHALL SUBMIT PROPOSED STANDARDS AND PROCEDURES TO THE EARLY INTERVENTION COORDINATING COUNCIL FOR ITS REVIEW AND ADVICE; provided however, that the commissioner may adopt an interim standard or procedure while awaiting such advice.

[7. Coordinated standards and procedures shall provide that any agency which is an approved program or service provider under section forty-four hundred ten of the education law, and which also plans to provide early intervention services may apply to the commissioner of education for approval to provide such services. Such approval shall be granted based on the agency's compliance with the coordinated standards and procedures for early intervention services and, where applicable, education certifications.

8. The early intervention service agencies, in consultation with the director of the budget, shall, where appropriate, require as a condition of approval that evaluators and providers of early intervention services participate in the medical assistance program.

9.] 6. The [coordinated] standards and procedures shall permit such evaluators and providers of services to rely on subcontracts or other written agreements with qualified professionals, or agencies employing such professionals, provided that such professionals perform their responsibilities in conformance with regulations of the commissioner and that providers and evaluators fully disclose any such arrangements, including any financial or personal interests, on all applications for approval.

[10. Coordinated standards] 7. STANDARDS and procedures may identify circumstances and procedures under which an evaluator or service provider may be disqualified under this title, including procedures whereby a municipality may request such disqualification.

S 8. Section 2552 of the public health law is amended by adding a new subdivision 5 to read as follows:

5. THE EARLY INTERVENTION OFFICIAL SHALL REQUIRE AN ELIGIBLE CHILD'S PARENT TO FURNISH DOCUMENTATION NECESSARY TO DETERMINE THE PARENT'S GROSS HOUSEHOLD INCOME. SUCH DOCUMENTATION SHALL BE PROVIDED TO THE DEPARTMENT OR THE DEPARTMENT'S AGENT FOR THE PURPOSE OF ASSESSING AND COLLECTING PARENTAL FEES IN ACCORDANCE WITH SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THIS TITLE.

S 9. Paragraph (b) of subdivision 2 of section 2553 of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

(b) advise and assist the commissioner [and other state early intervention service agencies] in the development of [coordinated] standards and procedures pursuant to section twenty-five hundred fifty-one of this title [in order to promote the full participation and cooperation of such agencies];

S 10. Paragraph (k) of subdivision 4 of section 2557 of the public health law is REPEALED.

S 10-a. Subdivisions 1, 2 and 5 of section 2557 of the public health law, subdivision 1 as amended by section 4 of part C of chapter 1 of the laws of 2002, subdivision 2 as added by chapter 428 of the laws of 1992 and subdivision 5 as added by section 7 of part B3 of chapter 62 of the laws of 2003, are amended to read as follows:

1. The approved costs for an eligible child who receives an evaluation and early intervention services pursuant to this title shall be a charge upon the municipality wherein the eligible child resides or, where the services are covered by the medical assistance program, upon the social services district of fiscal responsibility with respect to those eligible children who are also eligible for medical assistance. All approved costs, EXCEPT FOR SERVICES THAT ARE COVERED BY THE MEDICAL ASSISTANCE PROGRAM OR UNDER AN INSURANCE POLICY OR PLAN FOR THOSE CHILDREN WHO HAVE COVERAGE UNDER BOTH THE MEDICAL ASSISTANCE PROGRAM AND SUCH INSURANCE POLICY OR PLAN, shall be paid in the first instance and at least quarterly by the appropriate governing body or officer of the municipality upon vouchers presented and audited in the same manner as the case of other claims against the municipality. Notwithstanding the insurance law or regulations thereunder relating to the permissible exclusion of payments for services under governmental programs, no such exclusion shall apply with respect to payments made pursuant to this title. Notwithstanding the insurance law or any other law or agreement to the contrary, benefits under this title shall be considered secondary to [any plan of insurance or state government benefit program under which an eligible child may have] coverage AVAILABLE TO AN ELIGIBLE CHILD UNDER THE MEDICAL ASSISTANCE PROGRAM OR AN INSURANCE POLICY OR PLAN AND THE MEDICAL ASSISTANCE PROGRAM FOR THOSE CHILDREN WHO HAVE COVERAGE UNDER BOTH THE MEDICAL ASSISTANCE PROGRAM AND SUCH INSURANCE POLICY OR PLAN. Nothing in this section shall increase or enhance coverages provided for within an insurance contract subject to the provisions of this title.

2. REIMBURSEMENT FOR APPROVED COSTS PAID BY A MUNICIPALITY FOR THE PURPOSES OF THIS TITLE, OTHER THAN FOR THOSE APPROVED COSTS REIMBURSABLE BY THE MEDICAL ASSISTANCE PROGRAM OR UNDER AN INSURANCE POLICY OR PLAN AND THE MEDICAL ASSISTANCE PROGRAM FOR THOSE CHILDREN WHO HAVE COVERAGE UNDER BOTH THE MEDICAL ASSISTANCE PROGRAM AND SUCH INSURANCE POLICY OR PLAN SHALL BE AS FOLLOWS:

I. The department shall reimburse ONE HUNDRED PERCENT OF the approved costs paid by a municipality for the purposes of this title, [other than those reimbursable by the medical assistance program or by third party payors] PROVIDED HOWEVER THAT REIMBURSEMENT PURSUANT TO THIS PARAGRAPH SHALL NOT EXCEED THE DOLLAR AMOUNT SUCH MUNICIPALITY RECEIVED FROM JULY FIRST, TWO THOUSAND SEVEN TO JUNE THIRTIETH, TWO THOUSAND EIGHT FROM PRIVATE INSURANCE REIMBURSEMENT FOR SERVICES COVERED UNDER AN ELIGIBLE CHILD'S INSURANCE POLICY OR PLAN;

II. AFTER REIMBURSEMENT IS MADE IN ACCORDANCE WITH PARAGRAPH (I) OF THIS SUBDIVISION, THE DEPARTMENT SHALL REIMBURSE ONE HUNDRED PERCENT OF THE APPROVED COSTS PAID BY A MUNICIPALITY PROVIDED HOWEVER THAT REIMBURSEMENT PURSUANT TO THIS PARAGRAPH SHALL NOT EXCEED AN AMOUNT DETERMINED BY THE DEPARTMENT, AND APPROVED BY THE DIRECTOR OF THE BUDGET, BASED UPON A METHOD OF ALLOCATION PROPORTIONAL TO EACH MUNICIPALITY'S SHARE OF THE TOTAL PAYMENTS MADE BY MUNICIPALITIES FROM JULY FIRST, TWO THOUSAND SEVEN TO JUNE THIRTIETH, TWO THOUSAND EIGHT FOR SERVICES PROVIDED UNDER THE EARLY INTERVENTION PROGRAM;

III. THEREAFTER, THE DEPARTMENT SHALL REIMBURSE THE APPROVED COSTS PAID BY A MUNICIPALITY, in an amount of fifty percent of the amount expended in accordance with the rules and regulations of the commissioner.

IV. Such state reimbursement to the municipality MADE IN ACCORDANCE WITH PARAGRAPHS (I), (II) AND (III) OF THIS SUBDIVISION shall not be paid prior to April first of the year in which the approved costs are paid by the municipality.

5. The department shall contract with an independent organization to act as the fiscal agent for the department. [A municipality may elect to utilize the services of such organization for early intervention program fiscal management and claiming as determined by the commissioner or may select an independent agent to act as the fiscal agent for such municipality or may act as its own fiscal agent.] MUNICIPALITIES SHALL USE THE FISCAL AGENT UNDER CONTRACT WITH THE DEPARTMENT FOR THE MANAGEMENT OF MUNICIPAL PAYMENTS TO PROVIDERS UNLESS OTHERWISE APPROVED BY THE DEPARTMENT.

S 11. The public health law is amended by adding a new section 2557-a to read as follows:

S 2557-A. PARENTAL PARTICIPATION IN PAYMENT OF EARLY INTERVENTION SERVICES. 1. PARENTAL PARTICIPATION IN THE PAYMENT OF EARLY INTERVENTION SERVICES SHALL BE ESTABLISHED ANNUALLY FOR EACH FAMILY BASED ON A SLIDING SCHEDULE OF FEES AS SET FORTH IN SUBDIVISION THREE OF THIS SECTION. PARENTS SHALL PROVIDE DOCUMENTATION NECESSARY TO DETERMINE THE PARENT'S GROSS HOUSEHOLD INCOME AND PARENTAL FEE PAYMENT. THE DEPARTMENT OR DEPARTMENT'S AGENT SHALL BEGIN COLLECTING PARENT FEES ON APRIL FIRST, TWO THOUSAND TEN. THE FEE SHALL BE PAID ON A MONTHLY BASIS TO THE DEPARTMENT OR THE DEPARTMENT'S AGENT AND SHALL BE DEPOSITED INTO THE EARLY INTERVENTION PROGRAM ACCOUNT ESTABLISHED IN SECTION NINETY-NINE-Q OF THE STATE FINANCE LAW. THE DEPARTMENT SHALL PAY EACH MUNICIPALITY FIFTY PERCENT OF THE FEES COLLECTED IN ACCORDANCE WITH THIS SECTION FROM PARENTS OF ELIGIBLE CHILDREN FOR WHICH THE MUNICIPALITY HAS FINANCIAL RESPONSIBILITY. NO PARENTAL FEES, HOWEVER, MAY BE CHARGED FOR: IMPLEMENTING CHILD FIND, EVALUATION AND ASSESSMENT, SERVICE COORDINATION, DEVELOPMENT, REVIEW, AND EVALUATION OF INDIVIDUALIZED FAMILY SERVICES PLANS, OR THE IMPLEMENTATION OF PROCEDURAL SAFEGUARDS AND OTHER ADMINISTRATIVE COMPONENTS OF THE EARLY INTERVENTION SYSTEM.

2. PARENTS SHALL PAY A MONTHLY FEE AS DETERMINED BY THE SCHEDULE OF FEES SET FORTH IN SUBDIVISION THREE OF THIS SECTION FOR EACH CHILD IN THE FAMILY RECEIVING EARLY INTERVENTION SERVICES. THE PARENTAL FEE FOR A PARENT WHOSE GROSS HOUSEHOLD INCOME FALLS AT OR BELOW FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL (FPL) AND WHO HAS MORE THAN THREE CHILDREN RECEIVING SERVICES IN THE EARLY INTERVENTION PROGRAM, SHALL BE LIMITED TO THE MONTHLY FEE CHARGED FOR PARENTS WHO HAVE THREE CHILDREN RECEIVING SERVICES IN THE EARLY INTERVENTION PROGRAM. PARENTAL FEES SHALL APPLY WITHOUT REGARD TO WHETHER THE ELIGIBLE CHILD HAS COVERAGE UNDER AN INSURANCE POLICY OR PLAN.

3. PARENTAL FEES FOR THE EARLY INTERVENTION PROGRAM SHALL BE AS FOLLOWS:

GROSS HOUSEHOLD INCOME	PARENTAL FEE PER CHILD/PER MONTH
161% FPL TO 222% FPL	$15.00
223% FPL TO 250% FPL	$25.00
251% FPL TO 300% FPL	$35.00
301% FPL TO 350% FPL	$55.00
351% FPL TO 400% FPL	$75.00
401% FPL AND ABOVE	$150.00

4. IF A PARENT REFUSES TO PROVIDE DOCUMENTATION NECESSARY TO DETERMINE THE PARENT'S GROSS HOUSEHOLD INCOME, IT SHALL BE PRESUMED THAT THE PARENT FALLS WITHIN THE HIGHEST GROSS HOUSEHOLD INCOME BRACKET FOR THE PURPOSES OF ESTABLISHING THE PARENTAL FEE OBLIGATION.

5. AT THE WRITTEN REQUEST OF THE PARENT, THE PARENTAL FEE OBLIGATION MAY BE ADJUSTED PROSPECTIVELY AT ANY POINT DURING THE YEAR UPON PROOF OF A CHANGE IN HOUSEHOLD GROSS INCOME.

6. (A) THE DEPARTMENT OR THE DEPARTMENT'S AGENT SHALL MAIL A BILL TO THE PARENT FOR THE PARENT PARTICIPATION FEE SIXTY DAYS PRIOR TO THE FIRST DAY OF THE MONTH IN WHICH THE FEE IS DUE. THE BILL SHALL STATE THE AMOUNT OF THE FEE AND ITS DUE DATE.

(B) IF PAYMENT HAS NOT ALREADY BEEN RECEIVED, THE DEPARTMENT OR THE DEPARTMENT'S AGENT SHALL MAIL A NOTICE TO THE PARENT REMINDING THE PARENT OF THE FEE DUE AT LEAST FIFTEEN DAYS PRIOR TO ITS DUE DATE. THE NOTICE SHALL ALSO STATE THAT FAILURE TO PAY THE FEE SHALL RESULT IN THE TERMINATION OF SERVICES AND LOSS OF ELIGIBILITY FOR THE PROGRAM.

(C) IF THE PARENT PARTICIPATION FEE IS NOT PAID ON OR BEFORE ITS DUE DATE, THE DEPARTMENT OR DEPARTMENT'S AGENT SHALL MAIL THE PARENT A FINAL NOTICE STATING THAT FAILURE TO PAY THE FEE WITHIN THIRTY DAYS AFTER ITS DUE DATE SHALL RESULT IN TERMINATION OF SERVICES AND LOSS OF ELIGIBILITY FOR THE PROGRAM. IF THE PARENT PARTICIPATION FEE IS NOT PAID WITHIN THIRTY DAYS AFTER ITS DUE DATE, THE DEPARTMENT OR DEPARTMENT'S AGENT SHALL NOTIFY THE MUNICIPALITY THAT THE CHILD AND FAMILY ARE NO LONGER ELIGIBLE AND THAT SERVICES SHOULD CEASE. THE MUNICIPALITY SHALL NOTIFY ALL PROVIDERS CURRENTLY PROVIDING SERVICES TO THE CHILD THAT THE CHILD IS NO LONGER AUTHORIZED TO RECEIVE SERVICES. A PROVIDER SHALL BE PAID FOR SERVICES RENDERED UNTIL SUCH TIME AS THE PROVIDER IS NOTIFIED THAT THE CHILD IS NO LONGER AN ELIGIBLE CHILD.

7. THE INABILITY OF THE PARENTS OF AN ELIGIBLE CHILD TO PAY PARENTAL FEES DUE TO CATASTROPHIC CIRCUMSTANCES OR EXTRAORDINARY EXPENSES SHALL NOT RESULT IN THE DENIAL OF SERVICES TO THE CHILD OR THE CHILD'S FAMILY.

(A) PARENTS MUST DOCUMENT EXTRAORDINARY EXPENSES OR OTHER CATASTROPHIC CIRCUMSTANCES BY PROVIDING DOCUMENTATION OF ONE OF THE FOLLOWING:

(I) OUT-OF-POCKET MEDICAL EXPENSES IN EXCESS OF FIFTEEN PERCENT OF GROSS INCOME; OR

(II) OTHER EXTRAORDINARY EXPENSES OR CATASTROPHIC CIRCUMSTANCES CAUSING DIRECT OUT-OF-POCKET PAYMENTS IN EXCESS OF FIFTEEN PERCENT OF GROSS INCOME.

(B) PARENTS MUST PRESENT PROOF OF LOSS TO THE DEPARTMENT OR THE DEPARTMENT'S AGENT WHO SHALL DOCUMENT IT. THE DEPARTMENT OR DEPARTMENT'S AGENT SHALL DETERMINE WHETHER THE PARENTAL FEE OBLIGATION SHALL BE REDUCED, FORGIVEN, OR SUSPENDED WITHIN TEN BUSINESS DAYS AFTER RECEIPT OF THE PARENT'S REQUEST AND SUPPORTING DOCUMENTATION.

(C) A PARENT WHO DISAGREES WITH THE DETERMINATION SHALL HAVE THE ABILITY TO CONTEST THE DETERMINATION USING PROCEDURES SET FORTH IN SECTION TWENTY-FIVE HUNDRED FORTY-NINE OF THIS TITLE. IF A PARENT SUBMITS A

WRITTEN REQUEST FOR A MEDIATION OR HEARING TO DISPUTE THE DEPARTMENT'S DETERMINATION, EARLY INTERVENTION SERVICES SHALL NOT BE SUSPENDED FOR NONPAYMENT OF THE PARENTAL FEE PENDING RESOLUTION OF SUCH MEDIATION OR HEARING.

S 12. Subdivision 3 of section 2559 of the public health law, as added by chapter 428 of the laws of 1992, paragraph (a) as amended and paragraph (d) as added by chapter 231 of the laws of 1993, is amended to read as follows:

3. (a) [Providers] FOR THE PERIOD MARCH FIRST, TWO THOUSAND NINE TO MARCH THIRTY-FIRST, TWO THOUSAND TEN, PROVIDERS of early intervention services and transportation services shall [in the first instance and] where applicable, seek payment from [all third party payors including governmental agencies] THE MEDICAL ASSISTANCE PROGRAM UNDER WHICH AN ENROLLED CHILD HAS COVERAGE prior to claiming payment from a given municipality for services rendered to [eligible children,] THE ELIGIBLE CHILD; HOWEVER FOR CHILDREN WHO HAVE COVERAGE UNDER A PRIVATE INSURANCE POLICY OR PLAN AND ARE ALSO ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, PROVIDERS SHALL FIRST SEEK PAYMENT UNDER THE PRIVATE INSURANCE POLICY OR PLAN PRIOR TO CLAIMING PAYMENT FROM THE MEDICAL ASSISTANCE PROGRAM; provided that, for the purpose of seeking payment from the medical assistance program or from [other third party payors] PRIVATE INSURANCE POLICIES OR PLANS IN INSTANCES WHERE A CHILD ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM ALSO HAS COVERAGE UNDER SUCH PRIVATE INSURANCE POLICY OR PLAN, the municipality shall be deemed the provider of such early intervention services to the extent that the provider has promptly furnished to the municipality adequate and complete information necessary to support the municipality billing, and provided further that the obligation to seek payment shall not apply to a payment from [a third party payor] AN INSURER OR PLAN ADMINISTRATOR who is not prohibited from applying such payment, and will apply such payment, to an annual or lifetime limit specified in the insured's policy.

(A-1) EFFECTIVE ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, PROVIDERS OF EARLY INTERVENTION SERVICES AND TRANSPORTATION SERVICES SHALL, WHERE APPLICABLE, SEEK PAYMENT FROM THE MEDICAL ASSISTANCE PROGRAM UNDER WHICH AN ENROLLED CHILD HAS COVERAGE PRIOR TO CLAIMING PAYMENT FROM A GIVEN MUNICIPALITY FOR SERVICES RENDERED TO THE ELIGIBLE CHILD; HOWEVER FOR CHILDREN WHO HAVE COVERAGE UNDER A PRIVATE INSURANCE POLICY OR PLAN AND ARE ALSO ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, PROVIDERS SHALL FIRST SEEK PAYMENT UNDER THE PRIVATE INSURANCE POLICY OR PLAN PRIOR TO CLAIMING PAYMENT FROM THE MEDICAL ASSISTANCE PROGRAM; PROVIDED THAT A PROVIDER SHALL NOT BE REQUIRED TO SEEK PAYMENT FROM AN INSURER OR PLAN ADMINISTRATOR IF SUCH PAYMENT WILL BE APPLIED TO ANY ANNUAL OR LIFETIME LIMITS SPECIFIED IN THE INSURED'S POLICY.

(b) I. The commissioner, in consultation with the director of budget and the superintendent of insurance, shall promulgate regulations providing public reimbursement for deductibles and copayments which are imposed under an insurance policy or health benefit plan to the extent that such deductibles and copayments are applicable to early intervention services.

II. PARENTS SHALL PROVIDE THE MUNICIPALITY WITH INFORMATION ON ANY INSURANCE PLAN OR POLICY UNDER WHICH AN ELIGIBLE CHILD HAS COVERAGE. THE MUNICIPALITY SHALL PROVIDE SUCH INFORMATION TO THE DEPARTMENT OR THE DEPARTMENT'S AGENT ON A FORM OR IN A MANNER AS THE DEPARTMENT MAY PRESCRIBE. ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, THE MUNICIPALITY SHALL PROVIDE INFORMATION ON AN ELIGIBLE CHILD'S MEDICAL ASSISTANCE PROGRAM AND INSURANCE PLAN OR POLICY COVERAGE TO THE PROVIDER RENDERING

SERVICES TO THE CHILD TO ENABLE THE PROVIDER TO SEEK PAYMENT FROM SUCH PROGRAM, PLAN OR POLICY FOR COVERED SERVICES IN ACCORDANCE WITH PARAGRAPH (A-1) OF THIS SUBDIVISION.

III. PAYMENT FOR COVERED SERVICES RENDERED TO AN ELIGIBLE CHILD SHALL BE MADE IN THE FIRST INSTANCE BY THE MUNICIPALITY, EXCEPT THOSE COVERED BY THE MEDICAL ASSISTANCE PROGRAM OR UNDER AN INSURANCE POLICY OR PLAN AVAILABLE TO A CHILD WHO IS ALSO ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM. THE STATE SHALL REIMBURSE THE MUNICIPALITY FOR SUCH PAYMENT IN ACCORDANCE WITH SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN OF THIS TITLE. PARENTS SHALL NOT BE REQUIRED TO PAY INSURANCE COPAYMENTS OR DEDUCTIBLES FOR PAYMENT OF EARLY INTERVENTION SERVICES COVERED UNDER AN INSURANCE POLICY OR PLAN.

IV. EXCEPT IN THE CASE OF A CHILD WHO HAS COVERAGE UNDER AN INSURANCE POLICY OR PLAN AND IS ALSO ENROLLED IN THE MEDICAL ASSISTANCE PROGRAM, INSURERS AND PLAN ADMINISTRATORS SHALL NOT BE BILLED DIRECTLY FOR COVERED SERVICES RENDERED TO AN ELIGIBLE CHILD THAT ARE AUTHORIZED BY THE CHILD'S IFSP AND PROVIDED UNDER THE EARLY INTERVENTION PROGRAM.

(c) Payments made for early intervention services COVERED under an insurance policy or health benefit plan which are provided as part of an IFSP pursuant to section twenty-five hundred forty-five of this title shall not be applied by the insurer or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan, pursuant to section eleven of [the] chapter FOUR HUNDRED TWENTY-EIGHT of the laws of nineteen hundred ninety-two which added this title AND SHALL NOT OTHERWISE DECREASE COVERAGE OR VISIT LIMITS AVAILABLE FOR SERVICES UNDER THE CHILD'S INSURANCE POLICY OR HEALTH BENEFIT PLAN.

(d) [A] FOR THE PERIOD MARCH FIRST, TWO THOUSAND NINE TO MARCH THIRTY-FIRST, TWO THOUSAND TEN, A municipality, or its designee, shall be subrogated, to the extent of the expenditures by such municipality for early intervention services furnished to persons eligible for benefits under this title, to any rights such person may have or be entitled to from third party reimbursement. The right of subrogation does not attach to benefits paid or provided under any health insurance policy or health benefits plan prior to receipt of written notice of the exercise of subrogation rights by the insurer or plan administrator providing such benefits.

S 13. Intentionally omitted.

S 14. Section 2559-b of the public health law, as added by chapter 428 of the laws of 1992, is amended to read as follows:

S 2559-b. Regulations. The commissioner may adopt regulations necessary to carry out the provisions of this title. In promulgating such regulations, the commissioner shall [incorporate coordinated standards and procedures, where applicable, and shall] consider the regulations, guidelines and operating procedures of other state agencies that administer or supervise the administration of services to infants, toddlers and preschool children to ensure that families, service providers and municipalities are not unnecessarily required to meet differing eligibility, reporting or procedural requirements.

S 15. The state finance law is amended by adding a new section 99-q to read as follows:

S 99-Q. EARLY INTERVENTION PROGRAM ACCOUNT. 1. THERE IS HEREBY ESTABLISHED IN THE JOINT CUSTODY OF THE STATE COMPTROLLER AND THE COMMISSIONER OF THE DEPARTMENT OF TAXATION AND FINANCE AN ACCOUNT IN THE MISCELLANEOUS SPECIAL REVENUE FUND TO BE KNOWN AS THE "EARLY INTERVENTION PROGRAM ACCOUNT".

2. SUCH ACCOUNT SHALL CONSIST OF MONIES RECEIVED FROM EARLY INTERVENTION FEES.

3. MONIES OF THE ACCOUNT, WHEN ALLOCATED, SHALL BE AVAILABLE TO THE DEPARTMENT OF HEALTH FOR EARLY INTERVENTION PROGRAM ADMINISTRATIVE COSTS AND FOR THE STATE SHARE FOR REIMBURSEMENT OF EARLY INTERVENTION SERVICES.

S 16. The opening paragraph of paragraph a of subdivision 9 of section 4410 of the education law, as amended by chapter 82 of the laws of 1995, is amended to read as follows:

Providers of special services or programs shall apply to the commissioner for program approval on a form prescribed by the commissioner; such application shall include, but not be limited to, a listing of the services to be provided, the population to be served, a plan for providing services in the least restrictive environment and a description of its evaluation component, if any. [Providers of early intervention services seeking approval pursuant to subdivision seven of section twenty-five hundred fifty-one of the public health law shall apply to the commissioner for such approval on a form prescribed by the commissioner.] The commissioner shall approve programs in accordance with regulations adopted for such purpose and shall periodically review such programs at which time the commissioner shall provide the municipality in which the program is located or for which the municipality bears fiscal responsibility an opportunity for comment within thirty days of the review. In collaboration with municipalities and representatives of approved programs, the commissioner shall develop procedures for conducting such reviews. Municipalities shall be allowed to participate in such departmental review process. Such review shall be conducted by individuals with appropriate experience as determined by the commissioner and shall be conducted not more than once every three years.

S 17. Subdivision 18 of section 4403 of the education law is REPEALED.

S 17-a. Subsection (c) of section 3235-a of the insurance law is REPEALED.

S 18. Subsection (b) of section 3235-a of the insurance law, as added by section 3 of part C of chapter 1 of the laws of 2002, is amended and subsection (d) is relettered subsection (c) to read as follows:

(b) Where a policy of accident and health insurance, including a contract issued pursuant to article forty-three of this chapter, provides coverage for an early intervention program service, [such coverage] PAYMENTS MADE FOR SERVICES COVERED UNDER SUCH POLICY shall not be applied against any maximum annual or lifetime monetary limits set forth in such policy or contract. Visit limitations and other terms and conditions of the policy will continue to apply to early intervention services. However, any visits used for early intervention program services shall not reduce the number of visits otherwise available under the policy or contract for such services.

S 19. Paragraph (b) of subdivision 3 of section 602 of the public health law, as added by chapter 901 of the laws of 1986, subparagraph 2 as amended by section 5 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

(b) The extent to which services in the plan will promote the public health, which, as defined herein, shall be enhancing or sustaining the public health, protecting the public from the threats of disease and illness, or preventing premature death, and which assist in containing the costs of the health care system. Services that promote the public health are the following:

(1) family health, which shall include activities designed to reduce perinatal, infant and maternal mortality and morbidity and to promote the health of infants, children, adolescents, and people of childbearing age. Such activities shall include family centered perinatal care and other services appropriate to promote the birth of a healthy baby to a healthy mother, [and] services to prevent and detect health problems in infants, young children, and school age children, DENTAL HEALTH SERVICES TO CHILDREN LESS THAN TWENTY-ONE YEARS OF AGE AND, WHEN PROVIDED BY STAFF OF THE LOCAL HEALTH DEPARTMENT, EARLY INTERVENTION PROGRAM ADMINISTRATION AND SERVICE COORDINATION.

(2) disease control, which shall include activities to control and mitigate the extent of non-infectious diseases, particularly those of a chronic, degenerative nature, and infectious diseases. Such activities shall include surveillance and epidemiological programs, and programs to detect diseases in their early stages. Specific activities shall include immunizations against infectious diseases, prevention and treatment of sexually transmissible diseases, [and] arthropod vector-borne disease prevention, AND INPATIENT TUBERCULOSIS TREATMENT.

(3) health education and guidance, which shall include the use of information and education to modify or strengthen practices that will promote the public health and prevent illness. Such activities shall encourage people to assume personal responsibility for maintaining and improving their own health; increase their capacity to utilize appropriate health services; help them better control an illness they may have; and[,] provide information to stimulate community action on social and physical environmental factors that impact on health. Special emphasis shall be given to providing health education and guidance to individuals at the same time as they are receiving a health service.

(4) community health assessment, which shall include an analysis of community vital statistics and mortality and morbidity indices to detect the source of illnesses and diseases, particularly those of a carcinogenic and mutagenic nature, in order to prevent in an efficient manner as many persons as possible from contracting such illnesses and diseases and to assist in addressing other problems adversely affecting the public health. Such analysis shall also include data relating to toxic sites and occupational illnesses.

(5) environmental health, which shall include activities that promote health and prevent illness by ensuring sanitary conditions in water supplies, food service establishments, and other permit sites, [and by abating] TAKING MEASURES TO ASSURE ENFORCEMENT OF PROPERTY OWNER'S OBLIGATIONS TO ABATE public health nuisances, AND PERFORMING INSPECTIONS AND PROGRAMS RELATED TO RADIOACTIVE MATERIALS LICENSING AND INSPECTION, RADIATION-PRODUCING EQUIPMENT, HOUSING HYGIENE AND OCCUPANCY, INDIVIDUAL WATER SUPPLIES AND INDIVIDUAL SEWAGE SYSTEMS.

(6) THE PROVISION OF HOME CARE SERVICES PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, EXCEPT TO THE EXTENT SUCH SERVICES ARE PROVIDED BY A LONG TERM HOME HEALTH CARE PROGRAM, AS DEFINED IN SUCH ARTICLE THIRTY-SIX;

(7) THE OPERATION OF A PUBLIC HEALTH LABORATORY OR UTILIZATION OF A CONTRACT LABORATORY FOR THE TESTING, ANALYSIS, AND REPORTING OF CLINICAL OR ENVIRONMENTAL SPECIMENS COLLECTED BY THE LOCAL HEALTH DEPARTMENT IN THE CONDUCT OF BASIC PROGRAMS OR ACTIVITIES DESCRIBED IN THIS SECTION.

The commissioner shall promulgate rules and regulations that define the specific activities within each of the five categories. The commissioner prior to promulgation of rules and regulations defining the nature of the specific activities, shall consult with the public health

council and county health commissioners, boards and public health directors. The list of specific activities may be altered by the commissioner as necessary and after his consultation with the council, commissioners, boards and public health directors named herein.

S 20. Subdivision 2 of section 605 of the public health law, as amended by section 7 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made as follows:

[(a)] if the municipality is providing some or all of the basic public health services identified in paragraph (b) of subdivision three of section six hundred two of this title, pursuant to an approved plan, at a rate of no less than thirty-six per centum of the difference between the amount of moneys expended by the municipality for public health services required by paragraph (b) of subdivision three of section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services if they are not approved in a plan or if no plan is submitted for such services. NO REIMBURSEMENT SHALL BE PROVIDED TO THE EXTENT THE LIMITATIONS ON REIMBURSEMENT SET FORTH IN SECTION SIX HUNDRED SIXTEEN OF THIS ARTICLE ARE APPLICABLE.

[(b) if the municipality is providing other public health services within limits to be prescribed by regulation by the commissioner in addition to some or all of the public health services required in paragraph (b) of subdivision three of section six hundred two of this title, pursuant to an approved plan, at a rate of not less than thirty-six per centum of the moneys expended by the municipality for such other services. No such reimbursement shall be provided for services if they are not approved in a plan or if no plan is submitted for such services.]

S 21. Subdivisions 1 and 2 of section 609 of the public health law, as amended by chapter 474 of the laws of 1996, are amended and a new subdivision 5 is added to read as follows:

1. Where a laboratory shall have been or is hereafter established pursuant to article five of this chapter, the state, through the legislature and within the limits to be prescribed by the commissioner, shall provide aid at a per centum, determined in accordance with the provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the actual cost of installation, equipment and maintenance of the laboratory or laboratories. Such cost shall be the excess, if any, of such expenditures over available revenues of all types, including adequate and reasonable fees, derived from or attributable to the performance of laboratory services.

2. Where a county or city provides or shall have provided for laboratory service by contracting with an established laboratory, with the approval of the commissioner, it shall be entitled to state aid at a per centum, determined in accordance with the provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the cost of the contracts. State aid shall be available for a district laboratory supply station maintained and operated in accordance with article five of this chapter in the same manner and to the same extent as for laboratory services.

5. NO REIMBURSEMENT SHALL BE PROVIDED TO THE EXTENT THE LIMITATIONS ON REIMBURSEMENT SET FORTH IN SECTION SIX HUNDRED SIXTEEN OF THIS ARTICLE ARE APPLICABLE.

S 22. Subdivision 1 of section 616 of the public health law, as amended by section 9 of part B of chapter 57 of the laws of 2006, is amended and two new subdivisions 3 and 4 are added to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by [paragraph (a) of] subdivision two of section six hundred five of this article, at least thirty-six per centum of the difference between the amount of moneys expended by the municipality for public health services required by paragraph (b) of subdivision three of section six hundred two of this article during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article. [A municipality shall also receive not less than thirty-six per centum of the moneys expended for other public health services pursuant to paragraph (b) of subdivision two of section six hundred five of this article, and, at least the minimum amount so required for the services identified in title two of this article.]

3. NOTWITHSTANDING THE PROVISION OF SECTION SIX HUNDRED NINE OF THIS ARTICLE, NO PAYMENTS SHALL BE MADE FROM MONEYS APPROPRIATED FOR THE PURPOSE OF THIS ARTICLE FOR LABORATORY EXPENSES OR SERVICES, UNLESS SUCH SERVICES ARE DIRECTLY RELATED TO THE OPERATION OF A PUBLIC HEALTH LABORATORY, OR UTILIZATION OF A CONTRACT LABORATORY, FOR THE TESTING, ANALYSIS, AND REPORTING OF CLINICAL OR ENVIRONMENTAL SPECIMENS COLLECTED BY THE LOCAL HEALTH DEPARTMENT IN THE CONDUCT OF BASIC PROGRAMS OR ACTIVITIES DESCRIBED IN PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION SIX HUNDRED TWO OF THIS ARTICLE.

4. PAYMENTS SHALL BE MADE FROM MONEYS APPROPRIATED FOR THE PURPOSE OF THIS ARTICLE ONLY FOR SERVICES APPROVED BY THE DEPARTMENT AND RELATED TO SERVICES DESCRIBED IN PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION SIX HUNDRED TWO OF THIS ARTICLE. NO PAYMENT SHALL BE MADE FROM MONEYS APPROPRIATED FOR THE PURPOSE OF THIS ARTICLE FOR HOSPICE SERVICES, EMERGENCY MEDICAL SERVICES, MEDICAL EXAMINER PROGRAM, LONG-TERM HOME HEALTH CARE, PRE-SCHOOL ADMINISTRATIVE SERVICES, OR PRE-SCHOOL EDUCATION SERVICES PROVIDED TO CHILDREN THREE TO FIVE YEARS OF AGE, EXCEPT AS EXPRESSLY PROVIDED IN PARAGRAPH (B) OF SUBDIVISION THREE OF SECTION SIX HUNDRED TWO OF THIS ARTICLE.

S 23. Paragraphs (a) and (f) of subdivision 4 of section 576 of the public health law, as amended by chapter 436 of the laws of 1993, are amended and a new paragraph (h) is added to read as follows:

(a) The department may adopt and amend rules and regulations to effectuate the provisions and purposes of this title. [Such] FOR PERIODS PRIOR TO JULY FIRST, TWO THOUSAND NINE, SUCH rules and regulations shall establish inspection and reference fees for clinical laboratories and blood banks in amounts not exceeding the cost of the inspection and reference program for clinical laboratories and blood banks and shall be subject to the approval of the director of the budget.

(f) The commissioner may waive all or any part of such fee charges OR ASSESSMENT for clinical laboratories or blood banks operated by local governments and for nonprofit clinical laboratories or blood banks performing examinations and analyses or providing services under contract with the state or its local governments.

(H) NOTWITHSTANDING PARAGRAPHS (B) AND (E) OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW, FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE, THE DEPARTMENT SHALL CHARGE CLINICAL LABORATORIES AND BLOOD BANKS AN ANNUAL ASSESSMENT ON THE GROSS RECEIPTS RECEIVED BY SUCH

CLINICAL LABORATORIES AND BLOOD BANKS FOR ALL TESTS OR EXAMINATIONS OF SPECIMENS PERFORMED PURSUANT TO A PERMIT ISSUED IN ACCORDANCE WITH SECTION FIVE HUNDRED SEVENTY-FIVE OF THIS TITLE. THE ANNUAL ASSESSMENT TO BE CHARGED FOR JULY FIRST, TWO THOUSAND NINE THROUGH JUNE THIRTIETH, TWO THOUSAND TEN SHALL BE ONE PERCENT OF SUCH GROSS RECEIPTS FOR THE PRECEDING CALENDAR YEAR, AND FOR JULY FIRST, TWO THOUSAND TEN THROUGH JUNE THIRTIETH, TWO THOUSAND ELEVEN, ONE PERCENT OF SUCH GROSS RECEIPTS FOR THE PRECEDING CALENDAR YEAR. THE ANNUAL ASSESSMENT TO BE CHARGED FOR JULY FIRST, TWO THOUSAND ELEVEN THROUGH JUNE THIRTIETH, TWO THOUSAND TWELVE SHALL BE NINE-TENTHS OF ONE PERCENT OF SUCH GROSS RECEIPTS FOR THE PRECEDING CALENDAR YEAR. THE ANNUAL ASSESSMENT TO BE CHARGED FOR JULY FIRST, TWO THOUSAND TWELVE THROUGH JUNE THIRTIETH, TWO THOUSAND THIRTEEN AND FOR EVERY YEAR THEREAFTER SHALL BE EIGHT-TENTHS OF ONE PERCENT OF SUCH GROSS RECEIPTS FOR THE PRECEDING CALENDAR YEAR.

S 24. Section 4364 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. (A) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE DEPARTMENT SHALL CHARGE TISSUE BANKS AND STORAGE FACILITIES AN ANNUAL ASSESSMENT IN THE AMOUNT OF ONE PERCENT OF THE GROSS RECEIPTS RECEIVED FOR THE PRECEDING CALENDAR YEAR BY SUCH TISSUE BANKS AND STORAGE FACILITIES FOR ALL ACTIVITIES PERFORMED PURSUANT TO A LICENSE ISSUED IN ACCORDANCE WITH THIS SECTION.

(B) EACH TISSUE BANK OR STORAGE FACILITY SHALL SUBMIT TO THE DEPARTMENT, IN SUCH FORM AND AT SUCH TIMES AS THE DEPARTMENT MAY REQUIRE, A REPORT CONTAINING INFORMATION REGARDING ITS GROSS ANNUAL RECEIPTS FROM THE PERFORMANCE OF ALL ACTIVITIES PURSUANT TO A LICENSE ISSUED BY THE DEPARTMENT PURSUANT TO THIS SECTION. THE DEPARTMENT MAY REQUIRE ADDITIONAL INFORMATION AND AUDIT AND REVIEW SUCH INFORMATION TO VERIFY ITS ACCURACY.

S 25. Subdivision 8 of section 6524 of the education law, as amended by section 1 of part G of chapter 57 of the laws of 2008, is amended to read as follows:

(8) Fees: pay a fee of two hundred sixty dollars to the department for admission to a department conducted examination and for an initial license, a fee of one hundred seventy-five dollars for each reexamination, a fee of one hundred thirty-five dollars for an initial license for persons not requiring admission to a department conducted examination, a fee of five hundred seventy dollars for any biennial registration period commencing August first, nineteen hundred ninety-six THROUGH FEBRUARY TWENTY-EIGHTH, TWO THOUSAND NINE AND A FEE OF NINE HUNDRED SEVENTY DOLLARS FOR ANY BIENNIAL REGISTRATION PERIOD COMMENCING MARCH FIRST, TWO THOUSAND NINE and thereafter. The comptroller is hereby authorized and directed to deposit the fee for each biennial registration period into the special revenue funds-other entitled "professional medical conduct account" for the purpose of offsetting any expenditures made pursuant to section two hundred thirty of the public health law in relation to the operation of the office of professional medical conduct within the department of health, provided that for each biennial registration fee paid by the licensee using a credit card, the amount of the administrative fee incurred by the department in processing such credit card transaction shall be deposited by the comptroller in the office of the professions account established by section ninety-seven-nnn of the state finance law. The amount of the funds expended as a result of such increase shall not be greater than such fees collected over the registration period.

S 26. Subdivisions 9 and 10 of section 225 of the public health law are REPEALED.

S 27. Subdivision 4 of section 1352 of the public health law is REPEALED.

S 28. Paragraph (m) of subdivision 1 of section 201 of the public health law, as relettered by chapter 571 of the laws of 1976, is amended to read as follows:

(m) supervise and regulate the sanitary aspects of camps, hotels, boarding houses, public eating and drinking establishments, swimming pools, bathing establishments and other businesses and activities affecting public health AND RESPOND TO COMPLAINTS RELATING TO HOTELS, BOARDING HOUSES AND TEMPORARY RESIDENCES AS DEFINED IN THE STATE SANITARY CODE AND INSPECT SUCH FACILITIES WHEN OTHERWISE NECESSARY;

S 29. Paragraphs (a) and (c) of subdivision 2 and subdivision 3 of section 1370-a of the public health law, paragraphs (a) and (c) of subdivision 2 as added by chapter 485 of the laws of 1992 and subdivision 3 as added by section 23 of part B of chapter 58 of the laws of 2007, are amended to read as follows:

(a) promulgate and enforce regulations for screening children and pregnant women, INCLUDING REQUIREMENTS FOR BLOOD LEAD TESTING, for lead poisoning, and for follow up of children and pregnant women who have elevated blood lead levels;

(c) establish a statewide registry of LEAD LEVELS OF children [with elevated lead levels] provided such information is [monitored] MAINTAINED as confidential except for (i) disclosure for medical treatment purposes; [and] (ii) disclosure of non-identifying epidemiological data; AND (III) DISCLOSURE OF INFORMATION FROM SUCH REGISTRY TO THE STATEWIDE IMMUNIZATION INFORMATION SYSTEM ESTABLISHED BY SECTION TWENTY-ONE HUNDRED SIXTY-EIGHT OF THIS CHAPTER; and

3. The department shall identify and designate [a zip code in certain counties] AREAS IN THE STATE with significant concentrations of children identified with elevated blood lead levels AS COMMUNITIES OF CONCERN for purposes of implementing a [pilot] CHILDHOOD LEAD POISONING PRIMARY PREVENTION program [to work in cooperation with local health officials to develop a primary prevention plan for each such zip code identified to prevent exposure to lead-based paint], AND MAY, WITHIN AMOUNTS APPROPRIATED, PROVIDE GRANTS TO IMPLEMENT APPROVED PROGRAMS. THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL DEVELOP AND IMPLEMENT A CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM TO PREVENT EXPOSURE TO LEAD-BASED PAINT HAZARDS FOR THE COMMUNITIES OF CONCERN IN THEIR JURISDICTION. THE DEPARTMENT SHALL PROVIDE FUNDING TO THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR COUNTY HEALTH DEPARTMENTS TO IMPLEMENT THE APPROVED WORK PLAN FOR A CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM. THE WORK PLAN AND BUDGET, WHICH SHALL BE SUBJECT TO THE APPROVAL OF THE DEPARTMENT, SHALL INCLUDE, BUT NOT BE LIMITED TO: (A) IDENTIFICATION AND DESIGNATION OF AN AREA OR AREAS OF HIGH RISK WITHIN COMMUNITIES OF CONCERN; (B) A HOUSING INSPECTION PROGRAM THAT INCLUDES PRIORITIZATION AND INSPECTION OF AREAS OF HIGH RISK FOR LEAD HAZARDS, CORRECTION OF IDENTIFIED LEAD HAZARDS USING EFFECTIVE LEAD-SAFE WORK PRACTICES AND, APPROPRIATE OVERSIGHT OF REMEDIATION WORK; (C) PARTNERSHIPS WITH OTHER COUNTY OR MUNICIPAL AGENCIES OR COMMUNITY-BASED ORGANIZATIONS TO BUILD COMMUNITY AWARENESS OF THE CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM AND ACTIVITIES, COORDINATE REFERRALS FOR SERVICES, AND SUPPORT REMEDIATION

OF HOUSING THAT CONTAINS LEAD HAZARDS AND (D) A MECHANISM TO PROVIDE EDUCATION AND REFERRAL FOR LEAD TESTING FOR CHILDREN AND PREGNANT WOMEN TO FAMILIES WHO ARE ENCOUNTERED IN THE COURSE OF CONDUCTING PRIMARY PREVENTION INSPECTIONS AND OTHER OUTREACH ACTIVITIES. THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE SHALL ALSO ENTER INTO AN AGREEMENT OR SUBCONTRACT WITH A MUNICIPAL GOVERNMENT REGARDING INSPECTION OF THE PAINT CONDITIONS IN DWELLINGS BUILT PRIOR TO NINETEEN HUNDRED SEVENTY-EIGHT FOR THE AREA DEFINED AS THE COMMUNITY OF CONCERN. A PORTION OF GRANT FUNDING RECEIVED TO SUPPORT THE LOCAL PRIMARY PREVENTION PLAN MAY BE USED TO REDUCE BARRIERS TO LEAD TESTING OF CHILDREN AND PREGNANT WOMEN WITHIN THE COMMUNITIES OF CONCERN, INCLUDING THE PURCHASE OF LEAD TESTING DEVICES AND SUPPLIES WHEN THE NEED FOR SUCH RESOURCES IS IDENTIFIED WITHIN THE COMMUNITY. The commissioner, THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE is authorized to enter into agreements, CONTRACTS, SUBCONTRACTS or memoranda of understanding with, and provide technical and other resources to, local health officials, local building code officials, real property owners, and community organizations in such areas to create and implement policies, education and other forms of community outreach to address lead exposure, detection and risk reduction. [Such primary] PRIMARY prevention plans shall target children less than six years of age living in the highest risk housing in the [zip code] COMMUNITIES OF CONCERN identified. [Such primary prevention] THE plans shall also take into consideration the extent the weatherization assistance [or] PROGRAM AND other such programs can be used in [collaboration] CONJUNCTION with lead-based paint hazard risk reduction.

S 30. Subdivision 1 and paragraph (i) of subdivision 3 of section 1370-b of the public health law, as added by chapter 485 of the laws of 1992, is amended to read as follows:

1. The New York state advisory council on lead poisoning prevention is hereby established in the department, to consist of the following, or their designees: the commissioner; the commissioner of labor; the commissioner of environmental conservation; the commissioner of housing and community renewal; the commissioner of [social services] CHILDREN AND FAMILY SERVICES; THE COMMISSIONER OF TEMPORARY AND DISABILITY ASSISTANCE; THE SECRETARY OF STATE; THE SUPERINTENDENT OF INSURANCE; and fifteen public members appointed by the governor. The public members shall have a demonstrated expertise or interest in lead poisoning prevention and at least one public member shall be representative of each of the following: local government; community groups; labor unions; real estate; industry; parents; educators; local housing authorities; child health advocates; environmental groups; professional medical organizations and hospitals. The public members of the council shall have fixed terms of three years; except that five of the initial appointments shall be for two years and five shall be for one year. The council shall be chaired by the commissioner or his or her designee.

(i) To report on or before [January] DECEMBER first of each year to the governor and the legislature concerning the PREVIOUS YEAR'S development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary AND THE MOST CURRENTLY AVAILABLE LEAD SURVEILLANCE MEASURES, INCLUDING THE ACTUAL

NUMBER AND ESTIMATED PERCENTAGE OF CHILDREN SCREENED FOR LEAD IN ACCORDANCE WITH NEW YORK STATE REGULATIONS, INCLUDING AGE-SPECIFIC SCREENING REQUIREMENTS, AND THE ACTUAL NUMBER AND ESTIMATED PERCENTAGE OF CHILDREN IDENTIFIED WITH ELEVATED BLOOD LEAD LEVELS. SUCH REPORT SHALL BE MADE AVAILABLE ON THE DEPARTMENT'S WEBSITE.

S 31. Subdivision 3 of section 1370-e of the public health law, as added by chapter 485 of the laws of 1992, is amended to read as follows:

3. Whenever an analysis of a clinical specimen for lead is performed by a laboratory OR A PHYSICIAN OR AUTHORIZED PRACTITIONER, the director of such laboratory OR SUCH PHYSICIAN OR AUTHORIZED PRACTITIONER shall, within such period specified by the commissioner report the results and any related information in connection therewith to the local and state health officer to whom a physician or authorized practitioner is required to report such cases pursuant to this section.

S 32. Section 2168 of the public health law, as added by chapter 544 of the laws of 2006, is amended to read as follows:

S 2168. Statewide immunization [registry] INFORMATION SYSTEM. 1. The department is hereby directed to establish a statewide automated and electronic immunization [registry] INFORMATION SYSTEM that will serve, and shall be administered consistent with, the following public health purposes:

(a) collect reports of immunizations and thus reduce the incidence of illness, disability and death due to vaccine preventable diseases AND COLLECT RESULTS OF BLOOD LEAD ANALYSES PERFORMED BY PHYSICIAN OFFICE LABORATORIES TO PROVIDE TO THE STATEWIDE REGISTRY OF LEAD LEVELS OF CHILDREN ESTABLISHED PURSUANT TO SECTION THIRTEEN HUNDRED SEVENTY-A OF THIS CHAPTER;

(b) establish the public health infrastructure necessary to obtain, collect, preserve, and disclose information relating to vaccine preventable disease as it may promote the health and well-being of all children in this state;

(c) make available to an individual, or parents, guardians, or other person in a custodial relation to a child or, to local health districts, local social services districts responsible for the care and custody of children, health care providers and their designees, schools, WIC PROGRAMS, and [third party payers] HEALTH INSURERS the immunization status of children; and

(d) appropriately protecting the confidentiality of individual identifying information and the privacy of persons included in the [registry] STATEWIDE IMMUNIZATION INFORMATION SYSTEM and their families.

2. For the purposes of this section:

(a) The term "authorized user" shall mean any person or entity authorized to provide information to or to receive information from the STATEWIDE immunization [registry] INFORMATION SYSTEM and shall include health care providers and their designees, as defined in paragraph (d) of this subdivision, schools as defined in paragraph a of subdivision one of section twenty-one hundred sixty-four of this title, [health maintenance organizations certified under article forty-four of this chapter or article forty-three of the insurance law,] HEALTH INSURERS AS DEFINED IN PARAGRAPH (F) OF THIS SUBDIVISION, local health districts as defined by paragraph (c) of subdivision one of section two of this chapter, [and] local social services districts and the office of children and family services with regard to children in their legal custody, AND WIC PROGRAMS AS DEFINED IN PARAGRAPH (G) OF THIS SUBDIVISION. An authorized user may be located outside New York state. An entity other than a local health district shall be an authorized user only with respect to a

person seeking or receiving a health care service from the health care provider, a person enrolled or seeking to be enrolled in the school, a person insured by the health [maintenance organization] INSURER, [or] a person in the custody of the local social services district or the office of children and family services, OR A PERSON SEEKING OR RECEIVING SERVICES THROUGH WIC PROGRAMS, as the case may be.

(b) The term "STATEWIDE immunization [registry] INFORMATION SYSTEM" OR "SYSTEM" shall mean a statewide-computerized database maintained by the department capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons under nineteen years of age.

(c) The term "citywide immunization registry" shall mean the computerized database maintained by the city of New York department of health and mental hygiene capable of collecting, storing, and disclosing the electronic and paper records of vaccinations received by persons [under] LESS THAN nineteen years of age. THE TERM "CITYWIDE IMMUNIZATION REGISTRY" SHALL NOT INCLUDE THE CHILDHOOD BLOOD LEAD REGISTRY ESTABLISHED PURSUANT TO THE HEALTH CODE OF THE CITY OF NEW YORK. For the purposes of this section the term New York city department of health and mental hygiene shall mean such agency or any successor agency responsible for the citywide immunization registry.

(d) The term "health care provider" shall mean any person authorized by law to order [or administer] an immunization OR ANALYSIS OF A BLOOD SAMPLE FOR LEAD or any health care facility licensed under article twenty-eight of this chapter or any certified home health agency established under section thirty-six hundred six of this chapter; with respect to a person seeking or receiving a health care service from the health care provider.

(e) For purposes of this section a school is a public health authority, as defined in section 164.501 of part 45 of the federal code of rules, responsible for screening the immunization status of each child pursuant to section twenty-one hundred sixty-four of this article.

(F) THE TERM "HEALTH INSURER" SHALL MEAN HEALTH MAINTENANCE ORGANIZATIONS CERTIFIED UNDER ARTICLE FORTY-FOUR OF THIS CHAPTER, HEALTH SERVICE CORPORATIONS LICENSED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, HEALTH INSURANCE COMPANIES SUBJECT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW WHICH OFFER PREFERRED PROVIDER PRODUCTS, CORPORATIONS SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW WHICH OFFER PREFERRED PROVIDER PRODUCTS, MUNICIPAL COOPERATIVE HEALTH BENEFIT PLANS CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW WHICH OFFER PREFERRED PROVIDER PRODUCTS, AND PREFERRED PROVIDER ORGANIZATIONS AS DEFINED IN SECTION THREE HUNDRED FIFTY-TWO OF THE WORKERS' COMPENSATION LAW.

(G) FOR PURPOSES OF THIS SECTION A WIC PROGRAM IS A STATE OR LOCAL AGENCY, AS DESCRIBED PURSUANT TO SECTION 1786 OF TITLE 42 OF THE UNITED STATES CODE.

(H) THE TERM "PHYSICIAN OFFICE LABORATORY" SHALL MEAN A LABORATORY OPERATED BY A HEALTH CARE PROVIDER PURSUANT TO SUBDIVISION ONE OF SECTION FIVE HUNDRED SEVENTY-NINE OF THIS CHAPTER THAT IS CERTIFIED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES UNDER REGULATIONS IMPLEMENTING THE FEDERAL CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 (CLIA).

3. (a) Any health care provider who administers any vaccine to a person [under] LESS THAN nineteen years of age OR, ON OR AFTER SEPTEMBER FIRST, TWO THOUSAND NINE, CONDUCTS A BLOOD LEAD ANALYSIS OF A SAMPLE OBTAINED FROM A PERSON UNDER EIGHTEEN YEARS OF AGE IN ACCORDANCE WITH

PARAGRAPH (H) OF SUBDIVISION TWO OF THIS SECTION; and immunizations received by a person [under] LESS THAN nineteen years of age in the past if not already reported, shall report all such immunizations AND THE RESULTS OF ANY BLOOD LEAD ANALYSIS to the department in a format prescribed by the commissioner within fourteen days of administration OF SUCH IMMUNIZATIONS OR OF OBTAINING THE RESULTS OF ANY SUCH BLOOD LEAD ANALYSIS. Health care providers administering immunizations to persons [under] LESS THAN nineteen years of age in the city of New York shall report, in a format prescribed by the city of New York commissioner of health and mental hygiene, all such immunizations to the citywide immunization registry. The commissioner, and for the city of New York the commissioner of health and mental hygiene, shall have the discretion to accept for inclusion in the [registry] SYSTEM information regarding immunizations administered to individuals nineteen years of age or older with the express written consent of the vaccine. HEALTH CARE PROVIDERS WHO CONDUCT A BLOOD LEAD ANALYSIS ON A PERSON UNDER EIGHTEEN YEARS OF AGE AND WHO REPORT THE RESULTS OF SUCH ANALYSIS TO THE CITY OF NEW YORK COMMISSIONER OF HEALTH AND MENTAL HYGIENE PURSUANT TO NEW YORK CITY REPORTING REQUIREMENTS SHALL BE EXEMPT FROM THIS REQUIREMENT FOR REPORTING BLOOD LEAD ANALYSIS RESULTS TO THE STATE COMMISSIONER OF HEALTH; PROVIDED, HOWEVER, BLOOD LEAD ANALYSIS DATA COLLECTED FROM PHYSICIAN OFFICE LABORATORIES BY THE COMMISSIONER OF HEALTH AND MENTAL HYGIENE OF THE CITY OF NEW YORK PURSUANT TO THE HEALTH CODE OF THE CITY OF NEW YORK SHALL BE PROVIDED TO THE DEPARTMENT IN A FORMAT PRESCRIBED BY THE COMMISSIONER.

(b) The STATEWIDE immunization [registry] INFORMATION SYSTEM shall provide a method for health care providers to determine when the registrant is due or late for a recommended immunization and shall serve as a means for authorized users to receive prompt and accurate information, as reported to the [registry] SYSTEM, about the vaccines that the registrant has received.

4. (a) All information maintained by the department, or in the case of the citywide immunization registry, the city of New York under the provisions of this section shall be confidential except as necessary to carry out the provisions of this section and shall not be released for any other purpose.

(b) The department and for the city of New York the department of health and mental hygiene may also disclose or provide such information to an authorized user when (i) such person or agency provides sufficient identifying information satisfactory to the department to identify such registrant and (ii) such disclosure or provision of information is in the best interests of the registrant or his or her family, or will contribute to the protection of the public health.

(c) Any data collected by the department may be included in the STATEWIDE immunization [registry] INFORMATION SYSTEM AND THE STATEWIDE REGISTRY OF LEAD LEVELS OF CHILDREN if collection, storage and access of such data is otherwise authorized. Such data may be disclosed to the STATEWIDE immunization [registry] INFORMATION SYSTEM only if provided for in statute and regulation, and shall be subject to any provisions in such statute or regulation limiting the use or redisclosure of the data. Nothing contained in this paragraph shall permit inclusion of data in the STATEWIDE immunization [registry] INFORMATION SYSTEM if that data could not otherwise be accessed or disclosed in the absence of the [registry] SYSTEM. For the city of New York the commissioner of health and mental hygiene may include data collected in the citywide IMMUNIZATION registry as provided in this paragraph.

(d) A person, institution or agency to whom such immunization [registry] information is furnished or to whom, access to records or information has been given, shall not divulge any part thereof so as to disclose the identity of such person to whom such information or record relates, except insofar as such disclosure is necessary for the best interests of the person or other persons, consistent with the purposes of this section.

5. (a) All health care providers and their designees, except for providers reporting to the citywide immunization registry, shall submit to the commissioner information about any vaccinee [under] LESS THAN nineteen years of age and about each vaccination given after January first, two thousand eight. The information provided to the [registry] SYSTEM or the citywide immunization registry shall include the national immunization program data elements and other elements required by the commissioner. For the city of New York the commissioner of health and mental hygiene may require additional elements with prior notice to the commissioner of any changes.

(b) In addition to the immunization administration information required by this section, the operation of any immunization registry established under chapter five hundred twenty-one of the laws of nineteen hundred ninety-four, section 11.04 of title twenty-four of volume eight of the compilation of the rules of the city of New York and administered by a local health district collecting information from health care providers about vaccinations previously administered to a vaccinee prior to the effective date of this section shall provide the commissioner access to such information.

(c) All health care providers shall provide the department or, as appropriate, the city of New York with additional or clarifying information upon request reasonably related to the purposes of this section.

(d) Notwithstanding the above, submission of incomplete information shall not prohibit entry of incomplete but viable data into the [registry database] STATEWIDE IMMUNIZATION INFORMATION SYSTEM.

(e) The commissioner of the department of health and mental hygiene for the city of New York shall implement the requirements of this subdivision.

(f) The immunization status of children exempt from immunizations pursuant to subdivision eight and a parent claiming exemption pursuant to subdivision nine of section twenty-one hundred sixty-four of this title shall be reported by the health care provider.

6. In the city of New York, the commissioner of the department of health and mental hygiene of the city of New York may maintain its existing registry consistent with the requirements of this section and shall provide information to the commissioner and to authorized users.

7. Each parent or legal guardian of a newborn infant or a child newly enrolled in the [registry] STATEWIDE IMMUNIZATION INFORMATION SYSTEM shall receive information, developed by the department, describing the [registry] enrollment process and how to review and correct information and obtain a copy of the child's immunization record. The city of New York will be responsible for providing information about the processes for enrollment and access to the citywide immunization registry by a parent or legal guardian of a newborn infant or newly enrolled child residing in the city of New York.

8. Access and use of identifiable registrant information shall be limited to authorized users consistent with this subdivision and the purposes of this section. (a) The commissioner shall provide a method by which authorized users apply for access to the [registry] SYSTEM. For

the city of New York, the commissioner of health and mental hygiene shall provide a method by which authorized users apply for access to the CITYWIDE IMMUNIZATION registry.

(b) (i) The commissioner may use the STATEWIDE immunization [registry] INFORMATION SYSTEM AND THE BLOOD LEAD INFORMATION IN SUCH SYSTEM for purposes of outreach, quality improvement and [vaccine] accountability, research, epidemiological studies and disease control, AND TO OBTAIN BLOOD LEAD TEST RESULTS FROM PHYSICIAN OFFICE LABORATORIES FOR THE STATEWIDE REGISTRY OF LEAD LEVELS OF CHILDREN ESTABLISHED PURSUANT TO SUBDIVISION TWO OF SECTION THIRTEEN HUNDRED SEVENTY-A OF THIS CHAPTER; (ii) the commissioner of health and mental hygiene for the city of New York may use the immunization registry AND THE BLOOD LEAD INFORMATION IN SUCH SYSTEM for purposes of outreach, quality improvement and [vaccine] accountability, research, epidemiological studies and disease control; (iii) local health departments shall have access to the immunization [registry] INFORMATION SYSTEM AND THE BLOOD LEAD INFORMATION IN SUCH SYSTEM for purposes of outreach, quality improvement and [vaccine] accountability, epidemiological studies and disease control within their county; and

(c) health care providers and their designees shall have access to the STATEWIDE immunization [registry] INFORMATION SYSTEM AND THE BLOOD LEAD INFORMATION IN SUCH SYSTEM only for purposes of submission of information about vaccinations received by a specific registrant, determination of the immunization status of a specific registrant, DETERMINATION OF THE BLOOD LEAD TESTING STATUS OF A SPECIFIC REGISTRANT, SUBMISSION OF THE RESULTS FROM A BLOOD LEAD ANALYSIS OF A SAMPLE OBTAINED FROM A SPECIFIC REGISTRANT IN ACCORDANCE WITH PARAGRAPH (H) OF SUBDIVISION TWO OF THIS SECTION, review of practice coverage, generation of reminder notices, quality improvement and [vaccine] accountability and printing a copy of the immunization OR LEAD TESTING record for the registrant's medical record, for the registrant's parent or guardian, or other person in parental or custodial relation to a child, or for a registrant upon reaching eighteen years of age.

(d) The following authorized users shall have access to the STATEWIDE immunization [registry] INFORMATION SYSTEM AND THE BLOOD LEAD INFORMATION IN SUCH SYSTEM and the citywide immunization registry for the purposes stated in this paragraph: (i) schools for verifying IMMUNIZATION STATUS FOR eligibility for admission; (ii) health [maintenance organizations] INSURERS for performing quality assurance, accountability and outreach, relating to enrollees covered by the health [maintenance organization] INSURER; (iii) commissioners of local social services districts with regard to a child in his/her legal custody; [and] (iv) the commissioner of the office of children and family services with regard to children in their legal custody, and for quality assurance and accountability of commissioners of local social services districts, care and treatment of children in the custody of commissioners of local social services districts; AND (V) WIC PROGRAMS FOR THE PURPOSES OF VERIFYING IMMUNIZATION AND LEAD TESTING STATUS FOR THOSE SEEKING OR RECEIVING SERVICES.

9. The commissioner may judge the legitimacy of any request for immunization [registry] SYSTEM information and may refuse access to the STATEWIDE immunization [registry] INFORMATION SYSTEM based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation. For the city of New York the commissioner of health and mental hygiene may judge the legitimacy of requests for access to the citywide immunization registry and refuse

access to the immunization registry based on the authenticity of the request, credibility of the authorized user or other reasons as provided for in regulation.

10. The person to whom any immunization record relates, or his or her parent, or guardian, or other person in parental or custodial relation to such person may request a copy of an immunization OR LEAD TESTING record from the registrant's healthcare provider, the STATEWIDE immunization [registry] INFORMATION SYSTEM or the citywide immunization registry according to procedures established by the commissioner or, in the case of the citywide immunization registry, by the city of New York commissioner of the department of health and mental hygiene.

11. The commissioner, OR IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, may provide registrant specific immunization records to other state registries pursuant to a written agreement requiring that the [foreign] OUT-OF-STATE registry conform to national standards for maintaining the integrity of the data and will not be used for purposes inconsistent with the provisions of this section.

12. Information that would be provided upon the enrollment in the [registry] STATEWIDE IMMUNIZATION INFORMATION SYSTEM of a child being vaccinated, from birth records of all infants born in New York state on or after January first, two thousand four shall be entered into the STATEWIDE immunization [registry] INFORMATION SYSTEM, except in the city of New York, where birth record information shall be entered into the citywide immunization registry.

13. The commissioner shall promulgate regulations as necessary to effectuate the provisions of this section. Such regulations shall include provision for orderly implementation and operation of the [registry] STATEWIDE IMMUNIZATION INFORMATION SYSTEM, including the method by which each category of authorized user may access the [registry] SYSTEM. Access standards shall include at a minimum a method for assigning and authenticating each user identification and password assigned.

14. No authorized user shall be subjected to civil or criminal liability, or be deemed to have engaged in unprofessional conduct for reporting to, receiving from, or disclosing information relating to the [registry] STATEWIDE IMMUNIZATION INFORMATION SYSTEM when made reasonably and in good faith and in accordance with the provisions of this section or any regulation adopted thereto.

S 33. Section 215-b of the elder law is REPEALED.

S 34. Section 223 of the elder law is REPEALED.

S 35. Subdivision 21 of section 206 of the public health law, as added by section 24 of part B of chapter 58 of the laws of 2004, is REPEALED.

S 36. Section 210-a of the insurance law is REPEALED.

S 37. Paragraph (qq) of subdivision 1 of section 2807-v of the public health law is REPEALED.

S 38. This act shall take effect March 1, 2009; provided that the commissioner of health is authorized to promulgate emergency regulations to effectuate the requirements of subdivision 4 of section 2541 of the public health law as added by section one of this act; provided however that sections nineteen, twenty, twenty-one and twenty-two of this act shall take effect immediately and be deemed to have been in full force and effect on and after January 1, 2009.

PART B

Section 1. Subdivision 2 of section 3614-a of the public health law is amended by adding a new paragraph (c) to read as follows:

(C) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, FOR CERTIFIED HOME HEALTH AGENCIES AND FOR PROVIDERS OF LONG TERM HOME HEALTH CARE PROGRAMS THE ASSESSMENT SHALL BE SEVEN-TENTHS OF ONE PERCENT OF EACH AGENCY'S OR PROVIDER'S GROSS RECEIPTS RECEIVED FROM ALL HOME HEALTH CARE SERVICES AND OTHER OPERATING INCOME ON A CASH BASIS FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE.

S 2. Subdivision 4 of section 3614-a of the public health law, as amended by section 66 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

4. [For periods prior to January first, two thousand five, the] THE commissioner is authorized to contract with the article forty-three insurance law plans, or such other administrators as the commissioner shall designate, to receive and distribute home care provider assessment funds and personal care services provider assessment funds assessed pursuant to section three hundred sixty-seven-i of the social services law. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the assessment funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars for all assessments established pursuant to this section and the personal care services provider assessment established pursuant to section three hundred sixty-seven-i of the social services law, shall be paid from the assessment funds.

S 3. Subdivision 2 of section 3614-b of the public health law, as amended by section 9 of part CC of chapter 407 of the laws of 1999, is amended to read as follows:

2. (A) The assessment shall be six-tenths of one percent of such licensed home care services agency's gross receipts received from all patient care services and other operating income on a cash basis beginning April first, nineteen hundred ninety-two; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(B) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, THE ASSESSMENT SHALL BE SEVEN-TENTHS OF ONE PERCENT OF EACH SUCH LICENSED HOME CARE SERVICES AGENCY'S GROSS RECEIPTS RECEIVED FROM ALL PERSONAL CARE SERVICES AND OTHER OPERATING INCOME ON A CASH BASIS FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE.

S 4. Subdivision 2 of section 367-i of the social services law, as amended by section 10 of part CC of chapter 407 of the laws of 1999, is amended to read as follows:

2. (A) The assessment shall be six-tenths of one percent of each such provider's gross receipts received from all personal care services and other operating income on a cash basis beginning January first, nineteen hundred ninety-one; provided, however, that for all such gross receipts received on or after April first, nineteen hundred ninety-nine, such assessment shall be two-tenths of one percent, and further provided that such assessment shall expire and be of no further effect for all such gross receipts received on or after January first, two thousand.

(B) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, THE ASSESSMENT SHALL BE SEVEN-TENTHS OF ONE PERCENT OF EACH SUCH PROVIDER'S GROSS RECEIPTS FROM ALL PERSONAL CARE SERVICES AND OTHER OPERATING INCOME ON A CASH BASIS FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE.

S 5. (a) Notwithstanding any provision of law to the contrary, in the event that certain "proposed or final regulations of the federal Centers for Medicare and Medicaid Services," as defined in subdivision (b) of this section, become final and enforceable, the commissioner of health, in consultation with the director of the budget, may impose federal financial participation contingency requirements on expenditures that would otherwise be required to be made pursuant to state law but which, as a result of such final and enforceable regulations, would be required to be made entirely with non-federal funds. In such event, the commissioner of health, in consultation with the director of the budget, may make expenditures of such non-federal funds as he or she, in his or her discretion, deems to be available for such purposes.

(b) For purposes of this section, "proposed or final regulations of the Centers for Medicare and Medicaid Services" are regulations subject to a moratorium in effect until April 1, 2009 pursuant to P.L. 110-252, specifically: (i) interim final regulation dealing with case management and targeted case management published December 4, 2007 (CMS-2237-IFC); (ii) final rule implementing changes to Medicaid provider tax provisions published February 22, 2008 (CMS-2275-F); (iii) final rule dealing with public provider cost limits published May 29, 2007 (CMS-2258-FC); (iv) proposed rule dealing with Medicaid graduate medical education published May 23, 2007 (CMS-2279-P); (v) proposed rule dealing with the Medicaid rehabilitation services option published August 13, 2007 (CMS-2261-P); and (vi) final rule concerning school-based services published December 28, 2007 (CMS-2287-F).

S 6. Section 74 of the executive law is REPEALED.

S 7. Subdivision 2 of section 30-a of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

2. "Investigation" means investigations of fraud, abuse, or illegal acts perpetrated within the medical assistance program, by providers or recipients of medical assistance care, services and supplies; PROVIDED THAT FOR THE PURPOSES OF SECTION THIRTY-TWO-A OF THIS TITLE, INVESTIGATIONS OF FRAUD, ABUSE OR ILLEGAL ACTS RELATING TO THE PROGRAMS ADMINISTERED OR PROVIDED BY THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE, THE OFFICE OF CHILDREN AND FAMILY SERVICES OR LOCAL SOCIAL SERVICES DISTRICTS PURSUANT TO THE SOCIAL SERVICES LAW, OR THOSE PROGRAMS OF THE DEPARTMENT OF HEALTH THAT WERE TRANSFERRED TO SUCH DEPARTMENT PURSUANT TO SECTION TWO HUNDRED THIRTY-THREE OF CHAPTER FOUR HUNDRED SEVENTY-FOUR OF THE LAWS OF NINETEEN HUNDRED NINETY-SIX AND SECTION ONE HUNDRED TWENTY-TWO OF PART B OF CHAPTER FOUR HUNDRED THIRTY-SIX OF THE LAWS OF NINETEEN HUNDRED NINETY-SEVEN, INCLUDING BY CONTRACTEES OR RECIPIENTS OF SUCH PROGRAMS AS WELL AS SOCIAL SERVICES BENEFITS AS PROVIDED BY OR REGULATED BY THE DEPARTMENT OF LABOR.

S 8. Subdivisions 1, 3 and 7 of section 32 of the public health law, subdivisions 1 and 7 as added by chapter 442 of the laws of 2006 and subdivision 3 as amended by chapter 109 of the laws of 2007, are amended to read as follows:

1. to appoint such deputies, directors, assistants and other officers and employees as may be needed for the performance of his or her duties and may prescribe their duties and fix their compensation within the amounts appropriated therefor; PROVIDED, HOWEVER, THAT THE INSPECTOR

SHALL APPOINT A DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS SUBJECT TO THE LIMITATIONS OF, AND AS SET FORTH IN, SECTION THIRTY-TWO-A OF THIS TITLE;

3. to coordinate, to the greatest extent possible, activities to prevent, detect and investigate medical assistance program fraud and abuse amongst the following: the department; the offices of mental health, mental retardation and developmental disabilities, alcoholism and substance abuse services, temporary disability assistance, and children and family services; the commission on quality of care and advocacy for persons with disabilities; the department of education; the fiscal agent employed to operate the medical assistance information and payment system; local governments and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; [the welfare inspector general,] federal prosecutors, district attorneys within the state, the special investigative unit maintained by each health insurer operating within the state, and the state comptroller;

7. to make information and evidence relating to suspected criminal acts which he or she may obtain in carrying out his or her duties available to appropriate law enforcement officials and to consult with the deputy attorney general for Medicaid fraud control[, the welfare inspector general,] and other state and federal law enforcement officials for coordination of criminal investigations and prosecutions.

The inspector shall refer suspected fraud or criminality to the deputy attorney general for Medicaid fraud control and make any other referrals to such deputy attorney general as required or contemplated by federal law. At any time after such referral, with ten days written notice to the deputy attorney general for Medicaid fraud control or such shorter time as such deputy attorney general consents to, the inspector may additionally provide relevant information about suspected fraud or criminality to any other federal or state law enforcement agency that the inspector deems appropriate under the circumstances;

S 9. The public health law is amended by adding a new section 32-a to read as follows:

S 32-A. FUNCTIONS, DUTIES AND RESPONSIBILITIES REGARDING INVESTIGATIONS OF WELFARE FRAUD. 1. THE INSPECTOR SHALL APPOINT A DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS; PROVIDED, HOWEVER, THAT A PERSON WHO IS SERVING AS THE WELFARE INSPECTOR GENERAL, AS A RESULT OF AN APPOINTMENT BY THE GOVERNOR AND APPROVAL BY THE SENATE, ON THE EFFECTIVE DATE OF THIS SECTION, SHALL BECOME THE DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS AND CONTINUE IN THAT ROLE WITH THE SUPPORT OF AND IN COLLABORATION WITH THE INSPECTOR, THROUGH THE WELFARE INSPECTOR GENERAL'S TERM, OR UNTIL HIS OR HER RESIGNATION FROM OFFICE OR HIS OR HER REMOVAL FROM OFFICE FOR NEGLECT OR MALFEASANCE BY THE SENATE UPON A VOTE OF TWO-THIRDS OF ITS MEMBERS.

2. THE INSPECTOR SHALL, WITHIN AMOUNTS APPROPRIATED THEREFOR, APPOINT SUCH DIRECTORS, ASSISTANTS AND OTHER OFFICERS AND EMPLOYEES AS MAY BE NEEDED FOR THE PERFORMANCE OF THE DUTIES SET FORTH IN THIS SECTION; PROVIDED, HOWEVER, THAT ANY NECESSARY OFFICERS AND EMPLOYEES WHO ARE SUBSTANTIALLY ENGAGED IN THE PERFORMANCE OF THE FUNCTIONS OF THE OFFICE OF THE WELFARE INSPECTOR GENERAL ON THE EFFECTIVE DATE OF THIS SECTION SHALL BE DEEMED EMPLOYEES OF THE OFFICE OF THE MEDICAID INSPECTOR GENERAL. IN ACCORDANCE WITH SUBDIVISION TWO OF SECTION SEVENTY OF THE CIVIL SERVICE LAW, OFFICERS AND EMPLOYEES SO TRANSFERRED SHALL BE TRANSFERRED WITHOUT FURTHER EXAMINATION OR QUALIFICATION AND SHALL RETAIN THEIR RESPECTIVE CIVIL SERVICE CLASSIFICATIONS AND STATUS.

3. THE INSPECTOR, THROUGH THE DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS, AS SET FORTH IN SUBDIVISION TWO OF THIS SECTION, SHALL HAVE THE FOLLOWING FUNCTIONS, DUTIES AND RESPONSIBILITIES:

(A) TO CONDUCT AND SUPERVISE INVESTIGATIONS OF FRAUD, ABUSE OR ILLEGAL ACTS RELATING TO THE PROGRAMS DESCRIBED IN SUBDIVISION TWO OF SECTION THIRTY-A OF THIS ARTICLE;

(B) TO THE GREATEST EXTENT POSSIBLE, TO COORDINATE ITS INVESTIGATIVE ACTIVITIES WITH THE COMMISSIONER, THE DEPUTY ATTORNEY GENERAL FOR MEDICAID FRAUD CONTROL OR SUCH OTHER PERSON DESIGNATED BY THE ATTORNEY GENERAL, THE COMMISSIONER OF THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE, THE COMMISSIONER OF THE OFFICE OF CHILDREN AND FAMILY SERVICES, THE COMMISSIONER OF EDUCATION, THE COMMISSIONER OF LABOR, THE FISCAL AGENT EMPLOYED TO OPERATE THE MEDICAID MANAGEMENT INFORMATION SYSTEM AND THE STATE COMPTROLLER;

(C) TO MAKE INFORMATION AND EVIDENCE RELATING TO CRIMINAL ACTS WHICH HE OR SHE MAY OBTAIN AVAILABLE TO APPROPRIATE LAW ENFORCEMENT OFFICIALS AND TO CONSULT WITH LOCAL DISTRICT ATTORNEYS AND, WHERE APPROPRIATE, THE DEPUTY ATTORNEY GENERAL FOR MEDICAID FRAUD OR SUCH OTHER PERSON DESIGNATED BY THE ATTORNEY GENERAL, IN ADDITION TO FEDERAL OFFICIALS, TO COORDINATE INVESTIGATIONS AND CRIMINAL PROSECUTIONS;

(D) TO SUBPOENA WITNESSES, ADMINISTER OATHS OR AFFIRMATIONS, TAKE TESTIMONY AND COMPEL THE PRODUCTION OF SUCH BOOKS, PAPERS, RECORDS AND DOCUMENTS AS HE OR SHE MAY DEEM TO BE RELEVANT TO AN INVESTIGATION UNDERTAKEN PURSUANT TO THIS SECTION;

(E) TO KEEP THE GOVERNOR, ATTORNEY GENERAL, STATE COMPTROLLER, TEMPORARY PRESIDENT OF THE SENATE AND THE MINORITY LEADER OF THE SENATE, THE SPEAKER OF THE ASSEMBLY AND THE MINORITY AND MAJORITY LEADERS OF THE ASSEMBLY, APPRISED OF FRAUD AND ABUSE IN SOCIAL SERVICES PROGRAMS AND EXPENDITURES;

(F) TO RECOMMEND POLICIES RELATING TO THE PREVENTION AND DETECTION OF FRAUD AND ABUSE OR THE IDENTIFICATION AND PROSECUTION OF PARTICIPANTS IN SUCH FRAUD AND ABUSE;

(G) TO MONITOR THE IMPLEMENTATION BY THE RELEVANT OFFICE OF HIS OR HER RECOMMENDATIONS AND THOSE OF OTHER INVESTIGATIVE AGENCIES; AND

(H) TO RECEIVE COMPLAINTS OF ALLEGED FAILURES OF STATE AND LOCAL OFFICIALS TO PREVENT, DETECT AND PROSECUTE FRAUD AND ABUSE IN SOCIAL SERVICES PROGRAMS AND EXPENDITURES.

4. (A) IN ADDITION TO THE AUTHORITY OTHERWISE PROVIDED BY THIS SECTION, IN CARRYING OUT THE PROVISIONS OF THIS SECTION, THE INSPECTOR AND THE DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS, AS SET FORTH IN SUBDIVISION TWO OF THIS SECTION, ARE AUTHORIZED:

(I) TO HAVE FULL AND UNRESTRICTED ACCESS TO ALL RECORDS, REPORTS, AUDITS, REVIEWS, DOCUMENTS, PAPERS, RECOMMENDATIONS OR OTHER MATERIAL AVAILABLE TO THE DEPARTMENT, THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE, THE OFFICE OF CHILDREN AND FAMILY SERVICES, THE DEPARTMENT OF LABOR AND LOCAL SOCIAL SERVICES DISTRICTS RELATING TO PROGRAMS AND OPERATIONS AS DESCRIBED IN SUBDIVISION TWO OF SECTION THIRTY-A OF THIS ARTICLE;

(II) TO MAKE SUCH INVESTIGATIONS RELATING TO THE ADMINISTRATION OF SOCIAL SERVICES PROGRAMS AND EXPENDITURES AS ARE, IN THE JUDGMENT OF THE INSPECTOR, NECESSARY OR DESIRABLE; AND

(III) TO REQUEST SUCH INFORMATION, ASSISTANCE AND COOPERATION FROM ANY FEDERAL, STATE OR LOCAL GOVERNMENTAL DEPARTMENT, BOARD, BUREAU, COMMISSION, OR OTHER AGENCY OR UNIT THEREOF AS MAY BE NECESSARY FOR CARRYING OUT THE DUTIES AND RESPONSIBILITIES ENJOINED UPON THEM BY THIS SECTION.

STATE AND LOCAL AGENCIES OR UNITS THEREOF ARE HEREBY AUTHORIZED AND DIRECTED TO PROVIDE SUCH INFORMATION, ASSISTANCE AND COOPERATION.

(B) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, RULE OR REGULATION TO THE CONTRARY, NO PERSON SHALL PREVENT, SEEK TO PREVENT, INTERFERE WITH, OBSTRUCT OR OTHERWISE HINDER ANY INVESTIGATION BEING CONDUCTED PURSUANT TO THIS SECTION. SECTION ONE HUNDRED THIRTY-SIX OF THE SOCIAL SERVICES LAW SHALL IN NO WAY BE CONSTRUED TO RESTRICT ANY PERSON OR GOVERNMENTAL BODY FROM COOPERATING AND ASSISTING THE INSPECTOR OR HIS OR HER EMPLOYEES IN CARRYING OUT THEIR DUTIES UNDER THIS SECTION. ANY VIOLATION OF THIS PARAGRAPH SHALL CONSTITUTE CAUSE FOR SUSPENSION OR REMOVAL FROM OFFICE OR EMPLOYMENT.

5. THE INSPECTOR, IN CONSULTATION WITH THE DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS, SHALL, NO LATER THAN OCTOBER FIRST OF EACH YEAR SUBMIT TO THE GOVERNOR, THE STATE COMPTROLLER, THE ATTORNEY GENERAL AND THE LEGISLATURE A REPORT SUMMARIZING THE ACTIVITIES OF THE OFFICE DURING THE PRECEDING CALENDAR YEAR WITH RESPECT TO ITS RESPONSIBILITIES UNDER THIS SECTION.

6. (A) THE INSPECTOR AND THE DEPUTY INSPECTOR GENERAL FOR SOCIAL SERVICES INVESTIGATIONS SHALL NOT PUBLICLY DISCLOSE INFORMATION WHICH IS:

(I) A PART OF ANY ONGOING INVESTIGATION; OR

(II) SPECIFICALLY PROHIBITED FROM DISCLOSURE BY ANY OTHER PROVISION OF LAW.

(B) NOTWITHSTANDING PARAGRAPH (A) OF THIS SUBDIVISION, ANY REPORT UNDER THIS SECTION MAY BE DISCLOSED TO THE PUBLIC IN A FORM WHICH INCLUDES INFORMATION WITH RESPECT TO A PART OF AN ONGOING CRIMINAL INVESTIGATION IF SUCH INFORMATION HAS BEEN INCLUDED IN A PUBLIC RECORD.

7. WITH THE EXCEPTION OF ANY DOCUMENTS OR RECORDS REQUIRED BY THE ATTORNEY GENERAL PURSUANT TO SUBDIVISION EIGHT OF THIS SECTION, ANY DOCUMENTS AND RECORDS RELEVANT AND NECESSARY AND RELATED TO THE TRANSFER OF FUNCTIONS FROM THE OFFICE OF THE WELFARE INSPECTOR GENERAL SHALL BE TRANSFERRED TO THE OFFICE OF THE MEDICAID INSPECTOR GENERAL.

8. IF, PRIOR TO THE EFFECTIVE DATE OF THIS SECTION, THE WELFARE INSPECTOR GENERAL HAS COMMENCED A CRIMINAL PROCEEDING AGAINST ANY PERSON, PROSECUTION OF SUCH A CASE SHALL BECOME THE RESPONSIBILITY OF THE ATTORNEY GENERAL; PROVIDED, HOWEVER, THAT THE WELFARE INSPECTOR GENERAL MAY CONTINUE TO ASSIST IN THE PROSECUTION OF THE CASE AS A SPECIAL ASSISTANT ATTORNEY GENERAL, AT THE DISCRETION OF THE ATTORNEY GENERAL. FOR PURPOSES OF THIS SUBDIVISION, A CRIMINAL PROCEEDING HAS BEEN COMMENCED WHEN CRIMINAL CHARGES ARE PENDING IN ANY COURT OR A GRAND JURY HAS COMMENCED AN INVESTIGATION OF THE MATTER.

9. THE DIRECTOR OF THE BUDGET IS HEREBY AUTHORIZED TO TRANSFER TO THE OFFICE OF THE MEDICAID INSPECTOR GENERAL, FOR USE BY THE OFFICE, FUNDS OTHERWISE APPROPRIATED OR REAPPROPRIATED TO THE OFFICE OF THE WELFARE INSPECTOR GENERAL CONSISTENT WITH THE PURPOSES OF THIS SECTION.

10. ALL RULES, REGULATIONS, ACTS, DETERMINATIONS AND DECISIONS OF THE WELFARE INSPECTOR GENERAL WITH RESPECT TO THE FUNCTIONS, POWERS, DUTIES, AND OBLIGATIONS OF THE OFFICE OF THE WELFARE INSPECTOR GENERAL IN EFFECT ON THE EFFECTIVE DATE OF THIS SECTION SHALL CONTINUE IN FULL FORCE AND EFFECT AS RULES, REGULATIONS, ACTS, DETERMINATIONS AND DECISIONS OF THE MEDICAID INSPECTOR GENERAL UNTIL AMENDED OR REVISED BY THE MEDICAID INSPECTOR GENERAL.

S 10. 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, is amended to read as follows:

2. section two of this act shall expire and be deemed repealed on March 31, [2010] 2013;

S 11. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 64 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(e-1) Notwithstanding any inconsistent provision of law or regulation, the commissioner shall provide, in addition to payments established pursuant to this article prior to application of this section, additional payments under the medical assistance program pursuant to title eleven of article five of the social services law for non-state operated public residential health care facilities, including public residential health care facilities located in the county of Nassau, the county of Westchester and the county of Erie, but excluding public residential health care facilities operated by a town or city within a county, in aggregate annual amounts of up to one hundred fifty million dollars in additional payments for the state fiscal year beginning April first, two thousand six and for the state fiscal year beginning April first, two thousand seven and for the state fiscal year beginning April first, two thousand eight and for the state fiscal year beginning April first, two thousand nine, AND EACH STATE FISCAL YEAR THEREAFTER. The amount allocated to each eligible public residential health care facility for this period shall be computed in accordance with the provisions of paragraph (f) of this subdivision, provided, however, that patient days shall be utilized for such computation reflecting actual reported data for two thousand three and each representative succeeding year as applicable.

S 12. 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 health care facilities, as amended by section 65 of part C of chapter 58 of the laws of 2007, 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 EACH STATE FISCAL YEAR THEREAFTER, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals

up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006 and for state fiscal years beginning on and after April 1, 2007, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 13. Paragraph (b) of subdivision 1 of section 211 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 66 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning April 1, 2000, the department of health is authorized to pay public general hospitals, other than those operated by the state of New York or the state university of New York, as defined in subdivision 10 of section 2801 of the public health law, located in a city with a population of over 1 million, additional initial payments for inpatient hospital services of $120 million during each state fiscal year until March 31, 2003, and up to $120 million during the state fiscal year beginning April 1, 2005 through March 31, 2006 and during the state fiscal year beginning April 1, 2006 through March 31, 2007 and during the state fiscal year beginning April 1, 2007 through March 31, 2008 and during the state fiscal year beginning April 1, 2008 through March 31, 2009, AND EACH STATE FISCAL YEAR THEREAFTER, 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 based on the relative share of each such non-state operated public general hospital of medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospitals for payments made during the state fiscal year ending March 31, 2001, based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 or 2001 data, for payments made during the state fiscal year ending March 31, 2002, based initially on reported 1995 reconciled data as further reconciled to actual reported

2001 or 2002 data, for payments made during the state fiscal year ending March 31, 2003, based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 or 2003 data, for payments made during the state fiscal year ending on and after March 31, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported 2005 or 2006 data, for payments made during the state fiscal year ending on and after March 31, 2007, based initially on reported 2000 reconciled data as further reconciled to actual reported 2006 or 2007 data for payments made during the state fiscal years ending on and after March 31, 2008, based initially on reported 2000 reconciled data as further reconciled to actual reported 2007 or 2008 data, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 14. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 68 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 11. This act shall take effect immediately and:

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

(b) [sections four through ten shall expire on June 30, 2009, and

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

S 15. Subdivisions 2 and 4 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 69 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 AND ON AND AFTER APRIL 1, 2009;

4. Section one of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 AND ON AND AFTER APRIL 1, 2009.

S 16. Subparagraph (iii) of paragraph (f) of subdivision 4 of section 2807-c of the public health law, as amended by section 70 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods commencing April first, two thousand five through March thirty-first, two thousand six and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first,

two thousand seven through March thirty-first, two thousand nine, AND FOR PERIODS COMMENCING ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by state governmental agencies shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. Such election shall not alter the calculation of the group price component calculated pursuant to subparagraph (i) of paragraph (a) of subdivision seven of this section;

S 17. Subparagraph (iii) of paragraph (k) of subdivision 4 of section 2807-c of the public health law, as amended by section 71 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and commencing April first, two thousand five through March thirty-first, two thousand six, and for periods commencing on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods commencing on and after April first, two thousand seven through March thirty-first, two thousand nine, AND FOR PERIODS COMMENCING ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, the operating cost component of rates of payment, excluding any operating cost components related to direct and indirect expenses of graduate medical education, for patients eligible for payments made by a state governmental agency shall be reduced by three and thirty-three hundredths percent to encourage improved productivity and efficiency. The facility will be eligible to receive the financial incentives for the physician specialty weighting incentive towards primary care pursuant to subparagraph (ii) of paragraph (a) of subdivision twenty-five of this section.

S 18. The opening paragraph of subparagraph (vi) of paragraph (b) of subdivision 5 of section 2807-c of the public health law, as amended by section 72 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

for discharges on or after April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and for discharges on or after July first, nineteen hundred ninety-nine through March thirty-first, two thousand and for discharges on or after April first, two thousand through March thirty-first, two thousand five and for discharges on or after April first, two thousand five through March thirty-first, two thousand six, and for discharges on or after April first, two thousand six through March thirty-first, two thousand seven, and for discharges on or after April first, two thousand seven through March thirty-first, two thousand nine, AND FOR DISCHARGES ON OR AFTER APRIL FIRST, TWO THOUSAND NINE, for purposes of reimbursement of inpatient hospital services for patients eligible for payments made by state governmental agencies, the average reimbursable inpatient operating cost per discharge of a general hospital shall, to encourage improved productivity and efficiency, be the sum of:

S 19. The opening paragraph and subparagraph (i) of paragraph (c) of subdivision 5 of section 2807-c of the public health law, as amended by section 73 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

Notwithstanding any inconsistent provision of this section, commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, AND FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, rates of payment for a general hospital for patients eligible for payments made by state governmental agencies shall be further reduced by the commissioner to encourage improved productivity and efficiency by providers by a factor determined as follows:

(i) an aggregate reduction shall be calculated for each general hospital commencing July first, nineteen hundred ninety-six through March thirty-first, nineteen hundred ninety-nine and July first, nineteen hundred ninety-nine through March thirty-first, two thousand and April first, two thousand through March thirty-first, two thousand five and for periods on and after April first, two thousand five through March thirty-first, two thousand six, and for periods on and after April first, two thousand six through March thirty-first, two thousand seven, and for periods on and after April first, two thousand seven through March thirty-first, two thousand nine, AND FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, as the result of (A) eighty-nine million dollars on an annualized basis for each year, multiplied by (B) the ratio of patient days for patients eligible for payments made by state governmental agencies provided in a base year two years prior to the rate year by a general hospital, divided by the total of such patient days summed for all general hospitals; and

S 20. Clause (B-1) of subparagraph (i) of paragraph (f) of subdivision 11 of section 2807-c of the public health law, as amended by section 74 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(B-1) The increase in the statewide average case mix in the periods January first, nineteen hundred ninety-seven through March thirty-first, two thousand and on and after April first, two thousand through March thirty-first, two thousand six and on and after April first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, AND ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, from the statewide average case mix for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six shall not exceed one percent for nineteen hundred ninety-seven, two percent for nineteen hundred ninety-eight, three percent for the period January first, nineteen hundred ninety-nine through September thirtieth, nineteen hundred ninety-nine, four percent for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, and four percent for two thousand plus an additional one percent per year thereafter, based on comparison of data only for patients that are eligible for medical assistance pursuant to title eleven of article five of the social services law, including such patients enrolled in health maintenance organizations.

S 21. Subdivision 1 of section 46 of chapter 639 of the laws of 1996 amending the public health law and other laws relating to welfare

reform, as amended by section 75 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation to the contrary, 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 general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through June 30, 1996 and on or after July 1, 1996 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, 2005 and on and after April 1, 2005 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009, AND ON AND AFTER APRIL 1, 2009, shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

S 22. Section 4 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 76 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 4. Notwithstanding any inconsistent provision of law, except subdivision 15 of section 2807 of the public health law and section 364-j-2 of the social services law and section 32-g of part F of chapter 412 of the laws of 1999, rates of payment for diagnostic and treatment centers established in accordance with paragraphs (b) and (h) of subdivision 2 of section 2807 of the public health law for the period ending September 30, 1995 shall continue in effect through September 30, 2000 and for the periods October 1, 2000 through September 30, 2003 and October 1, 2003 through September 30, 2007 and October 1, 2007 through September 30, 2009, AND ON AND AFTER OCTOBER 1, 2009, and further provided that rates in effect on March 31, 2003 as established in accordance with paragraph (e) of subdivision 2 of section 2807 of the public health law shall continue in effect for the period April 1, 2003 through September 30, 2007 and October 1, 2007 through September 30, 2009, AND ON AND AFTER OCTOBER 1, 2009, provided however that, subject to the approval of the director of the budget, such rates may be adjusted to include expenditures in those components of rates not subject to the ceilings of the corresponding rate methodology.

S 23. Subdivision 5 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 77 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

5. Section three 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;

S 24. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates of residential health care facilities, as amended by section 78 of part C of chapter 58 of the laws of 2007, 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 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 25. 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 major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 fiscal year, 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 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

S 26. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 79 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008 [and], February 1, 2009 AND FEBRUARY 1 OF EACH YEAR THEREAFTER the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009 AND EACH YEAR THEREAFTER statewide target percentage respectively.

S 27. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as

amended by section 80 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

S 28. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 81 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER reduction amount.

S 29. Paragraph (b) of subdivision 5 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 82 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER target percentage compared to the base percent-

age. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER facility specific reduction amounts respectively.

S 30. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 85 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

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

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

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

(d) Regional group shall mean all those CHHAs and LTHHCPs, respectively, located within a region.

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 AND EACH YEAR THEREAFTER THE TARGET PERIOD SHALL BE JANUARY 1 THROUGH NOVEMBER 30, FOR THAT RESPECTIVE YEAR.

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

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, and prior to February 1, 2007, and prior to February 1, 2008 and prior to February 1, 2009, AND PRIOR TO FEBRUARY 1 OF EACH YEAR THEREAFTER for each regional group the commis-

sioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

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

4. (a) For each regional group, the 1996 target medicaid revenue percentage shall be calculated by subtracting the 1996 medicaid revenue reduction percentages from the base period medicaid revenue percentages. The 1996 medicaid revenue reduction percentage, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

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

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

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

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

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:

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

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

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

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

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

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

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

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

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

5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996

medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

6. (a) For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

(i) two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

(ii) seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region;

(iii) one million two hundred seventy thousand dollars ($1,270,000) for LTHHCPs located within the downstate region; and

(iv) five hundred ninety thousand dollars ($590,000) for LTHHCPs located within the upstate region.

For each regional group reduction, if the reduction factor for a particular year shall be zero, there shall be no state share reduction amount for such year.

(c) For each regional group, the 1999 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1999 state share reduction amount:

(i) one million seven hundred ninety-two thousand five hundred dollars ($1,792,500) for CHHAs located within the downstate region;

(ii) five hundred sixty-two thousand five hundred dollars ($562,500) for CHHAs located within the upstate region;

(iii) nine hundred fifty-two thousand five hundred dollars ($952,500) for LTHHCPs located within the downstate region; and

(iv) four hundred forty-two thousand five hundred dollars ($442,500) for LTHHCPs located within the upstate region.

For each regional group reduction, if the 1999 reduction factor shall be zero, there shall be no 1999 state share reduction amount.

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph (a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, AND EACH YEAR THEREAFTER for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

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

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

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

10. On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided in paragraph (a) of subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 of this section. The provider specific state share reduction amount calculated in accordance with this subdivision shall be compared to the 1996 provider specific state share reduction amount calculated in accordance with paragraph (a) of subdivision 7 of this section. Any amount in excess of the amount determined in

accordance with paragraph (a) of subdivision 7 of this section shall be due to the state from each CHHA and LTHHCP and may be recouped in accordance with paragraph (a) of subdivision 8 of this section. If the amount is less than the amount determined in accordance with paragraph (a) of subdivision 7 of this section, the difference shall be refunded to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

11. If a CHHA or LTHHCP fails to submit data and information as required for purposes of this section:

(a) such CHHA or LTHHCP shall be presumed to have no decrease in medicaid revenue percentage between the applicable base period and the applicable target period for purposes of the calculations pursuant to this section; and

(b) the commissioner of health shall reduce the current rate paid to such CHHA and such LTHHCP by state governmental agencies pursuant to article 36 of the public health law by one percent for a period beginning on the first day of the calendar month following the applicable due date as established by the commissioner of health and continuing until the last day of the calendar month in which the required data and information are submitted.

12. The commissioner of health shall inform in writing the director of the budget and the chair of the senate finance committee and the chair of the assembly ways and means committee of the results of the calculations pursuant to this section.

S 31. Notwithstanding any inconsistent provision of law, rule or regulation, the annual percentage reductions set forth in sections twenty-six through thirty of this act shall be prorated by the commissioner of health for periods on and after April 1, 2009.

S 32. 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 86 of part C of chapter 58 of the laws of 2007, 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;

S 33. 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 87 of part C of chapter 58 of the laws of 2007, 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.

S 34. Paragraph (s-8) of subdivision 11 of section 2807-c of the public health law, as amended by section 57 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(s-8) To the extent funds are available and otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods on and after April first, two thousand seven through [March thirty-first]

JUNE THIRTIETH, two thousand nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed sixty million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit general hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have medicaid inpatient discharges percentages equal to or greater than thirty-five percent. This percentage shall be computed based upon data reported to the department in each hospital's two thousand four institutional cost report, as submitted to the department on or before January first, two thousand seven. The rate adjustments calculated in accordance with this paragraph shall be allocated proportionally based on each eligible hospital's total reported medicaid inpatient discharges in two thousand four, to the total reported medicaid inpatient discharges for all such eligible hospitals in two thousand four, provided, however, that such rate adjustments shall be subject to reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation to the extent allowable under federal law. Such payments may be added to rates of payment or made as aggregate payments to eligible hospitals, provided, however, that subject to the availability of federal financial participation and solely for the period April first, two thousand seven through March thirty-first, two thousand eight, six million dollars in the aggregate of this sixty million dollars shall be allocated to voluntary non-profit hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have Medicaid inpatient discharge percentages of less than thirty-five percent and which had previously qualified for distributions pursuant to paragraph (s-7) of this subdivision. The rate adjustment calculated in accordance with this paragraph shall be allocated proportionally based on the amount of money the hospital had received in two thousand six.

S 35. Section 3 of chapter 629 of the laws of 1986, amending the social services law relating to establishing a demonstration program for the delivery of long term home health care services to certain persons, as amended by section 71 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 3. This act shall take effect July 1, 1986, and shall remain in effect until March 31, [2012] 2013, when upon such date the provisions of this act shall be deemed repealed.

S 36. Subdivision 1 of section 2807-p of the public health law is amended by adding two new paragraphs (c) and (d) to read as follows:

(C) NOTWITHSTANDING PARAGRAPH (A) OF THIS SUBDIVISION, SUBDIVISION FOUR-C OF THIS SECTION OR ANY OTHER INCONSISTENT PROVISION OF THIS SECTION, DISTRIBUTIONS MADE PURSUANT TO THIS SECTION FOR ANNUAL PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE SHALL BE SUBJECT TO A UNIFORM REDUCTION OF TWO PERCENT.

(D) THE COMMISSIONER MAY REQUIRE FACILITIES RECEIVING DISTRIBUTIONS PURSUANT TO THIS SECTION AS A CONDITION OF PARTICIPATING IN SUCH DISTRIBUTIONS, TO PROVIDE REPORTS AND DATA TO THE DEPARTMENT AS THE COMMISSIONER DEEMS NECESSARY TO ADEQUATELY IMPLEMENT THE PROVISIONS OF THIS SECTION.

S 37. Subdivision 6-a 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 major components of legislation necessary to implement the

health and mental hygiene budget for the 2007-2008 fiscal year, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed on [March] DECEMBER 31, [2010] 2013; provided that such section shall not apply to any person as to whom federal financial participation is available for the costs of services provided under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

S 38. 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, 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, [2009] 2011;

S 39. Subdivision (r) of section 427 of chapter 55 of the laws of 1992, amending the tax law and other laws relating to taxes, surcharges, fees and funding, as amended by section 15 of part C of chapter 56 of the laws of 2007, is amended to read as follows:

(r) the provisions of sections two hundred eighty-six through two hundred ninety-one of this act shall apply to all persons released on medical parole prior to September 1, [2009] 2011, and shall expire and be of no further effect on September 1, [2009] 2011;

S 40. Section 3 of chapter 942 of the laws of 1983, relating to foster family care demonstration programs, as amended by chapter 219 of the laws of 2007, is amended to read as follows:

S 3. This act shall take effect immediately and shall expire December 31, [2009] 2013.

S 41. Section 3 of chapter 541 of the laws of 1984, relating to foster family care demonstration programs, as amended by chapter 219 of the laws of 2007, is amended to read as follows:

S 3. This section and subdivision two of section two of this act shall take effect immediately and the remaining provisions of this act shall take effect on the one hundred twentieth day next thereafter. This act shall expire December 31, [2009] 2013.

S 42. Section 6 of chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, as amended by chapter 219 of the laws of 2007, is amended to read as follows:

S 6. This act shall take effect immediately and shall expire December 31, [2009] 2013 and upon such date the provisions of this act shall be deemed to be repealed.

S 43. Section 2 of chapter 693 of the laws of 1996, amending the social services law relating to authorizing patient discharge to hospices and residential health care facilities, under the medical assistance presumptive eligibility program, as amended by chapter 124 of the laws of 2006, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed repealed on July 31, [2009] 2012.

S 44. Section 2 of chapter 631 of the laws of 1997, amending the social services law relating to authorizing medical assistance payments to certain clinics or diagnostic and treatment centers, as amended by chapter 47 of the laws of 2007, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed to apply to claims for reimbursement payments whether submitted before, on

or after the effective date of this act, and shall expire and be deemed repealed July 1, [2009] 2011.

S 45. Section 4 of chapter 519 of the laws of 1999, amending the alcoholic beverage control law and the public health law relating to the sale of alcohol and tobacco products to minors, as amended by chapter 594 of the laws of 2007, is amended to read as follows:

S 4. This act shall take effect September 1, 1999[, and shall remain in full force and effect until January 1, 2010 when upon such date the provisions of this act shall expire and be deemed repealed]; provided, however, the state liquor authority, state department of motor vehicles and state department of health shall promulgate rules and regulations necessary to implement the provisions of this act on or before such date; [provided further that the provisions of this act shall apply after such expiration date to any proceeding pursuant to the alcoholic beverage control law or public health law to invoke or enforce the provisions of this act which were commenced prior to such expiration date;] and provided, further however, that the amendments to section 65-b of the alcoholic beverage control law made by section two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

S 46. The opening paragraph of subdivision 7-a of section 3614 of the public health law, as amended by section 89 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, AND ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

S 47. This act shall take effect immediately; provided, however, that the amendments to section 2807-c of the public health law made by sections sixteen, seventeen, eighteen, and nineteen of this act shall not affect the expiration of such provisions and shall be deemed to expire therewith.

PART C

Section 1. Legislative intent. (a) The legislature finds that New York leads the nation in Medicaid spending per capita and ranks third highest in overall health care spending per capita. Despite this extraordinary level of spending, 2.3 million New Yorkers are uninsured and New York's health care system is ranked average among states and below average on hospitalizations that could have been avoided if patients had timely access to quality outpatient care. It is the intent of this legislation to ensure that New Yorkers have access to a high-performing health system and that New York Medicaid buys quality, cost-effective care by: implementing a transparent and accurate inpatient reimbursement system that rewards quality and efficiency; investing in ambulatory care services and supporting the development of health care homes; supporting providers that serve uninsured patients; increasing affordable coverage in partnership with the federal government; investing in health informa-

tion technology; and more effectively and efficiently managing pharmaceutical benefits.

(b) With respect to improper influences exerted on prescribing decisions and the lack of transparency in the administration of pharmacy benefits by pharmacy benefit managers, the legislature finds that:

i. The pharmaceutical, biological product and medical device industries spend billions of dollars annually to attempt to influence prescribers' decisions about which drugs or other treatment to prescribe to their patients, including more than half of all formal continuing medical education programs. Legislation is necessary to prohibit drug and device manufacturers from making payments to prescribers in an attempt to influence their prescribing decisions and further to require prescribers and manufacturers to disclose the things of value that are legitimately transferred from drug and device manufacturers to prescribers.

ii. There is compelling evidence that the vast majority of physicians accept some type of gift or payment from pharmaceutical and medical device manufacturers, and often such gifts and payments, even when of little value, influence physicians to prescribe treatments that are more expensive and no more effective or safe, and are sometimes less effective and more dangerous, than other available treatments.

iii. Legislation is necessary to prohibit presenters at continuing professional education programs from providing false or misleading information to prescribers and to require all potential conflicts of interest be disclosed to attendees of such programs.

iv. Drug manufacturers, including labelers, make payments to pharmacy benefit managers and their affiliates in an effort to influence the drugs covered by the health plans which contract with the pharmacy benefit manager and, therefore, the drugs purchased by the health plans' participants. Health plans have been unable to obtain from pharmacy benefit managers information about these payments and other information material to a health plan's choice of pharmacy benefit manager and to the health plan's evaluation of the quality and value of the pharmacy benefit services it receives. Legislation is needed to require pharmacy benefit managers to disclose to the health plans that contract with them basic information about their financial dealings that affect the health plans and their participants.

S 1-a. Short title. This act shall be known and may be cited as the "health care improvement act".

S 2. Section 2807-c of the public health law is amended by adding a new subdivision 35 to read as follows:

35. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR GENERAL HOSPITAL INPATIENT SERVICES WITH REGARD TO DISCHARGES OCCURRING ON AND AFTER JULY FIRST, TWO THOUSAND NINE SHALL BE IN ACCORDANCE WITH THE FOLLOWING:

(A) FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE THE OPERATING COST COMPONENT OF SUCH RATES OF PAYMENTS SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS OTHERWISE COMPUTED IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBDIVISION;

(B) THE COMMISSIONER SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING METHODOLOGIES FOR THE COMPUTATION OF GENERAL HOSPITAL INPATIENT RATES AND SUCH REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(I) THE COMPUTATION OF A CASE MIX NEUTRAL STATEWIDE BASE PRICE APPLICABLE TO EACH RATE PERIOD, BUT EXCLUDING ADJUSTMENTS FOR GRADUATE MEDICAL EDUCATION COSTS, HIGH COST OUTLIER COSTS AND COST RELATED TO PATIENT TRANSFERS, AND AS MAY BE PERIODICALLY ADJUSTED TO REFLECT CHANGES IN PROVIDER CODING PATTERNS AND CASE-MIX.

(II) ONLY THOSE TWO THOUSAND FIVE BASE YEAR COSTS WHICH RELATE TO THE COST OF SERVICES PROVIDED TO MEDICAID INPATIENTS, AS DETERMINED BY THE APPLICABLE RATIO OF COSTS TO CHARGES METHODOLOGY, SHALL BE UTILIZED FOR RATE-SETTING AND CASE-MIX PURPOSES;

(III) SUCH RATES SHALL REFLECT THE APPLICATION OF HOSPITAL SPECIFIC WAGE EQUALIZATION FACTORS AND POWER EQUALIZATION FACTORS REFLECTING DIFFERENCES IN WAGE RATES AND UTILITY COSTS;

(IV) SUCH RATES SHALL REFLECT THE UTILIZATION OF THE ALL PATIENT REFINED (APR) CASE MIX METHODOLOGY, UTILIZING DIAGNOSTIC RELATED GROUPS WITH ASSIGNED WEIGHTS THAT INCORPORATE DIFFERING LEVELS OF SEVERITY OF PATIENT CONDITION AND THE ASSOCIATED RISK OF MORTALITY, AND AS MAY BE PERIODICALLY UPDATED BY THE COMMISSIONER;

(V) SUCH REGULATIONS MAY INCORPORATE QUALITY RELATED MEASURES PERTAINING TO POTENTIALLY PREVENTABLE COMPLICATIONS AND RE-ADMISSIONS;

(VI) SUCH REGULATIONS SHALL ADDRESS ADJUSTMENTS BASED ON THE COSTS OF HIGH COST OUTLIER PATIENTS;

(VII) SUCH RATES SHALL CONTINUE TO REFLECT TREND FACTOR ADJUSTMENTS AS OTHERWISE PROVIDED IN PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION;

(VIII) SUCH RATES SHALL NOT INCLUDE ANY ADJUSTMENTS PURSUANT TO SUBDIVISION NINE OF THIS SECTION;

(IX) RATES FOR NON-PUBLIC, NOT-FOR-PROFIT GENERAL HOSPITALS WHICH HAVE NOT, AS OF THE EFFECTIVE DATE OF THIS SUBDIVISION, PUBLISHED AN ANCILLARY CHARGES SCHEDULE AS PROVIDED IN PARAGRAPH (J) OF SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED THREE OF THIS ARTICLE SHALL HAVE THEIR INLIER PAYMENTS INCREASED BY AN AMOUNT EQUAL TO THE STATEWIDE AVERAGE OF COST OUTLIER PAYMENTS AS DETERMINED BY SUCH REGULATIONS;

(X) SUCH REGULATIONS SHALL PROVIDE FOR ADMINISTRATIVE RATE APPEALS, BUT ONLY WITH REGARD TO: (A) THE CORRECTION OF COMPUTATIONAL ERRORS OR OMISSIONS OF DATA, INCLUDING WITH REGARD TO THE HOSPITAL SPECIFIC COMPUTATIONS PERTAINING TO GRADUATE MEDICAL EDUCATION, WAGE EQUALIZATION FACTOR ADJUSTMENTS AND POWER EQUALIZATION FACTOR ADJUSTMENTS, AND (B) CAPITAL COST REIMBURSEMENT;

(XI) RATES FOR TEACHING GENERAL HOSPITALS SHALL INCLUDE REIMBURSEMENT FOR DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION AS DEFINED AND CALCULATED PURSUANT TO SUCH REGULATIONS. IN ADDITION, SUCH REGULATIONS SHALL SPECIFY THE REPORTS AND INFORMATION REQUIRED BY THE COMMISSIONER TO ASSESS THE COST, QUALITY AND HEALTH SYSTEM NEEDS FOR MEDICAL EDUCATION PROVIDED.

(C) THE BASE PERIOD REPORTED COSTS AND STATISTICS USED FOR RATE-SETTING FOR OPERATING COST COMPONENTS, INCLUDING THE WEIGHTS ASSIGNED TO DIAGNOSTIC RELATED GROUPS, SHALL BE UPDATED NO LESS FREQUENTLY THAN EVERY FOUR YEARS AND THE NEW BASE PERIOD SHALL BE NO MORE THAN FOUR YEARS PRIOR TO THE FIRST APPLICABLE RATE PERIOD THAT UTILIZES SUCH NEW BASE PERIOD.

(D) CAPITAL COST REIMBURSEMENT FOR GENERAL HOSPITALS OTHERWISE SUBJECT TO THE PROVISIONS OF THIS SUBDIVISION SHALL REMAIN SUBJECT TO THE PROVISIONS OF SUBDIVISION EIGHT OF THIS SECTION.

(E) THE PROVISIONS OF THIS SUBDIVISION SHALL NOT APPLY TO THOSE GENERAL HOSPITALS OR DISTINCT UNITS OF GENERAL HOSPITALS WHOSE INPATIENT REIMBURSEMENT DOES NOT, AS OF JUNE THIRTIETH, TWO THOUSAND NINE, REFLECT CASE BASED PAYMENT PER DIAGNOSIS-RELATED GROUP OR WHOSE INPATIENT

REIMBURSEMENT IS, FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE, GOVERNED BY THE PROVISIONS OF PARAGRAPHS (E-1) OR (E-2) OF SUBDIVISION FOUR OF THIS SECTION.

(F) NOTWITHSTANDING SECTION ONE HUNDRED TWELVE OR ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW OR ANY OTHER LAW, RULE OR REGULATION TO THE CONTRARY, THE COMMISSIONER MAY CONTRACT WITH A VENDOR FOR CONSIDERATION TO DEVELOP THE SPECIFICATIONS FOR THE DIAGNOSIS-RELATED GROUPS METHODOLOGY AS PROVIDED FOR IN REGULATIONS PROMULGATED PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION IF THE COMMISSIONER CERTIFIES TO THE COMPTROLLER THAT SUCH CONTRACT IS IN THE BEST INTEREST OF THE HEALTH OF THE PEOPLE OF THE STATE. NOTWITHSTANDING THAT SUCH SPECIFICATIONS SHALL BE AVAILABLE PURSUANT TO ARTICLE SIX OF THE PUBLIC OFFICERS LAW, SUCH CONTRACT MAY PROVIDE THAT THE SPECIFICATIONS FOR SUCH ADJUSTED OR ADDITIONAL DIAGNOSIS-RELATED GROUPS PROVIDED BY THE VENDOR SHALL BE SUBJECT TO COPYRIGHT PROTECTION PURSUANT TO FEDERAL COPYRIGHT LAW.

(G) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER MAY, FOR RATE PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, MAKE ADDITIONAL ADJUSTMENTS TO THE INPATIENT RATES OF PAYMENT OF ELIGIBLE GENERAL HOSPITALS, TO FACILITATE IMPROVEMENTS IN HOSPITAL OPERATIONS AND FINANCES, IN ACCORDANCE WITH THE FOLLOWING:

(I) GENERAL HOSPITALS ELIGIBLE FOR DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH SHALL BE THOSE NON-PUBLIC HOSPITALS WHICH, AS DETERMINED BY THE COMMISSIONER, EXPERIENCE A REDUCTION IN THEIR MEDICAID INPATIENT REVENUE OF A PERCENTAGE AS DETERMINED BY THE COMMISSIONER, AS A RESULT OF THE APPLICATION OF THE PROVISIONS OF PARAGRAPHS (A) AND (B) OF THIS SUBDIVISION.

(II) FUNDS DISTRIBUTED PURSUANT TO THIS PARAGRAPH SHALL BE ALLOCATED BASED ON EACH ELIGIBLE FACILITY'S RELATIVE NEED AS DETERMINED BY THE COMMISSIONER.

(III) FUNDING PURSUANT TO THIS PARAGRAPH SHALL BE AVAILABLE FOR THE FOLLOWING PERIODS AND IN THE FOLLOWING AMOUNTS:

(A) FOR THE PERIOD JULY FIRST, TWO THOUSAND NINE THROUGH JUNE THIRTIETH, TWO THOUSAND TEN, UP TO SEVENTY-FIVE MILLION DOLLARS;

(B) FOR THE PERIOD JULY FIRST, TWO THOUSAND TEN THROUGH JUNE THIRTIETH, TWO THOUSAND ELEVEN, UP TO SEVENTY-FIVE MILLION DOLLARS;

(C) FOR THE PERIOD JULY FIRST, TWO THOUSAND ELEVEN THROUGH JUNE THIRTIETH, TWO THOUSAND TWELVE, UP TO FIFTY MILLION DOLLARS;

(D) FOR THE PERIOD JULY FIRST, TWO THOUSAND TWELVE THROUGH JUNE THIRTIETH, TWO THOUSAND THIRTEEN, UP TO TWENTY-FIVE MILLION DOLLARS.

(IV) PAYMENTS MADE PURSUANT TO THIS PARAGRAPH SHALL NOT BE SUBJECT TO RETROACTIVE ADJUSTMENT OR RECONCILIATION AND MAY BE ADDED TO RATES OF PAYMENT OR MADE AS LUMP SUM PAYMENTS.

(V) EACH HOSPITAL RECEIVING FUNDS PURSUANT TO THIS PARAGRAPH SHALL, AS A CONDITION FOR ELIGIBILITY FOR SUCH FUNDS, ADOPT A RESOLUTION OF THE BOARD OF DIRECTORS OF EACH SUCH HOSPITAL SETTING FORTH ITS CURRENT FINANCIAL CONDITION AND A PLAN FOR REFORMING AND IMPROVING SUCH FINANCIAL CONDITION, INCLUDING ONGOING BOARD OVERSIGHT, AND SHALL, AFTER TWO YEARS, ISSUE A REPORT AS ADOPTED BY EACH SUCH BOARD OF DIRECTORS SETTING FORTH WHAT PROGRESS HAS BEEN ACHIEVED REGARDING SUCH IMPROVEMENT, PROVIDED, HOWEVER, IF SUCH REPORT IS NOT ISSUED AND ADOPTED BY EACH SUCH BOARD OF DIRECTORS, OR IF SUCH REPORT FAILS TO SET FORTH ADEQUATE PROGRESS, AS DETERMINED BY THE COMMISSIONER, THE COMMISSIONER MAY DEEM SUCH FACILITY INELIGIBLE FOR FURTHER DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH AND MAY REDISTRIBUTE SUCH FURTHER DISTRIBUTIONS TO OTHER

ELIGIBLE FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF THIS PARAGRAPH. THE COMMISSIONER SHALL BE PROVIDED WITH COPIES OF ALL SUCH RESOLUTIONS AND REPORTS.

(H) INPATIENT RATE ADJUSTMENTS MADE PURSUANT TO PARAGRAPHS (A) THROUGH (F) OF THIS SUBDIVISION AFTER APPLICATION OF ADJUSTMENTS AUTHORIZED PURSUANT TO SUBDIVISION THIRTY-THREE OF THIS SECTION SHALL RESULT IN A NET STATEWIDE DECREASE IN AGGREGATE MEDICAID PAYMENTS OF NO LESS THAN ONE HUNDRED SIXTY-EIGHT MILLION DOLLARS FOR THE PERIOD JULY FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN, AND NO LESS THAN TWO HUNDRED TWENTY-FIVE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN.

S 3. Notwithstanding any contrary provision of law, if the commissioner of health determines that federal financial participation will not be available with regard to the provisions of subparagraph (ii) of paragraph (g) of subdivision 35 of section 2807-c of the public health law, such commissioner may deem such provision null and void and instead may allocate funds pursuant to such paragraph (g) proportionally, based on each eligible facility's relative share of Medicaid inpatient discharges in the year two years prior to the distribution year.

S 4. Clause (A) of subparagraph (i) of paragraph (a) of subdivision 30 of section 2807-c of the public health law, as amended by section 22-b of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(A) ninety-three million two hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; one hundred eighty-seven million eight hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; two hundred sixty-two million one hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; one hundred thirty-one million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and two hundred forty-three million five hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, two hundred forty-three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine; [two hundred forty-three] SIXTY million [five] EIGHT hundred SEVENTY-FIVE thousand dollars for the period April first, two thousand nine through [March thirty-first] JUNE THIRTIETH, two thousand [ten] NINE[; two hundred forty-three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven].

S 5. Clause (A) of subparagraph (i) of paragraph (b) of subdivision 30 of section 2807-c of the public health law, as amended by section 22-b of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(A) eighteen million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; twenty-six million one hundred thousand dollars for the period January first, two thousand seven through June

thirtieth, two thousand seven[;], forty-nine million dollars for the period July first, two thousand seven through March thirty-first, two thousand eight[;], AND forty-nine million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine[; forty-nine million dollars for the period April first, two thousand nine through March thirty-first, two thousand ten; and forty-nine million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven].

S 6. Paragraphs (x) and (y) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

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

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

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

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

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

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

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

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

(viii) [fifty-three] TWENTY-SIX million [one] FIVE hundred [fifty] SEVENTY-FIVE thousand dollars for the period January first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine[;

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

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

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

control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

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

(viii) [forty-nine] TWELVE million TWO HUNDRED FIFTY THOUSAND dollars for the period January first, two thousand nine through [December] MARCH thirty-first, two thousand nine[;

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

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

Provided, however, amounts pursuant to this paragraph may be reduced in an amount to be approved by the director of the budget to reflect amounts received from the federal government under the state's 1115 waiver which are directed under its terms and conditions to the health workforce recruitment and retention program.

S 7. Paragraphs (ggg) and (hhh) of subdivision 1 of section 2807-v of the public health law, as added by section 5 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

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

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

(ii) [sixteen] EIGHT million dollars for the period January first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine[;

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

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

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

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

(ii) [two] ONE million [five] TWO hundred FIFTY thousand dollars for the period January first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine[;

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

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

S 8. Paragraph (s) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

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

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

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

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

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

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

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

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

(ix) up to [twenty-four] TWELVE million dollars for the period January first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine[;

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

(xi) up to six million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven].

S 9. Paragraph (n) of subdivision 1 of section 2807-l of the public health law, as amended by section 4 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

S 10. Paragraph (xx) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

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

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

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

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

(v) [three] ONE million [five hundred] SEVEN HUNDRED FIFTY thousand dollars for the period January first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine[;

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

(vii) eight hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(viii) provided, however, in the event federal financial participation is not available with regard to rate adjustments pursuant to subdivision thirty-two of section twenty-eight hundred seven-c of this article, allocations pursuant to this paragraph shall, on an annualized basis be

increased to seven million dollars for the period January first, two thousand five through March thirty-first, two thousand eleven].

S 11. Paragraph (l) of subdivision 4 of section 2807-c of the public health law, as added by section 15 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(l) Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospitals which are certified by the office of alcoholism and substance abuse services to provide inpatient detoxification and withdrawal services and, with regard to inpatient services provided to patients discharged on and after December first, two thousand eight and who are determined to be in diagnosis-related groups numbered seven hundred forty-three, seven hundred forty-four, seven hundred forty-five, seven hundred forty-six, seven hundred forty-seven, seven hundred forty-eight, seven hundred forty-nine, seven hundred fifty, or seven hundred fifty-one, shall be made on a per diem basis in accordance with the following:

(i) for the period December first, two thousand eight through [December thirty-first] FEBRUARY TWENTY-EIGHTH, two thousand nine, seventy-five percent of the operating cost component of such rates of payments shall reflect the operating cost component of rates of payment effective for December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and twenty-five percent of such rates shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph [(v)] (III) of this paragraph;

(ii) [for the period January first, two thousand ten through December thirty-first, two thousand ten, fifty percent of the operating cost component of such rates of payment shall reflect the operating cost component of rates of payment effective December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and fifty percent of such rates of payment shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (v) of this paragraph;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of the operating cost component of such rates of payment shall reflect the operating cost component of rates of payment effective December thirty-first, two thousand seven, as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statutes, and seventy-five percent of such rates of payment shall reflect the use of two thousand six operating costs as reported by each facility to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph (v) of this paragraph; and

(iv)] for periods on and after [January] MARCH first, two thousand [twelve] NINE, one hundred percent of the operating cost component of such rates of payment shall reflect the use of two thousand six operating costs as reported to the department prior to two thousand eight and as computed in accordance with the provisions of subparagraph [(v)] (III) of this paragraph.

[(v)] (III) rates of payment computed in accordance with this paragraph and reflecting the use of two thousand six base year operating costs shall be in accord with the following, provided, however that the commissioner may establish criteria under which reimbursement may be provided at higher percentages and for longer periods.

(A) For each of the regions within the state as described in clause (E) of this subparagraph the commissioner shall determine the average per diem cost incurred by general hospitals in that region subject to the provisions of this paragraph with regard to inpatients requiring medically managed detoxification services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services. In determining such costs the commissioner shall utilize two thousand six costs and statistics as reported by such hospitals to the department prior to two thousand eight.

(B) Per diem payments for inpatients requiring medically managed inpatient detoxification services shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located and as trended forward to adjust for inflation, provided however, that such payments shall be reduced by fifty percent for any such services provided on or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on or after the eleventh day.

(C) Per diem payments for inpatients requiring medically supervised withdrawal services, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall reflect one hundred percent of the per diem amounts computed pursuant to clause (A) of this subparagraph for the applicable region in which the facility is located for the period January first, two thousand nine through December thirty-first, two thousand nine, and as trended forward to adjust for inflation, and shall reflect seventy-five percent of such per diem amounts for periods on and after January first, two thousand ten, as trended forward to adjust for inflation, provided, however, that such payments shall be reduced by fifty percent for any services provided on or after the sixth day of services through the tenth day of services, and further provided that no payments shall be made for any services provided on and after the eleventh day.

(D) Per diem payments for inpatients placed in observation beds, as defined by applicable regulations promulgated by the office of alcoholism and substance abuse services, shall be at the same level as would be paid pursuant to clause (A) of this [paragraph] SUBPARAGRAPH, provided, however, that such payments shall not apply for more than two days of care, after which payments for such inpatients shall reflect their designation as requiring either medically managed detoxification services or medically supervised withdrawal services, and further provided that days of care provided in such observation beds shall, for reimbursement purposes, be fully reflected in the computation of the initial five days of care as set forth in clauses (A) and (B) of this [paragraph] SUBPARAGRAPH.

(E) For the purposes of this paragraph, the regions of the state shall be as follows:

(I) New York city, consisting of the counties of Bronx, New York, Kings, Queens and Richmond;

(II) Long Island, consisting of the counties of Nassau and Suffolk;

(III) Northern metropolitan, consisting of the counties of Columbia, Delaware, Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester;

(IV) Northeast, consisting of the counties of Albany, Clinton, Essex, Fulton, Greene, Hamilton, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington;

(V) Utica/Watertown, consisting of the counties of Franklin, Herkimer, Lewis, Oswego, Otsego, St. Lawrence, Jefferson, Chenango, Madison and Oneida;

(VI) Central, consisting of the counties of Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Seneca, Steuben, Tioga and Tompkins;

(VII) Rochester, consisting of Monroe, Ontario, Livingston, Wayne and Yates; AND

(VIII) Western, consisting of the counties of Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming.

(F) Capital cost reimbursement for general hospitals otherwise subject to the provisions of this paragraph shall remain subject to the provisions of subdivision eight of this section.

S 12. Subdivision 4 of section 2807-c of the public health law is amended by adding a new paragraph (e-1) to read as follows:

(E-1) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF PARAGRAPH (E) OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, PER DIEM RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR A GENERAL HOSPITAL OR A DISTINCT UNIT OF A GENERAL HOSPITAL FOR INPATIENT PSYCHIATRIC SERVICES THAT WOULD OTHERWISE BE SUBJECT TO THE PROVISIONS OF PARAGRAPH (E) OF THIS SUBDIVISION, AND RATES OF PAYMENT FOR OUTPATIENT PSYCHIATRIC SERVICES PROVIDED BY SUCH FACILITIES AS SPECIFIED IN THIS PARAGRAPH, SHALL, WITH REGARD TO DAYS OF SERVICE AND VISITS OCCURRING ON AND AFTER JULY FIRST, TWO THOUSAND NINE, BE IN ACCORDANCE WITH THE FOLLOWING:

(I) FOR THE PERIOD JULY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE, THE OPERATING COST COMPONENT OF SUCH INPATIENT RATES SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUE, PROVIDED, HOWEVER, THAT SUCH TWO THOUSAND FIVE REPORTED OPERATING COSTS, SHALL, FOR INPATIENT RATE-SETTING PURPOSES, BE HELD TO A CEILING OF ONE HUNDRED TEN PERCENT OF THE AVERAGE OF SUCH REPORTED INPATIENT COSTS BY SUCH FACILITIES IN THE REGION IN WHICH THE FACILITY IS LOCATED, AS DETERMINED PURSUANT TO CLAUSE (E) OF SUBPARAGRAPH (III) OF PARAGRAPH (L) OF THIS SUBDIVISION.

(II) FOR RATE PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN, THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING METHODOLOGIES FOR DETERMINING THE OPERATING COST COMPONENTS OF RATES OF PAYMENTS FOR SERVICES DESCRIBED IN THIS PARAGRAPH. SUCH REGULATIONS SHALL UTILIZE TWO THOUSAND FIVE OPERATING COSTS AS SUBMITTED TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND SHALL PROVIDE FOR METHODOLOGIES ESTABLISHING PER DIEM INPATIENT RATES THAT UTILIZE CASE MIX ADJUSTMENT MECHANISMS AND PROVIDE FOR POST-DISCHARGE REFERRAL TO OUTPATIENT SERVICES. SUCH REGULATIONS SHALL CONTAIN CRITERIA FOR ADJUSTMENTS BASED ON LENGTH OF STAY. SUCH REGULATIONS SHALL ALSO ESTABLISH OUTPATIENT RATES OF PAYMENT FOR THE EVALUATION OF POTENTIAL INPATIENT PSYCHIATRIC PATIENTS AND THE PRE-AD-

MISSION REFERRAL OF SUCH PATIENTS, WHEN APPROPRIATE, TO OUTPATIENT SERVICES.

(III) RATES OF PAYMENT ESTABLISHED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH SHALL REFLECT AN AGGREGATE NET STATEWIDE INCREASE IN REIMBURSEMENT FOR SUCH SERVICES OF UP TO THIRTY-FOUR MILLION DOLLARS ON AN ANNUAL BASIS.

(IV) CAPITAL COST REIMBURSEMENT FOR GENERAL HOSPITALS OTHERWISE SUBJECT TO THE PROVISIONS OF THIS PARAGRAPH SHALL REMAIN SUBJECT TO THE PROVISIONS OF SUBDIVISION EIGHT OF THIS SECTION.

S 13. Subdivision 4 of section 2807-c of the public health law is amended by adding a new paragraph (e-2) to read as follows:

(E-2) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF PARAGRAPH (E) OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, PER DIEM RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR INPATIENT SERVICES PROVIDED BY A GENERAL HOSPITAL OR A DISTINCT UNIT OF A GENERAL HOSPITAL FOR SERVICES, AS DESCRIBED BELOW, THAT WOULD OTHERWISE BE SUBJECT TO THE PROVISIONS OF PARAGRAPH (E) OF THIS SUBDIVISION, SHALL, WITH REGARD TO DAYS OF SERVICE OCCURRING ON AND AFTER JULY FIRST, TWO THOUSAND NINE, BE IN ACCORD WITH THE FOLLOWING:

(I) FOR PHYSICAL MEDICAL REHABILITATION SERVICES AND FOR CHEMICAL DEPENDENCY REHABILITATION SERVICES, THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS FOR EACH RESPECTIVE CATEGORY OF SERVICES AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTE, PROVIDED, HOWEVER, THAT SUCH TWO THOUSAND FIVE REPORTED OPERATING COSTS SHALL, FOR RATE-SETTING PURPOSES, BE HELD TO A CEILING OF ONE HUNDRED TEN PERCENT OF THE AVERAGE OF SUCH REPORTED COSTS IN THE REGION IN WHICH THE FACILITY IS LOCATED, AS DETERMINED PURSUANT TO CLAUSE (E) OF SUBPARAGRAPH (III) OF PARAGRAPH (1) OF THIS SUBDIVISION.

(II) FOR SERVICES PROVIDED BY RURAL HOSPITALS DESIGNATED AS CRITICAL ACCESS HOSPITALS IN ACCORDANCE WITH TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTES, PROVIDED, HOWEVER, THAT SUCH TWO THOUSAND FIVE REPORTED OPERATING COSTS SHALL, FOR RATE-SETTING PURPOSES, BE HELD TO A CEILING OF ONE HUNDRED TEN PERCENT OF THE AVERAGE OF SUCH REPORTED COSTS FOR ALL SUCH DESIGNATED HOSPITALS STATEWIDE.

(III) FOR INPATIENT SERVICES PROVIDED BY SPECIALTY LONG TERM ACUTE CARE HOSPITALS AND FOR INPATIENT SERVICES PROVIDED BY CANCER HOSPITALS AS SO DESIGNATED AS OF DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS FOR EACH RESPECTIVE CATEGORY OF FACILITY AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTES.

(IV) FOR FACILITIES DESIGNATED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES AS EXEMPT ACUTE CARE CHILDREN'S HOSPITALS, FOR WHICH A DISCRETE INSTITUTIONAL COST REPORT WAS FILED FOR THE TWO THOUSAND SIX CALENDAR YEAR, AND WHICH HAS REPORTED MEDICAID DISCHARGES GREATER THAN

FIFTY PERCENT OF TOTAL DISCHARGES IN SUCH COST REPORT, THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND SIX OPERATING COSTS AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTES, AND AS DETERMINED ON A PER CASE BASIS OR PER DIEM BASIS, AS SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER.

(V) RATES ESTABLISHED PURSUANT TO THIS PARAGRAPH SHALL BE DEEMED AS EXCLUDING REIMBURSEMENT FOR PHYSICIAN SERVICES FOR INPATIENT SERVICES AND CLAIMS FOR MEDICAID FEE PAYMENTS FOR SUCH PHYSICIAN SERVICES FOR SUCH INPATIENT CARE MAY BE SUBMITTED SEPARATELY FROM THE RATE IN ACCORDANCE WITH OTHERWISE APPLICABLE LAW.

(VI) CAPITAL COST REIMBURSEMENT FOR GENERAL HOSPITALS OTHERWISE SUBJECT TO THE PROVISIONS OF THIS PARAGRAPH SHALL REMAIN SUBJECT TO THE PROVISIONS OF SUBDIVISION EIGHT OF THIS SECTION.

(VII) THE COMMISSIONER MAY PROMULGATE REGULATIONS, INCLUDING EMERGENCY REGULATIONS, IMPLEMENTING THE PROVISIONS OF THIS PARAGRAPH.

(VIII) THE OPERATING COST COMPONENT OF RATES OF PAYMENT PURSUANT TO THIS PARAGRAPH FOR A GENERAL HOSPITAL OR DISTINCT UNIT OF A GENERAL HOSPITAL WITHOUT ADEQUATE COST EXPERIENCE SHALL BE BASED ON THE LOWER OF THE FACILITY'S OR UNIT'S INPATIENT BUDGETED OPERATING COSTS PER DAY, ADJUSTED TO ACTUAL, OR THE APPLICABLE REGIONAL CEILING, IF ANY.

S 14. Paragraphs (a) and (b) of subdivision 2-a of section 2807 of the public health law, as added by section 18 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(a)(i) for the period December first, two thousand eight through [December thirty-first] JUNE THIRTIETH, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period [January] JULY first, two thousand [ten] NINE through [December thirty-first] JUNE THIRTIETH, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period [January] JULY first, two thousand [eleven] TEN through [December thirty-first] JUNE THIRTIETH, two thousand eleven, twenty-five percent of such rates shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility for the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the

utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after [January] JULY first, two thousand [twelve] ELEVEN, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(v) This paragraph shall be effective the later of: (i) December first, two thousand eight, or (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate methodology established pursuant to subparagraph (i) of paragraph (a) of subdivision thirty-three of section twenty-eight hundred seven-c of this article.

(b)(i) for the period March first, two thousand nine through [December thirty-first] JUNE THIRTIETH, two thousand nine, seventy-five percent of such rates of payment for services provided by each diagnostic and treatment center and each free-standing ambulatory surgery center shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period [January] JULY first, two thousand [ten] NINE through [December thirty-first] JUNE THIRTIETH, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period [January] JULY first, two thousand [eleven] TEN through [December thirty-first] JUNE THIRTIETH, two thousand eleven, twenty-five percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after [January] JULY first, two thousand [twelve] ELEVEN, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

S 15. Paragraph (e) subdivision 2-a of section 2807 of the public health law, as added by section 18 of part C of chapter 58 of the laws 2008, is amended to read as follows:

(e) (I) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodol-

ogies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

IF THE COMMISSIONER DETERMINES THAT THE USE OF THE APG METHODOLOGY IS NOT, OR IS NOT YET, APPROPRIATE OR PRACTICAL FOR SPECIFIED SERVICES, THE COMMISSIONER MAY UTILIZE EXISTING PAYMENT METHODOLOGIES FOR SUCH SERVICES OR MAY PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING ALTERNATIVE PAYMENT METHODOLOGIES FOR SUCH SERVICES.

(II) NOTWITHSTANDING THIS SUBDIVISION AND ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER MAY INCORPORATE WITHIN THE PAYMENT METHODOLOGY DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH PAYMENT FOR SERVICES PROVIDED BY FACILITIES PURSUANT TO LICENSURE UNDER THE MENTAL HYGIENE LAW, PROVIDED, HOWEVER, THAT SUCH APG PAYMENT METHODOLOGY MAY BE PHASED INTO EFFECT IN ACCORDANCE WITH A SCHEDULE OR SCHEDULES AS JOINTLY DETERMINED BY THE COMMISSIONER, THE COMMISSIONER OF MENTAL HEALTH, THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AND THE COMMISSIONER OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES.

S 16. Paragraph (i) of subdivision 2-a of section 2807 of the public health law, as added by section 19 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, SUCH AMOUNTS MAY BE ADJUSTED TO REFLECT PROJECTED DECREASES IN FEE-FOR-SERVICE MEDICAID UTILIZATION AND CHANGES IN CASE-MIX WITH REGARD TO SUCH SERVICES FROM THE TWO THOUSAND SEVEN CALENDAR YEAR TO THE APPLICABLE RATE YEAR, AND PROVIDED FURTHER, HOWEVER, THAT FUNDS MADE AVAILABLE AS A RESULT OF ANY SUCH DECREASES MAY BE UTILIZED BY THE COMMISSIONER TO INCREASE CAPITATION RATES PAID TO MEDICAID MANAGED CARE PLANS AND FAMILY HEALTH PLUS PLANS TO COVER INCREASED PAYMENTS TO HEALTH CARE PROVIDERS FOR AMBULATORY CARE SERVICES AND TO INCREASE SUCH OTHER AMBULATORY CARE PAYMENT RATES AS THE COMMISSIONER DETERMINES NECESSARY TO FACILITATE ACCESS TO QUALITY AMBULATORY CARE SERVICES.

S 16-a. Subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the public health law, as added by section 18 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with

rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY UTILIZE EXISTING PAYMENT METHODOLOGIES OR MAY PROMULGATE REGULATIONS ESTABLISHING ALTERNATIVE PAYMENT METHODOLOGIES FOR ONE OR MORE OF THE SERVICES SPECIFIED IN CLAUSES (C) AND (D) OF THIS SUBPARAGRAPH, EFFECTIVE FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE:

(A) services provided in accordance with the provisions of paragraphs (q) and (r) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, to persons under the age of nineteen and to persons requiring such services as a result of or related to pregnancy or giving birth[.]; AND

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven[.]; AND

(E) SERVICES PROVIDED TO PREGNANT WOMEN PURSUANT TO PARAGRAPH (S) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW AND, FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN, ALL OTHER SERVICES PROVIDED PURSUANT TO SUCH PARAGRAPH (S) AND SERVICES PROVIDED PURSUANT TO PARAGRAPH (T) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW.

S 17. Notwithstanding any contrary provision of law, except section 43.02 of the mental hygiene law, subject to availability of federal financial participation, and within amounts appropriated therefore, commencing on or after October 1, 2009 the commissioners of mental health and health are jointly authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology, for clinic services rendered by providers pursuant to their licensure under article 31 of the mental hygiene law.

S 18. The commissioners of mental health and health, subject to the approval of the state director of the budget, are jointly authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology for determining rates of payment for outpatient clinic services rendered pursuant to providers' licensure under article 31 of the mental hygiene law. The commissioner of mental health, subject to the approval of the commissioner of health and the director of the budget, shall promulgate regulations pursuant to article 31 of the mental hygiene law which shall reflect utilization of the Ambulatory Patient Group (APG) methodology, as described in subdivision 2-a of section 2807 of the public health law, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to

establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

S 19. Notwithstanding any contrary provision of law, and within amounts appropriated, commencing October 1, 2009, the commissioners of mental health and health are jointly authorized to expand programs including but not limited to the home-based crisis intervention program and critical time intervention programs to reduce utilization of inpatient hospital services.

S 20. Notwithstanding any contrary provision of law, and subject to federal financial participation under Title XIX of the Social Security Act, and within amounts appropriated therefore, commencing on or after October 1, 2009, the commissioners of health and mental retardation and developmental disabilities are jointly authorized to implement the Ambulatory Patient Group (APG) reimbursement methodology, for clinic services rendered by providers pursuant to their licensure under article 16 of the mental hygiene law.

S 21. The commissioners of mental retardation and developmental disabilities, and health, subject to the approval of the state director of the budget, are jointly authorized to implement the Ambulatory Patient Group (APG) reimbursement methodology for determining rates of payment for clinic services rendered pursuant to providers' licensure under article 16 of the mental hygiene law. The commissioner of mental retardation and developmental disabilities, subject to the approval of the commissioner of health and director of the budget, shall promulgate regulations pursuant to article 16 of the mental hygiene law which shall reflect utilization of the Ambulatory Patient Group (APG) methodology, as described in subdivision 2-a of section 2807 of the public health law, in which patients are grouped based on their diagnosis, the intensity of the services provided and the procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

S 22. Notwithstanding any contrary provision of law, subject to federal financial participation under Title XIX of the Social Security Act, and within amounts appropriated therefore, commencing on or after October 1, 2009 the commissioners of health, and alcoholism and substance abuse services are authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology for clinic services rendered pursuant to providers' operating certificates under article 32 of the mental hygiene law.

S 23. The commissioners of alcoholism and substance abuse services, and health, subject to the approval of the state director of the budget, are jointly authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology for determining rates of payment for outpatient clinic services rendered pursuant to providers' operating certificates under article 32 of the mental hygiene law. The commissioner of alcoholism and substance abuse services, subject to the approval of the commissioner of health and the director of the budget, shall promulgate regulations pursuant to article 32 of the mental hygiene law which shall reflect utilization of the Ambulatory Patient Group (APG) methodology, as described in subdivision 2-a of section 2807 of the public health law, in which patients are grouped based on their diagnosis, the intensity of the services provided and the

procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

S 23-a. Notwithstanding any contrary provision of law, and within amounts appropriated, commencing April 1, 2009 the commissioners of alcoholism and substance abuse services, and health are jointly authorized to increase medical assistance fees for medically supervised withdrawal services.

S 24. Intentionally omitted.

S 25. The social services law is amended by adding a new section 364-m to read as follows:

S 364-M. STATEWIDE HEALTH CARE HOME PROGRAM. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO CERTIFY CERTAIN CLINICIANS AND CLINICS AS HEALTH CARE HOMES IN ORDER TO IMPROVE HEALTH OUTCOMES AND EFFICIENCY THROUGH PATIENT CARE CONTINUITY AND COORDINATION OF HEALTH SERVICES. THESE PROVIDERS WILL BE ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THIS TITLE ("MEDICAID FEE-FOR-SERVICE"); ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUCH TITLE AND ENROLLED IN APPROVED MANAGED CARE ORGANIZATIONS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE ("MEDICAID MANAGED CARE"); ENROLLEES ELIGIBLE FOR FAMILY HEALTH PLUS AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ELEVEN-D OF THIS ARTICLE ("FAMILY HEALTH PLUS"); AND ENROLLEES ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW ("CHILD HEALTH PLUS PROGRAM").

2. BY OCTOBER FIRST, TWO THOUSAND NINE, THE COMMISSIONER OF HEALTH SHALL DEVELOP AND IMPLEMENT STANDARDS OF CERTIFICATION FOR HEALTH CARE HOMES FOR MEDICAID FEE-FOR-SERVICE AND MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS PROGRAMS. IN DEVELOPING SUCH STANDARDS, THE COMMISSIONER OF HEALTH SHALL: (A) CONSIDER EXISTING STANDARDS DEVELOPED BY NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS; AND (B) CONSULT WITH NATIONAL AND LOCAL ORGANIZATIONS WORKING ON MEDICAL HOME MODELS, PHYSICIANS, HOSPITALS, CLINICS, HEALTH PLANS AND CONSUMERS AND THEIR REPRESENTATIVES.

3. TO MAINTAIN THEIR CERTIFICATION, HEALTH CARE HOMES MUST: (A) RENEW THEIR CERTIFICATION AT A FREQUENCY DETERMINED BY THE COMMISSIONER OF HEALTH; AND (B) PROVIDE DATA TO THE DEPARTMENT OF HEALTH AND TO HEALTH PLANS TO PERMIT THE COMMISSIONER OF HEALTH, OR HIS OR HER CONTRACTOR OR DESIGNEE, TO EVALUATE THE IMPACT OF HEALTH CARE HOMES ON QUALITY, OUTCOMES AND COST.

4. SUBJECT TO THE AVAILABILITY OF FUNDING AND FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER OF HEALTH IS AUTHORIZED:

(A) TO PAY ENHANCED RATES OF PAYMENT TO CLINICS AND CLINICIANS THAT ARE CERTIFIED AS HEALTH CARE HOMES UNDER THIS SECTION. SUCH ENHANCEMENTS MAY BE TIERED BASED ON THE LEVEL OF STANDARD ACHIEVED BY THE CLINICIAN OR CLINIC; AND

(B) TO PAY ADDITIONAL AMOUNTS FOR HEALTH CARE HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER OF HEALTH.

5. BY DECEMBER THIRTY-FIRST, TWO THOUSAND TWELVE, THE COMMISSIONER OF HEALTH SHALL REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE IMPACT OF THE STATEWIDE HEALTH CARE HOME PROGRAM ON QUALITY, COST AND OUTCOMES FOR

ENROLLEES IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS.

S 26. Sections 2950 through 2958 of article 29-A of the public health law are designated title 1 and a new title heading is added to read as follows:

RURAL HEALTH CARE ACCESS

S 26-a. Article 29-A of the public health law is amended by adding a new title 2 to read as follows:

TITLE 2

ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM

SECTION 2959. ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM.

S 2959. ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH AN ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM FOR THE PURPOSE OF CERTIFYING CERTAIN CLINICIANS AND CLINICS IN THE UPPER NORTHEASTERN REGION OF NEW YORK AS HEALTH CARE HOMES ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW ("MEDICAID FEE-FOR-SERVICE"); ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUCH TITLE AND ENROLLED IN APPROVED MANAGED CARE ORGANIZATIONS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF SUCH TITLE ("MEDICAID MANAGED CARE"); ENROLLEES ELIGIBLE FOR FAMILY HEALTH PLUS AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW ("FAMILY HEALTH PLUS"); ENROLLEES ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER ("CHILD HEALTH PLUS PROGRAM"); ENROLLEES AND SUBSCRIBERS OF COMMERCIAL MANAGED CARE PLANS OPERATING IN ACCORDANCE WITH THE PROVISIONS OF ARTICLE FORTY-FOUR OF THIS CHAPTER OR BY HEALTH MAINTENANCE ORGANIZATIONS ORGANIZED AND OPERATING IN ACCORDANCE WITH ARTICLE FORTY-THREE OF THE INSURANCE LAW; ENROLLEES AND SUBSCRIBERS OF OTHER COMMERCIAL INSURANCE PRODUCTS; AND EMPLOYEES OF EMPLOYER-SPONSORED SELF-INSURED PLANS. THE PURPOSE OF THIS DEMONSTRATION PROGRAM IS TO IMPROVE HEALTH CARE OUTCOMES AND EFFICIENCY THROUGH PATIENT CARE CONTINUITY AND COORDINATION OF HEALTH SERVICES.

2. (A) IN ORDER TO PROMOTE IMPROVED QUALITY OF, AND ACCESS TO, HEALTH CARE SERVICES AND PROMOTE IMPROVED CLINICAL OUTCOMES TO THE RESIDENTS IN THE UPPER NORTHEASTERN REGION OF NEW YORK, IT SHALL BE THE POLICY OF THE STATE TO ENCOURAGE COOPERATIVE, COLLABORATIVE AND INTEGRATIVE ARRANGEMENTS BETWEEN PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE SERVICES PROVIDERS WHO MIGHT OTHERWISE BE COMPETITORS, UNDER THE ACTIVE SUPERVISION OF THE COMMISSIONER. TO THE EXTENT SUCH ARRANGEMENTS MIGHT BE ANTI-COMPETITIVE WITHIN THE MEANING AND INTENT OF THE FEDERAL ANTITRUST LAWS, THE INTENT OF THE STATE IS TO SUPPLANT COMPETITION WITH SUCH ARRANGEMENT TO THE EXTENT NECESSARY TO ACCOMPLISH THE PURPOSES OF THIS ARTICLE, AND PROVIDE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS WITH RESPECT TO THE PLANNING, IMPLEMENTATION AND OPERATION OF THE ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM AND PAYORS OF HEALTH CARE SERVICES AND HEALTH CARE SERVICES PROVIDERS.

(B) THE COMMISSIONER OR HIS OR HER DULY AUTHORIZED REPRESENTATIVE MAY ALSO ENGAGE IN APPROPRIATE STATE SUPERVISION NECESSARY TO PROMOTE STATE ACTION IMMUNITY UNDER THE STATE AND FEDERAL ANTITRUST LAWS, AND MAY INSPECT OR REQUEST ADDITIONAL DOCUMENTATION TO VERIFY THAT THE DEMONSTRATION IS IMPLEMENTED IN ACCORDANCE WITH ITS INTENT AND PURPOSE.

3. THE COMMISSIONER IS AUTHORIZED TO PARTICIPATE IN, ACTIVELY SUPERVISE, FACILITATE AND APPROVE A PRIMARY CARE HEALTH CARE HOME COLLABORATIVE WITH HEALTH CARE SERVICES PROVIDERS, WHICH MAY INCLUDE HOSPITALS, DIAGNOSTIC AND TREATMENT CENTERS, AND PRIVATE PRACTICES, AND PAYORS OF HEALTH CARE SERVICES, INCLUDING EMPLOYERS, HEALTH PLANS AND INSURERS, TO ESTABLISH: (A) THE BOUNDARIES OF THE DEMONSTRATION AND THE PROVIDERS ELIGIBLE TO PARTICIPATE; (B) PRACTICE STANDARDS FOR THE HEALTH CARE HOME CONSISTENT WITH EXISTING STANDARDS DEVELOPED BY NATIONAL ACCREDITING AND PROFESSIONAL ORGANIZATIONS INCLUDING THE JOINT PRINCIPLES OF THE AMERICAN COLLEGE OF PHYSICIANS ("ACP"), THE AMERICAN ACADEMY OF FAMILY PHYSICIANS ("AAFP"), THE AMERICAN ACADEMY OF PEDIATRICS ("AAP"), THE AMERICAN OSTEOPATHIC ASSOCIATION ("AOA"), AND AS FURTHER DEFINED BY "PATIENT-CENTERED MEDICAL HOME," AS REPRESENTED IN CERTIFICATION PROGRAMS DEVELOPED BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE ("NCQA"); (C) METHODOLOGIES BY WHICH PAYORS WILL PROVIDE ENHANCED RATES OF PAYMENT TO CERTIFIED HEALTH CARE HOMES; AND (D) METHODOLOGIES TO PAY ADDITIONAL AMOUNTS FOR HEALTH CARE HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS ESTABLISHED BY THE ADIRONDACK HEALTH CARE HOME COLLABORATIVE.

4. PATIENT AND HEALTH CARE SERVICES PROVIDER PARTICIPATION IN THE ADIRONDACK HEALTH CARE HOME MULTIPAYOR DEMONSTRATION PROGRAM SHALL BE ON A VOLUNTARY BASIS.

5. CLINICS AND CLINICIANS PARTICIPATING IN THIS DEMONSTRATION ARE NOT ELIGIBLE FOR ADDITIONAL ENHANCEMENTS OR BONUSES UNDER THE STATEWIDE HEALTH CARE HOME PROGRAM, ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-M OF THE SOCIAL SERVICES LAW, FOR SERVICES PROVIDED TO PARTICIPANTS IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS OR CHILD HEALTH PLUS.

6. SUBJECT TO THE AVAILABILITY OF FUNDING AND FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED:

(A) TO PAY ENHANCED RATES OF PAYMENT UNDER MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS TO CLINICS AND CLINICIANS THAT ARE CERTIFIED AS HEALTH CARE HOMES UNDER THIS TITLE; AND

(B) TO PAY ADDITIONAL AMOUNTS FOR HEALTH CARE HOMES THAT MEET SPECIFIC PROCESS OR OUTCOME STANDARDS SPECIFIED BY THE COMMISSIONER, IN CONSULTATION WITH THE ADIRONDACK HEALTH CARE HOME COLLABORATIVE.

S 27. Subdivision 2 of section 365-a of the social services law is amended by adding three new paragraphs (s), (t) and (u) to read as follows:

(S) SMOKING CESSATION COUNSELING SERVICES FOR A PREGNANT WOMAN ON ANY DAY OF HER PREGNANCY THROUGH THE END OF THE MONTH IN WHICH THE ONE HUNDRED EIGHTIETH DAY FOLLOWING THE END OF THE PREGNANCY OCCURS, AND CHILDREN AND ADOLESCENTS TEN TO NINETEEN YEARS OF AGE, DURING A MEDICAL VISIT WHEN PROVIDED BY A GENERAL HOSPITAL OUTPATIENT DEPARTMENT OR A FREE-STANDING CLINIC, OR BY A PHYSICIAN, REGISTERED PHYSICIAN'S ASSISTANT, REGISTERED NURSE PRACTITIONER OR LICENSED MIDWIFE IN OFFICE-BASED SETTINGS; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO SMOKING CESSATION COUNSELING SERVICES SHALL NOT TAKE EFFECT UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH SERVICES.

(T) CARDIAC REHABILITATION SERVICES WHEN ORDERED BY THE ATTENDING PHYSICIAN AND PROVIDED IN A HOSPITAL-BASED OR FREE-STANDING CLINIC IN AN AREA SET ASIDE FOR CARDIAC REHABILITATION, OR IN A PHYSICIAN'S OFFICE; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO CARDIAC REHABILITATION SERVICES SHALL NOT TAKE EFFECT UNLESS ALL NECES-

SARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH SERVICES.

(U) SCREENING, BRIEF INTERVENTION, REFERRAL AND TREATMENT IN HOSPITAL EMERGENCY DEPARTMENTS OF INDIVIDUALS AT RISK FOR SUBSTANCE ABUSE INCLUDING REFERRAL TO THE APPROPRIATE LEVEL OF INTERVENTION AND TREATMENT IN A COMMUNITY SETTING; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO SCREENING, BRIEF INTERVENTION, REFERRAL AND TREATMENT SERVICES SHALL NOT TAKE EFFECT UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN SUCH COSTS.

S 28. Notwithstanding any contrary provision of law, in the event sections two through ten of this act are not enacted into law then the provisions of sections twenty-five through twenty-seven and section twenty-nine of this act shall be deemed null and void and of no effect.

S 29. Section 365-h of the social services law, as added by chapter 81 of the laws of 1995, subdivision 3 as amended by section 26 of part B of chapter 1 of the laws of 2002, is amended to read as follows:

S 365-h. Provision and reimbursement of transportation costs. 1. The local social services official AND, SUBJECT TO THE PROVISIONS OF SUBDIVISION FOUR OF THIS SECTION, THE COMMISSIONER OF HEALTH, shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official AND, AS APPROPRIATE, THE COMMISSIONER OF HEALTH shall:

(a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

(b) maintain quality assurance mechanisms in order to ensure that (i) only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided and (ii) no expenditures for taxi or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

4. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ASSUME RESPONSIBILITY FROM A LOCAL SOCIAL SERVICES OFFICIAL FOR THE PROVISION AND REIMBURSEMENT OF TRANSPORTATION COSTS UNDER THIS SECTION. IF THE COMMISSIONER ELECTS TO ASSUME SUCH RESPONSIBILITY, THE COMMISSIONER SHALL NOTIFY THE LOCAL SOCIAL SERVICES OFFICIAL IN WRITING AS TO THE ELECTION, THE DATE UPON WHICH THE ELECTION SHALL BE EFFECTIVE AND SUCH INFORMATION AS TO TRANSITION OF RESPONSIBILITIES AS THE COMMISSIONER DEEMS PRUDENT. THE COMMISSIONER IS AUTHORIZED TO CONTRACT WITH A TRANSPORTATION MANAGER OR MANAGERS THAT HAVE EXPERIENCE IN COORDINATING TRANSPORTATION SERVICES IN THE STATE TO MANAGE THE PROVISION OF SERVICES UNDER THIS SECTION. SUCH A CONTRACT OR CONTRACTS MAY INCLUDE, WITHOUT LIMITATION, RESPONSIBILITY FOR: REVIEW, APPROVAL AND PROCESSING OF TRANSPORTATION ORDERS; MANAGE-

MENT OF THE APPROPRIATE LEVEL OF TRANSPORTATION BASED ON DOCUMENTED PATIENT MEDICAL NEED; AND DEVELOPMENT OF NEW TECHNOLOGIES AND APPROACHES LEADING TO EFFICIENT TRANSPORTATION SERVICES. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ENTER INTO A CONTRACT UNDER THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS.

S 30. Section 364-f of the social services law, as added by chapter 904 of the laws of 1984, is amended to read as follows:

S 364-f. [Physician] PRIMARY CARE case management programs. 1. The department is authorized to establish [physician] PRIMARY CARE case management [demonstration] programs, under the medical assistance program, in accordance with applicable federal law and regulations. PRIMARY CARE CASE MANAGEMENT PROGRAMS SHALL ONLY BE AUTHORIZED IN AREAS OF THE STATE WHERE COMPREHENSIVE HEALTH SERVICES PLANS, AS DEFINED IN SECTION FORTY-FOUR HUNDRED ONE OF THE PUBLIC HEALTH LAW, ARE NOT YET AVAILABLE. Subject to the approval of the director of the budget, the commissioner is authorized to apply for the appropriate waivers under federal law and regulation, and may waive any of the provisions of sections three hundred sixty-five-a, three hundred sixty-six, three hundred sixty-seven-b [and], three hundred sixty-eight-a AND THREE HUNDRED SIXTY-FOUR-J of this chapter or any regulation of the department when such action would be necessary to assist in promoting the objectives of this section.

2. (a) A [physician] PRIMARY CARE case management program shall provide individuals eligible for medical assistance with the opportunity to select [voluntarily] a PRIMARY CARE case [management provider] MANAGER who shall provide medical assistance services to such eligible individuals, either directly, or through referral [by a physician case manager].

(b) [Physician] PRIMARY CARE case managers shall be limited to qualified, licensed primary care [physicians] PRACTITIONERS, AS DEFINED IN PARAGRAPH (F) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS CHAPTER, who meet standards established by the commissioner [of health] for the purposes of this program.

(c) Services [for which a physician case manager will be responsible] THAT MAY BE COVERED BY THE PRIMARY CARE CASE MANAGEMENT PROGRAM ARE DEFINED BY THE COMMISSIONER IN THE BENEFIT PACKAGE. COVERED SERVICES MAY include all medical assistance services defined under section three hundred sixty-five-a of this chapter, except:

(i) SERVICES EXCLUDED UNDER PARAGRAPH (E) OF SUBDIVISION THREE OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS CHAPTER SHALL BE EXCLUDED UNDER THIS SECTION;

(II) services provided by residential health care facilities, long term home health care programs, child care agencies, and entities offering comprehensive health services plans;

[(ii)] (III) services provided by dentists and optometrists; and

[(iii)] (IV) eyeglasses, emergency care, mental health services and family planning services.

(d) Case management services provided by [physician] PRIMARY CARE case managers shall include, but need not be limited to:

(i) management of the medical and health care of each recipient to assure that all services provided under paragraph (c) of this subdivision and which are found to be necessary, are made available in a timely manner;

(ii) referral to, and coordination, monitoring and follow-up of, appropriate providers for diagnosis and treatment, the need for which has been identified by the [physician] PRIMARY CARE case manager but which is not directly available from the [physician] PRIMARY CARE case manager, and assisting medical assistance recipients in the prudent selection of medical services;

(iii) arrangements for referral of recipients to appropriate providers; and

(iv) [services provided in accordance with child health assurance program standards for individuals under twenty-one years of age] ALL EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SERVICES, AS WELL AS INTERPERIODIC SCREENING AND REFERRAL, TO EACH PARTICIPANT UNDER THE AGE OF TWENTY-ONE AT REGULAR INTERVALS.

3. (a) [Physician] PRIMARY CARE case management programs may be conducted only in accordance with [plans submitted by social services districts and approved] GUIDELINES ESTABLISHED by the commissioner[, after consultation with the commissioner of health, and only to the extent and period for which such plans have been approved by the commissioner. The commissioner shall not authorize the implementation of such plans in more than ten social services districts. For the purpose of implementing and administering the physician case management programs, social services districts may]. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO A contract with [private not-for-profit and public agencies] QUALIFIED ENTITIES AS DEFINED IN GUIDELINES ESTABLISHED BY THE COMMISSIONER for the management AND ADMINISTRATION of [these plans provided, however, that such contracts shall require prior approval by the commissioner] THE PRIMARY CARE CASE MANAGEMENT PROGRAM WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS.

(b) The [commissioner shall only approve plans submitted pursuant to this section which: (i) identify and document the specific problems which the physician case management program is designed to address within the social services district;] PRIMARY CARE CASE MANAGEMENT PROGRAM MUST:

[(ii)] (I) assure access to and delivery of high quality, appropriate medical services;

[(iii) include a description of the quality assurance mechanisms to be implemented] (II) PARTICIPATE IN QUALITY ASSURANCE ACTIVITIES AS REQUIRED BY THE COMMISSIONER, as well as other mechanisms designed to protect recipient rights under such program;

[(iv) designate the entity to be responsible for the administration of the program within the social services district and describe the responsibilities of this entity;

(v) include a fiscal impact statement which describes the anticipated savings to federal, state and local governments, including an estimate of those costs, including both inpatient and ambulatory costs, which would have been incurred in the absence of the program and the projected costs under the program;

(vi)] (III) ensure that persons eligible for medical assistance will be provided sufficient information regarding the program to make an informed and voluntary choice whether to participate; AND

[(vii)] (IV) provide for adequate safeguards to protect recipients from being misled concerning the program and from being coerced into

participating in the [physician] PRIMARY CARE case management program[;].

[(viii) assure adequate opportunity for public review and comment prior to implementation of the program and provide adequate grievance procedures for recipients who participate in the program; and

(ix) include any other information which the department shall deem appropriate.]

4. (a) Individuals eligible [for medical assistance] TO PARTICIPATE IN THE STATE'S MANAGED CARE PROGRAM, as defined in SUBPARAGRAPH THREE OF section three hundred [sixty-six] SIXTY-FOUR-J of this chapter, may [voluntarily] participate in a [physician] PRIMARY CARE case management program, subject to the availability of such a program within the applicable social services district, except for individuals: (i) enrolled in an entity offering a comprehensive health services plan as defined in paragraph (k) of subdivision two of section three hundred sixty-five-a of this chapter; (ii) participating in another medical assistance reimbursed demonstration or pilot project, or (iii) receiving services as an inpatient from a nursing home or intermediate care facility or residential services from a child care agency or services from a long term home health care program.

(b) [All individuals eligible for medical assistance] INDIVIDUALS choosing to participate [voluntarily] in a [physician] PRIMARY CARE case management program will be given thirty days from the effective date of enrollment in the program to disenroll without cause. After this thirty day disenrollment period, all individuals participating in the program will be enrolled for a period of [six] TWELVE months, except that all participants will be permitted to disenroll for good cause, as defined IN GUIDELINES ESTABLISHED by the commissioner [in regulation].

5. (a) [Physician] PRIMARY CARE case management programs may include provisions for innovative payment mechanisms, including, but not limited to, [sharing of any savings with providers,] payment of case management fees [and], capitation arrangements, AND FEE-FOR-SERVICE PAYMENTS.

(b) Any new payment mechanisms and levels of payment implemented under the [physician] PRIMARY CARE case management program shall be developed [jointly] by the commissioner [and the commissioner of health] subject to the approval of the director of the budget.

6. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, PARTICIPATION IN A PRIMARY CARE CASE MANAGEMENT PROGRAM WILL NOT DIMINISH THE SCOPE OF AVAILABLE MEDICAL SERVICES TO WHICH A RECIPIENT IS ENTITLED.

7. This section shall be effective if, and as long as, federal financial participation is available therefor.

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 33. Section 2818 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. (A) NOTWITHSTANDING SUBDIVISION ONE, TWO OR THREE OF THIS SECTION, THE COMMISSIONER, WITH THE APPROVAL OF THE DIRECTOR OF THE BUDGET, MAY EXPEND FUNDS FOR THE PURPOSE OF PROVIDING COST EFFECTIVE INCREASED ACCESS TO THE CAPITAL MARKETS, INCLUDING BUT NOT LIMITED TO THROUGH THE USE OF MORTGAGE INSURANCE, CREDIT ENHANCEMENT, LETTERS OF CREDIT, BOND INSURANCE OR OTHER ARRANGEMENTS, FOR CAPITAL PROJECTS THAT ARE DETERMINED TO MEET ONE OR MORE OF THE FOLLOWING OBJECTIVES FOR HOSPITALS LICENSED UNDER THIS ARTICLE:

(I) SECURING FINANCING FOR FACILITIES IN A MANNER THAT WILL IMPROVE THE OPERATION AND EFFICIENCY OF THE HEALTH CARE DELIVERY SYSTEM WITHIN THE STATE;

(II) SECURING FINANCING FOR FACILITIES IN A MANNER CONSISTENT WITH THE OBJECTIVES AND DETERMINATIONS OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY, ESTABLISHED PURSUANT TO CHAPTER SIXTY-THREE OF THE LAWS OF TWO THOUSAND FIVE;

(III) SECURING FINANCING FOR FACILITIES IN A MANNER THAT WILL HELP RIGHTSIZE THE STATE'S ACUTE CARE INFRASTRUCTURE, INCLUDING REDUCING INPATIENT CAPACITY, DOWNSIZING, RESTRUCTURING, AND CLOSING FACILITIES;

(IV) SECURING FINANCING FOR FACILITIES IN A MANNER THAT ADVANCES THE REFORM OF THE LONG-TERM CARE SYSTEM, INCLUDING THROUGH RIGHTSIZING AND PROVIDING COMMUNITY-BASED SERVICES;

(V) SECURING FINANCING FOR FACILITIES IN A MANNER THAT IMPROVES THE PRIMARY AND AMBULATORY CARE SYSTEM; AND

(VI) SUCH OTHER OBJECTIVES AS THE COMMISSIONER DEEMS APPROPRIATE TO EFFECTUATE THE INTENT OF THIS SUBDIVISION.

(B) THE COMMISSIONER MAY TRANSFER FUNDS TO OTHER STATE AGENCIES OR PUBLIC AUTHORITIES, WITH THE APPROVAL OF THE DIRECTOR OF BUDGET, TO EFFECTUATE THE PURPOSES OF THIS SUBDIVISION.

S 34. Subdivision 3 of section 1680-j of the public authorities law, as amended by section 7 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA) resources fund (061) to the general fund, upon the request of the director of the budget, up to $6,500,000 on or before March 31, 2006, and the comptroller is further hereby authorized and directed to transfer from the healthcare reform act (HCRA); Resources fund (061) to the Capital Projects Fund, upon the request of the director of budget, up to $139,000,000 for the period April 1, 2006 through March 31, 2007, up to $171,100,000 for the period April 1, 2007 through March 31, 2008, up to $208,100,000 for the period April 1, 2008 through March 31, 2009, up to $151,600,000 for the period April 1, 2009 through March 31, 2010, and up to [$182,000,000] $238,000,000 for the period April 1, 2010 through March 31, 2011.

S 35. Subdivision 7 of section 367-a of the social services law is amended by adding a new paragraph (e) to read as follows:

(E) THE COMMISSIONER IS AUTHORIZED TO NEGOTIATE DIRECTLY WITH PHARMACEUTICAL MANUFACTURERS FOR REBATES, AND TO ENTER INTO A CONTRACT OR CONTRACTS WITH QUALIFIED ENTITIES FOR SUCH PURPOSE. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO A CONTRACT UNDER THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS.

S 36. Subdivision 4 of section 272 of the public health law is REPEALED.

S 37. Section 3-a of part Z2 of chapter 62 of the laws of 2003, amending the social services law and the public health law relating to expanding Medicaid coverage and rates of payment for residential health care facilities is REPEALED.

S 38. Section 369-aa of the social services law is amended by adding a new subdivision 16 to read as follows:

16. "STEP THERAPY" SHALL MEAN THE PRACTICE OF BEGINNING DRUG THERAPY FOR A MEDICAL CONDITION WITH THE MOST MEDICALLY APPROPRIATE AND COST EFFECTIVE THERAPY AND PROGRESSING TO OTHER DRUGS AS MEDICALLY NECESSARY.

S 39. Section 369-cc of the social services law is amended by adding a new subdivision 4 to read as follows:

4. THE COMMISSIONER, THROUGH THE PROSPECTIVE DUR PROGRAM, MAY REQUIRE STEP THERAPY WHEN THERE IS MORE THAN ONE DRUG APPROPRIATE TO TREAT A MEDICAL CONDITION. THE PURPOSE OF STEP THERAPY IS TO ENCOURAGE THE USE OF MEDICALLY APPROPRIATE, COST EFFECTIVE DRUGS WHEN CLINICALLY INDICATED AND TO LIMIT USE OF ALTERNATIVE DRUG THERAPIES UNLESS CERTAIN CLINICAL REQUIREMENTS ARE MET. THE DUR BOARD SHALL RECOMMEND GUIDELINES FOR SPECIFIC DIAGNOSES AND THERAPY REGIMENS WITHIN WHICH PRACTITIONERS MAY PRESCRIBE DRUGS WITHOUT THE REQUIREMENT FOR PRIOR AUTHORIZATION OF THOSE DRUGS. IN ESTABLISHING THESE GUIDELINES, THE BOARD SHALL CONSIDER CLINICAL EFFECTIVENESS, SAFETY, AND COST EFFECTIVENESS.

S 40. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 1 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department, provided that the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when less than seventy-five percent of the previously dispensed amount per fill should have been used were the product used as normally indicated; PROVIDED FURTHER THAT THE COMMISSIONER OF HEALTH MAY FROM TIME TO TIME LIMIT THE AMOUNT, FREQUENCY AND DURATION OF DRUG THERAPY THROUGH PRIOR AUTHORIZATION AS PART OF THE DRUG UTILIZATION REVIEW PROGRAM ESTABLISHED UNDER TITLE ELEVEN-C OF THIS ARTICLE; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

S 41. Paragraph (b) of subdivision 8 of section 369-bb of the social services law is amended by adding a new subparagraph (viii) to read as follows:

(VIII) THE DEVELOPMENT OF CLINICAL PRESCRIBING GUIDELINES RELATING TO QUANTITY, FREQUENCY AND DURATION OF DRUG THERAPY FOR THE COMMISSIONER'S USE IN DETERMINING WHEN TO REQUIRE PRIOR AUTHORIZATION OF DRUGS IN THE

DUR PROGRAM PURSUANT TO THE AUTHORITY OF PARAGRAPH (G) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS ARTICLE; EXCEPTIONS TO ANY PRIOR AUTHORIZATION IMPOSED AS A RESULT OF THESE GUIDELINES SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, PROVISION FOR EMERGENCY CIRCUMSTANCES WHERE A MEDICAL CONDITION REQUIRES ALLEVIATION OF SEVERE PAIN OR WHICH THREATENS TO CAUSE DISABILITY OR TO TAKE A LIFE IF NOT PROMPTLY TREATED.

S 42. Paragraph (g) of subdivision 4 of section 365-a of the social services law, as amended by section 61 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act[; provided however that, for purposes of this paragraph, "covered part D drugs" shall not mean atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants].

S 43. Subparagraph (ii) of paragraph (b) of subdivision 9 of section 367-a of the social services law, as amended by section 4 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies, or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less sixteen and twenty-five one hundredths percent thereof, and updated monthly by the department[; or, for a specialized HIV pharmacy, as defined in paragraph (f) of this subdivision, acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twelve percent thereof, and updated monthly by the department]. For multiple source generic drugs, estimated acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision[; or, for a specialized HIV pharmacy, as defined in paragraph (f) of this subdivision, acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twelve percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision].

S 44. Paragraph (f) of subdivision 9 of section 367-a of the social services law is REPEALED.

S 45. Subdivision 7 of section 274 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

7. In the event that the patient does not meet the criteria for approval established by the commissioner in subdivision six of this section, the clinical drug review program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justifica-

tion for prior authorization. If, after [consultation with] the program[, the prescriber, in his or her reasonable professional judgment, determines that the use of the prescription drug is warranted, the prescriber's determination shall be final and prior authorization shall be granted under this section; provided, however, that] PROVIDES THE PRESCRIBER SUCH REASONABLE OPPORTUNITY, THE PROGRAM DETERMINES THAT THE USE OF THE DRUG IS NOT MEDICALLY NECESSARY, PRIOR AUTHORIZATION MAY BE DENIED. IN ADDITION, prior authorization may be denied in cases where the department has substantial evidence that the prescriber or patient is engaged in fraud or abuse relating to the drug.

S 46. Paragraph (a-1) of subdivision 4 of section 365-a of the social services law, as amended by section 11 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(a-1) (I) a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the department of health. The commissioner of health is authorized to exempt, for good cause shown, any brand name drug from the restrictions imposed by this [paragraph] SUBPARAGRAPH. This [paragraph] SUBPARAGRAPH shall not apply to any drug that is in a therapeutic class included on the preferred drug list under section two hundred seventy-two of the public health law or is in the clinical drug review program under section two hundred seventy-four of the public health law;

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE COMMISSIONER IS AUTHORIZED TO DENY REIMBURSEMENT FOR A GENERIC EQUIVALENT, INCLUDING A GENERIC EQUIVALENT THAT IS ON THE PREFERRED DRUG LIST OR THE CLINICAL DRUG REVIEW PROGRAM, WHEN THE NET COST OF THE BRAND NAME DRUG, AFTER CONSIDERATION OF ALL REBATES, IS LESS THAN THE COST OF THE GENERIC EQUIVALENT;

S 47. Subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law, as amended by section 9 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar and for each brand name prescription drug dispensed shall be three dollars; provided, however, that the co-payments charged for each brand name prescription drug on the preferred drug list established pursuant to section two hundred seventy-two of the public health law AND THE CO-PAYMENTS CHARGED FOR EACH BRAND NAME PRESCRIPTION DRUG REIMBURSED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A-2) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE shall be one dollar.

S 48. Subparagraph (ii) of paragraph (d) of subdivision 9 of section 367-a of the social services law, as amended by chapter 19 of the laws of 1998, is amended to read as follows:

(ii) for prescription drugs categorized as brand-name prescription [drug] DRUGS by the prescription drug pricing service used by the department, three dollars and fifty cents per prescription, PROVIDED, HOWEVER, THAT FOR BRAND NAME PRESCRIPTION DRUGS REIMBURSED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A-2) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE, THE DISPENSING FEE SHALL BE FOUR DOLLARS AND FIFTY CENTS PER PRESCRIPTION.

S 49. Subdivision 9 of section 367-a of the social services law is amended by adding a new paragraph (i) to read as follows:

(I) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO PAY FINANCIAL INCENTIVES TO MEDICAL PRACTITIONERS AND TO PHARMACIES FOR THE PURPOSE OF ENCOURAGING THE ELECTRONIC TRANSMISSION OF PRESCRIPTIONS FOR DRUGS FOR

WHICH PAYMENTS ARE MADE UNDER THIS SUBDIVISION. SUCH PAYMENTS SHALL BE IN THE FOLLOWING AMOUNTS: FOR MEDICAL PRACTITIONERS, EIGHTY CENTS PER DISPENSED ELECTRONIC PRESCRIPTION; FOR DISPENSING PHARMACIES, TWENTY CENTS PER DISPENSED ELECTRONIC PRESCRIPTION. ELECTRONIC PRESCRIBING SOFTWARE SHALL NOT USE ANY MEANS OR PERMIT ANY OTHER PERSON TO USE ANY MEANS, INCLUDING, BUT NOT LIMITED TO, ADVERTISING, INSTANT MESSAGING, AND POP-UP ADS, TO INFLUENCE OR ATTEMPT TO INFLUENCE, THROUGH ECONOMIC INCENTIVES OR OTHERWISE, THE PRESCRIBING DECISION OF A PRESCRIBING PRACTITIONER AT THE POINT OF CARE. SUCH MEANS SHALL NOT BE TRIGGERED OR IN SPECIFIC RESPONSE TO THE INPUT, SELECTION, OR ACT OF A PRESCRIBING PRACTITIONER OR HIS OR HER AGENT IN PRESCRIBING A CERTAIN PHARMACEUTICAL OR DIRECTING A PATIENT TO A CERTAIN PHARMACY. THE PROVISIONS OF THIS PARAGRAPH SHALL NOT TAKE EFFECT UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SERVICES PROVIDED UNDER THIS PARAGRAPH.

S 50. The public health law is amended by adding a new section 279 to read as follows:

S 279. PROHIBITED ACTS AND DISCLOSURE REQUIREMENTS RELATING TO DRUG MANUFACTURERS' PROVISION OF THINGS OF VALUE TO PRESCRIBERS. 1. DEFINITIONS. AS USED IN THIS SECTION:

(A) "DRUG" MEANS: (I) ARTICLES RECOGNIZED IN THE OFFICIAL UNITED STATES PHARMACOPOEIA, OFFICIAL HOMEOPATHIC PHARMACOPOEIA OF THE UNITED STATES, OR OFFICIAL NATIONAL FORMULARY;

(II) ARTICLES INTENDED FOR USE IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE IN HUMANS;

(III) ARTICLES (OTHER THAN FOOD) INTENDED TO AFFECT THE STRUCTURE OR ANY FUNCTION OF THE BODY OF HUMANS;

(IV) ARTICLES INTENDED FOR USE AS A COMPONENT OF ANY ARTICLE SPECIFIED IN SUBPARAGRAPH (I), (II) OR (III) OF THIS PARAGRAPH BUT DOES NOT INCLUDE DEVICES OR THEIR COMPONENTS, PARTS OR ACCESSORIES;

(B) "DEVICE" MEANS ANY INSTRUMENT, APPARATUS, OR CONTRIVANCE, INCLUDING COMPONENTS, PARTS OR ACCESSORIES, INTENDED:

(I) FOR USE IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT, OR PREVENTION OF DISEASE IN HUMANS; OR

(II) TO AFFECT THE STRUCTURE OR ANY FUNCTION OF THE BODY OF HUMANS.

(C) "MANUFACTURER" MEANS (I) A PERSON OR ENTITY THAT FABRICATES, MAKES, COMPOUNDS, MIXES, PREPARES, PRODUCES, BOTTLES OR PACKS DRUGS OR DEVICES FOR THE PURPOSE OF DISTRIBUTING OR SELLING TO PHARMACIES, HEALTH CARE PROVIDERS OR OTHER CHANNELS OF DISTRIBUTION, OR (II) A PERSON OR ENTITY THAT, PURSUANT TO AN AGREEMENT WITH A PERSON OR ENTITY DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, MARKETS A DRUG OR DEVICE UNDER A DIFFERENT NAME OR LABELER CODE.

(D) "PRESCRIBER" MEANS A PHYSICIAN, DENTIST, PHYSICIAN ASSISTANT, SPECIALIST'S ASSISTANT, NURSE PRACTITIONER, MIDWIFE, OPTOMETRIST AND OTHER LICENSED HEALTH CARE PROVIDER AUTHORIZED UNDER TITLE EIGHT OF THE EDUCATION LAW TO PRESCRIBE DRUGS OR DEVICES.

(E) "HEALTH CARE PROVIDER" MEANS (I) A PRESCRIBER WHO PRACTICES IN THIS STATE IN AN INDIVIDUAL PRACTICE, GROUP PRACTICE, PARTNERSHIP, PROFESSIONAL CORPORATION OR OTHER AUTHORIZED FORM OF ASSOCIATION, OR IN A HOSPITAL OR OTHER HEALTH CARE INSTITUTION ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS CHAPTER OR THE MENTAL HYGIENE LAW; (II) SUCH PRESCRIBER'S INDIVIDUAL PRACTICE, GROUP PRACTICE, PARTNERSHIP, PROFESSIONAL CORPORATION OR OTHER AUTHORIZED FORM OF ASSOCIATION; AND (III) AN EMPLOYEE OF A PERSON OR ENTITY DESCRIBED IN SUBPARAGRAPH (I) OR (II) OF THIS PARAGRAPH.

(F) "DOCTOR-IN-TRAINING" MEANS A PERSON ACTIVELY ENGAGED IN THE STATE IN POST-BACCALAUREATE EDUCATION OR PROFESSIONAL TRAINING DESIGNED TO PREPARE PERSONS TO BE ELIGIBLE TO BE LICENSED AS A DOCTOR OF MEDICINE OR DOCTOR OF OSTEOPATHY AND IS NOT AUTHORIZED TO PRESCRIBE DRUGS OR DEVICES.

(G) "PAYMENT" MEANS ANYTHING WITH AN ECONOMIC VALUE, INCLUDING BUT NOT LIMITED TO MONEY, GOODS AND SERVICES.

(H) "BENEFIT" MEANS ONE OR MORE THINGS WITH AN AGGREGATED FAIR MARKET VALUE FOR THE YEAR EQUAL TO OR GREATER THAN FIFTY DOLLARS, THAT WOULD BE A PAYMENT, AS DEFINED IN PARAGRAPH (G) OF THIS SUBDIVISION, EXCEPT THAT IT COMES WITHIN THE EXCEPTION SET OUT IN PARAGRAPH (B) OR (D) OF SUBDIVISION THREE OF THIS SECTION.

(I) "FAIR MARKET VALUE" MEANS THE VALUE IN ARMS LENGTH TRANSACTIONS, CONSISTENT WITH THE GENERAL MARKET VALUE.

(J) "FINANCIAL RELATIONSHIP" MEANS AN OWNERSHIP INTEREST, INVESTMENT INTEREST OR COMPENSATION ARRANGEMENT. AN OWNERSHIP INTEREST OR INVESTMENT INTEREST MAY BE THROUGH EQUITY, DEBT OR OTHER MEANS; BUT SHALL NOT INCLUDE OWNERSHIP OF INVESTMENT SECURITIES, INCLUDING SHARES OR BONDS, DEBENTURES, NOTES OR OTHER DEBT INSTRUMENTS, WHICH WERE PURCHASED ON TERMS GENERALLY AVAILABLE TO THE PUBLIC AND WHICH ARE IN A CORPORATION THAT IS LISTED FOR TRADING ON THE NEW YORK STOCK EXCHANGE OR ON THE AMERICAN STOCK EXCHANGE, OR IS A NATIONAL MARKET SYSTEM SECURITY TRADED UNDER AN AUTOMATED INTERDEALER QUOTATION SYSTEM OPERATED BY THE NATIONAL ASSOCIATION OF SECURITIES DEALERS, AND HAD, AT THE END OF THE CORPORATION'S MOST RECENT FISCAL YEAR, TOTAL ASSETS EXCEEDING ONE HUNDRED MILLION DOLLARS.

(K) "DISCOUNT" MEANS A REDUCTION IN THE AMOUNT A HEALTH CARE PROVIDER, ACTING AS A BUYER OR PAYER, IS CHARGED FOR AN ITEM OR SERVICE, WHERE THE REDUCTION IS OFFERED BY OR ON BEHALF OF A MANUFACTURER, AND INCLUDES ALL SUCH REDUCTIONS WHENEVER THEY ARE GIVEN, INCLUDING BEFORE OR AFTER THE TIME OF SALE, PROVIDED THAT SUCH REDUCTIONS GIVEN TO A HEALTH CARE PROVIDER HAVE A FAIR MARKET VALUE AGGREGATED FOR THE CALENDAR YEAR EQUAL TO OR GREATER THAN FIFTY DOLLARS. FOR THE PURPOSE OF THIS PARAGRAPH, "REDUCTION" MEANS A DECREASE FROM THE AMOUNT THAT WOULD BE CHARGED BASED ON AN ARMS-LENGTH TRANSACTION OR THAT IS REPRESENTED TO THE PRESCRIBER AS CONSTITUTING SUCH A DECREASE.

2. PROHIBITED ACTS. (A) A MANUFACTURER SHALL NOT, DIRECTLY OR INDIRECTLY, GIVE OR OFFER TO GIVE ONE OR MORE PAYMENTS WITH AN AGGREGATED FAIR MARKET VALUE IN EXCESS OF FIFTY DOLLARS DURING A CALENDAR YEAR, TO ANY HEALTH CARE PROVIDER OR DOCTOR-IN-TRAINING.

(B) A HEALTH CARE PROVIDER OR A DOCTOR-IN-TRAINING SHALL NOT, DIRECTLY OR INDIRECTLY, REQUEST OR RECEIVE FROM ANY MANUFACTURER ONE OR MORE PAYMENTS WITH AN AGGREGATED FAIR MARKET VALUE IN EXCESS OF FIFTY DOLLARS DURING A CALENDAR YEAR.

3. EXCEPTIONS. THE FOLLOWING PAYMENTS SHALL NOT BE PROHIBITED UNDER SUBDIVISION TWO OF THIS SECTION AND SHALL BE DISCLOSED, AS APPLICABLE, PURSUANT TO SUBDIVISION FOUR OF THIS SECTION:

(A) SAMPLES OF PRESCRIPTION DRUGS THAT THE MANUFACTURER'S EMPLOYEE PROVIDES DIRECTLY TO A PRESCRIBER WHO PROVIDES OR ADMINISTERS SUCH SAMPLE TO A PATIENT WITHOUT CHARGE;

(B) ANY PAYMENT TO SUPPORT A SPECIFIED AND BONA FIDE RESEARCH, CLINICAL OR EDUCATIONAL ACTIVITY IN CONNECTION WITH WHICH THE RECIPIENT (I) PRIOR TO RECEIPT OF ANY SUCH PAYMENT, HAS SUBMITTED TO THE MANUFACTURER A PROPOSAL THAT DESCRIBES THE PURPOSE AND METHODS TO BE USED IN CARRYING OUT THE ACTIVITY, THE OUTCOMES OF THE ACTIVITY THAT WILL BE MEASURED AND THE METHODS TO BE USED TO MEASURE SUCH OUTCOMES, A PROCEDURE FOR

ACCOUNTING FOR SUCH PAYMENT AND A DEADLINE FOR SUBMITTING TO THE MANUFACTURER A FINAL REPORT CONCERNING THE ACTIVITY; (II) HAS SUBMITTED TO THE MANUFACTURER THE FINAL REPORT, WITH ALL REQUIRED INFORMATION AS DESCRIBED IN ITS PROPOSAL AS SET FORTH IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, WITHIN THE DEADLINE SET OUT IN SUCH PROPOSAL OR AS EXTENDED IN WRITING BY THE MANUFACTURER; AND (III) MAKES SUCH FINAL REPORT AVAILABLE TO THE DEPARTMENT AND HEALTH CARE PROVIDERS UPON REQUEST;

(C) A REDUCTION IN THE COST TO THE HEALTH CARE PROVIDER OF ONE OR MORE OF THE MANUFACTURER'S DRUGS OR DEVICES;

(D) REIMBURSEMENT FOR TRAVEL, LODGING AND PERSONAL EXPENSES OR REMUNERATION PROVIDED TO A PRESCRIBER OR SUCH REIMBURSEMENT PROVIDED TO A DOCTOR-IN-TRAINING, THE AMOUNT OF WHICH REMUNERATION OR REIMBURSEMENT IS NOT DEPENDENT, DIRECTLY OR INDIRECTLY, ON THE AMOUNT OR VOLUME OF THE MANUFACTURER'S DRUGS OR DEVICES ANY PERSON OR ENTITY PRESCRIBES, IF:

(I) WITH RESPECT TO PRESCRIBERS, THE REMUNERATION OR REIMBURSEMENT IS PROVIDED IN CONNECTION WITH BONA FIDE TEACHING, SCIENTIFIC RESEARCH, WRITING OR CONSULTING SERVICES THE PRESCRIBER ACTUALLY PROVIDES, THE NATURE AND PROVISION OF WHICH CAN BE VERIFIED BY DOCUMENTS THE MANUFACTURER MAINTAINS FOR NOT LESS THAN THREE YEARS, PROVIDED THAT (A) THE AMOUNT OF BOTH THE REMUNERATION AND REIMBURSEMENT IS CONSISTENT WITH THE FAIR MARKET VALUE OF THE SERVICES THE PRESCRIBER PROVIDES TO OR ON BEHALF OF THE MANUFACTURER, (B) WITH RESPECT TO TEACHING ACTIVITIES, THE PRESCRIBER IS PART OF THE FACULTY FOR AN EDUCATIONAL PROGRAM AND PROVIDES ATTENDEES WITH SIGNIFICANT SCIENTIFIC OR CLINICAL INFORMATION, AND (C) WITH RESPECT TO WRITING, THE PRESCRIBER IS IDENTIFIED AS AN AUTHOR ONLY WHEN HE OR SHE HAS HAD UNRESTRICTED ACCESS TO ALL DATA PERTAINING TO THE SUBJECT OF THE MANUSCRIPT, HAS GIVEN FINAL APPROVAL OF THE MANUSCRIPT, HAS PARTICIPATED SUFFICIENTLY IN THE WORK TO TAKE PUBLIC RESPONSIBILITY FOR AT LEAST PART OF THE CONTENT, AND HAS MADE SUBSTANTIAL CONTRIBUTIONS TO THE INTELLECTUAL CONTENT OF THE WRITTEN WORK IN EITHER CONCEPTION AND DESIGN OR ACQUISITION OF DATA AND IN EITHER DRAFTING OR CRITICAL REVISION OF THE MANUSCRIPT FOR IMPORTANT INTELLECTUAL CONTENT; AND

(II) WITH RESPECT TO DOCTORS-IN-TRAINING, THE REIMBURSEMENT IS PROVIDED IN CONNECTION WITH ATTENDANCE AT A BONA FIDE MEDICAL CONFERENCE, THE PRINCIPAL PURPOSE OF WHICH IS TO IMPART SCIENTIFIC OR CLINICAL INFORMATION, PROVIDED THAT (A) THE AMOUNT OF ANY REIMBURSEMENT IS CONSISTENT WITH THE FAIR MARKET VALUE OF THE TRAVEL, LODGING AND PERSONAL EXPENSES BEING REIMBURSED, AND (B) THE MANUFACTURER TRANSFERS ALL SUCH FUNDS TO THE DOCTOR'S-IN-TRAINING MEDICAL SCHOOL OR PROFESSIONAL EMPLOYER, THE MEDICAL SCHOOL OR PROFESSIONAL EMPLOYER SELECTS THE DOCTORS-IN-TRAINING WHOSE ATTENDANCE THE MANUFACTURER WILL FUND AND THE MEDICAL CONFERENCES THEY WILL ATTEND, AND THE SCHOOL, EMPLOYER AND MANUFACTURER DO NOT, DIRECTLY OR INDIRECTLY, INFORM THE DOCTOR-IN-TRAINING OF THE SOURCE OF SUCH FUNDS; AND

(E) ANYTHING OF ECONOMIC VALUE GIVEN BY A PERSON WITH A FINANCIAL RELATIONSHIP WITH A MANUFACTURER WHO IS RELATED BY BLOOD, MARRIAGE OR ADOPTION WITHIN THREE DEGREES OF CONSANGUINITY TO THE RECIPIENT PRESCRIBER.

4. DISCLOSURE. (A) ANNUAL DISCLOSURE. ANNUALLY, AT A TIME AND IN A MANNER TO BE DETERMINED BY THE DEPARTMENT, EACH HEALTH CARE PROVIDER OR DOCTOR-IN-TRAINING AND EACH MANUFACTURER DOING BUSINESS WITH ANY SUCH HEALTH CARE PROVIDER OR DOCTOR-IN-TRAINING SHALL PROVIDE TO THE DEPARTMENT A REPORT THAT CONTAINS THE INFORMATION REQUIRED BY PARAGRAPHS (B), (C), AND (D) OF THIS SUBDIVISION WHERE (I) SUCH HEALTH CARE PROVIDER OR DOCTOR-IN-TRAINING OFFERED, GAVE OR RECEIVED A BENEFIT; (II) SUCH

MANUFACTURER GAVE A DISCOUNT TO A HEALTH CARE PROVIDER; OR (III) A FINANCIAL RELATIONSHIP EXISTED BETWEEN SUCH A MANUFACTURER AND SUCH A PROVIDER OR DOCTOR-IN-TRAINING. ACCESS TO SUCH REPORTS SHALL NOT BE DENIED, THE REPORTS SHALL NOT BE WITHHELD, AND IDENTIFYING INFORMATION SHALL NOT BE DELETED FROM SUCH REPORTS PURSUANT TO SECTION EIGHTY-SEVEN OR EIGHTY-NINE OF THE PUBLIC OFFICERS LAW.

(B) DISCLOSURE OF BENEFITS. EACH REPORT REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION PERTAINING TO A BENEFIT TRANSFERRED DURING THE REPORTING PERIOD SHALL DESCRIBE THE NATURE AND FAIR MARKET VALUE OF THE BENEFIT THAT WAS OFFERED OR TRANSFERRED; THE NATURE OF ANY GOOD OR SERVICE THAT WAS PROVIDED TO THE MANUFACTURER OR ANY OTHER PERSON OR ENTITY IN CONNECTION WITH THE PROVISION OF THE BENEFIT; AND SUCH OTHER INFORMATION AS SHALL BE REQUIRED BY THE DEPARTMENT BY REGULATION.

(C) DISCLOSURE OF DISCOUNTS. THE REPORTS REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL NOT REQUIRE A MANUFACTURER TO DISCLOSE DISCOUNT INFORMATION SEPARATELY FOR EACH TRANSACTION. THE DEPARTMENT SHALL BY REGULATION SPECIFY THE MANNER IN WHICH THE VALUE OF THE DISCOUNT SHALL BE REPORTED, INCLUDING A THRESHOLD FOR THE VALUE OF DISCOUNTS THAT MUST BE REPORTED. THE MANUFACTURER SHALL REPORT ALL DISCOUNTS THAT OCCURRED DURING THE REPORTING PERIOD, INCLUDING THOSE DISCOUNTS THE VALUE OF WHICH WAS REALIZED BY THE PURCHASER DURING THE REPORTING PERIOD BUT PERTAIN TO SALES THAT OCCURRED AT A DIFFERENT TIME.

(D) DISCLOSURE OF FINANCIAL RELATIONSHIPS. EACH REPORT A MANUFACTURER, HEALTH CARE PROVIDER OR DOCTOR-IN-TRAINING IS REQUIRED TO MAKE BY PARAGRAPH (A) OF THIS SUBDIVISION PERTAINING TO FINANCIAL RELATIONSHIPS SHALL CONTAIN SUCH INFORMATION AS IS REQUIRED BY THE DEPARTMENT BY REGULATION, WHICH SHALL SPECIFY THE MANNER IN WHICH THE VALUE OF FINANCIAL RELATIONSHIPS SHALL BE REPORTED, INCLUDING THE THRESHOLD VALUE OF FINANCIAL RELATIONSHIPS THAT MUST BE REPORTED.

5. VIOLATIONS. THE COMMISSIONER MAY ASSESS A CIVIL PENALTY FOR VIOLATIONS OF THIS SECTION IN AN AMOUNT THAT IS, FOR A MANUFACTURER'S VIOLATION OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION OR SUBDIVISION FOUR OF THIS SECTION, NOT LESS THAN FIVE THOUSAND DOLLARS AND NOT MORE THAN FIFTY THOUSAND DOLLARS PER VIOLATION, AND FOR A HEALTH CARE PROVIDER'S VIOLATION OF PARAGRAPH (B) OF SUBDIVISION TWO OF THIS SECTION OR SUBDIVISION FOUR OF THIS SECTION, NOT LESS THAN FIVE THOUSAND DOLLARS AND NOT MORE THAN TEN THOUSAND DOLLARS PER VIOLATION.

S 51. Section 6509 of the education law is amended by adding a new subdivision 15 to read as follows:

(15) A VIOLATION OF SECTION TWO HUNDRED SEVENTY-NINE OF THE PUBLIC HEALTH LAW.

S 52. Section 6530 of the education law is amended by adding a new subdivision 50 to read as follows:

50. A VIOLATION OF SECTION TWO HUNDRED SEVENTY-NINE OF THE PUBLIC HEALTH LAW.

S 53. Article 29-D of the public health law is amended by adding a new title 4 to read as follows:

TITLE 4

CONTINUING PROFESSIONAL EDUCATION

SECTION 2999-G. DEFINITIONS.

2999-H. REQUIREMENTS FOR CONDUCTING A CONTINUING PROFESSIONAL EDUCATION PROGRAM.

2999-I. VIOLATIONS.

S 2999-G. DEFINITIONS. FOR THE PURPOSE OF THIS TITLE:

1. "CONTINUING PROFESSIONAL EDUCATION PROGRAM" MEANS COURSE WORK OR TRAINING PROVIDED TO PHYSICIANS, DENTISTS, PHYSICIAN ASSISTANTS,

SPECIALIST ASSISTANTS, NURSE PRACTITIONERS, MIDWIVES, OPTOMETRISTS OR OTHER LICENSED HEALTH CARE PROVIDERS AUTHORIZED BY LAW TO PRESCRIBE DRUGS OR DEVICES, WHICH PERTAINS TO THE PRACTICE OF THEIR PROFESSION AND FOR WHICH CONTINUING MEDICAL EDUCATION OR CONTINUING PROFESSIONAL EDUCATION CREDITS MAY BE AWARDED.

2. "PROVIDER" MEANS THE PERSON OR ENTITY THAT REPRESENTS TO MEMBERS OF THE RELEVANT PROFESSION THAT IT IS THE ORGANIZER OF A CONTINUING PROFESSIONAL EDUCATION PROGRAM. A CONTINUING PROFESSIONAL EDUCATION PROGRAM CAN HAVE MORE THAN ONE PROVIDER, BUT EVERY SUCH PROGRAM MUST HAVE AT LEAST ONE PROVIDER. MANUFACTURERS AND DISTRIBUTORS ARE NOT PROVIDERS.

3. "MANUFACTURER" MEANS (I) A PERSON OR ENTITY THAT FABRICATES, MAKES, COMPOUNDS, MIXES, PREPARES, PRODUCES, BOTTLES OR PACKS DRUGS OR DEVICES FOR THE PURPOSE OF DISTRIBUTING OR SELLING TO PHARMACIES, HEALTH CARE PROVIDERS OR OTHER CHANNELS OF DISTRIBUTION, OR (II) A PERSON OR ENTITY THAT, PURSUANT TO AN AGREEMENT WITH A PERSON OR ENTITY DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, MARKETS A DRUG OR DEVICE UNDER A DIFFERENT NAME OR LABELER CODE.

4. "DISTRIBUTOR" MEANS A PERSON OR ENTITY THAT DELIVERS, OTHER THAN BY DISPENSING, A DRUG PRODUCT TO ANY PERSON.

5. "DRUG" MEANS: (I) ARTICLES RECOGNIZED IN THE OFFICIAL UNITED STATES PHARMACOPOEIA, OFFICIAL HOMEOPATHIC PHARMACOPOEIA OF THE UNITED STATES, OR OFFICIAL NATIONAL FORMULARY;

(II) ARTICLES INTENDED FOR USE IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE IN HUMANS;

(III) ARTICLES (OTHER THAN FOOD) INTENDED TO AFFECT THE STRUCTURE OR ANY FUNCTION OF THE BODY OF HUMANS;

(IV) ARTICLES INTENDED FOR USE AS A COMPONENT OF ANY ARTICLE SPECIFIED IN SUBPARAGRAPH (I), (II) OR (III) OF THIS PARAGRAPH BUT DOES NOT INCLUDE DEVICES OR THEIR COMPONENTS, PARTS OR ACCESSORIES;

6. "DEVICE" MEANS ANY INSTRUMENT, APPARATUS, OR CONTRIVANCE, INCLUDING COMPONENTS, PARTS OR ACCESSORIES, INTENDED:

(I) FOR USE IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT, OR PREVENTION OF DISEASE IN HUMANS; OR

(II) TO AFFECT THE STRUCTURE OR ANY FUNCTION OF THE BODY OF HUMANS.

7. "PRESENTER" IS A NATURAL PERSON WHO CONDUCTS, TEACHES AND PARTICIPATES, OTHER THAN SOLELY AS AN ATTENDEE, IN ANY ASPECT OF A CONTINUING PROFESSIONAL EDUCATION PROGRAM, REGARDLESS OF WHETHER SUCH PROGRAM IS PROVIDED IN PERSON OR BY ELECTRONIC OR OTHER MEANS.

8. "FINANCIAL RELATIONSHIP" MEANS AN OWNERSHIP INTEREST, INVESTMENT INTEREST OR COMPENSATION ARRANGEMENT. AN OWNERSHIP INTEREST OR INVESTMENT INTEREST MAY BE THROUGH EQUITY, DEBT OR OTHER MEANS; BUT SHALL NOT INCLUDE OWNERSHIP OF INVESTMENT SECURITIES, INCLUDING SHARES OR BONDS, DEBENTURES, NOTES OR OTHER DEBT INSTRUMENTS, WHICH WERE PURCHASED ON TERMS GENERALLY AVAILABLE TO THE PUBLIC AND WHICH ARE IN A CORPORATION THAT IS LISTED FOR TRADING ON THE NEW YORK STOCK EXCHANGE OR ON THE AMERICAN STOCK EXCHANGE, OR IS A NATIONAL MARKET SYSTEM SECURITY TRADED UNDER AN AUTOMATED INTERDEALER QUOTATION SYSTEM OPERATED BY THE NATIONAL ASSOCIATION OF SECURITIES DEALERS, AND HAD, AT THE END OF THE CORPORATION'S MOST RECENT FISCAL YEAR, TOTAL ASSETS EXCEEDING ONE HUNDRED MILLION DOLLARS.

9. "CONTINUING PROFESSIONAL EDUCATION MATERIAL" MEANS ANY INFORMATION CONCERNING ANY ASPECT OF THE PRACTICE OF A PROFESSION REFERENCED IN SUBDIVISION ONE OF THIS SECTION WHICH IS COMMUNICATED BY ORAL, WRITTEN, GRAPHIC, AUDIO, VISUAL, ELECTRONIC OR OTHER MEANS DURING A CONTINUING PROFESSIONAL EDUCATION PROGRAM AND IS NOT BEING DISSEMINATED BY OR ON

BEHALF OF A MANUFACTURER OR DISTRIBUTOR CONCERNING ONE OR MORE OF ITS PRODUCTS.

S 2999-H. REQUIREMENTS FOR CONDUCTING A CONTINUING PROFESSIONAL EDUCATION PROGRAM. 1. IN CONNECTION WITH ANY CONTINUING PROFESSIONAL EDUCATION PROGRAM CONDUCTED IN THE STATE, A PRESENTER:

(A) SHALL NOT KNOWINGLY PRESENT ANY CONTINUING PROFESSIONAL EDUCATION MATERIALS THAT ARE FALSE OR MISLEADING;

(B) SHALL NOT REPRESENT, EXPLICITLY OR BY NOT DISCLOSING ANOTHER AUTHOR, THAT HE OR SHE WAS THE AUTHOR OF ANY CONTINUING PROFESSIONAL EDUCATION MATERIALS UNLESS THE PRESENTER HAS GIVEN FINAL APPROVAL OF SUCH MATERIALS, HAS PARTICIPATED SUFFICIENTLY IN THE DEVELOPMENT OF SUCH MATERIALS TO TAKE PUBLIC RESPONSIBILITY FOR THE CONTENT, AND HAS MADE SUBSTANTIAL CONTRIBUTIONS TO THE INTELLECTUAL CONTENT OF SUCH MATERIALS EITHER IN DRAFTING OR IN CRITICAL REVISION OF SUCH MATERIALS FOR IMPORTANT INTELLECTUAL CONTENT;

(C) SHALL DISCLOSE TO THE PROVIDER ALL FINANCIAL RELATIONSHIPS HE OR SHE HAS WITH ANY MANUFACTURER OR DISTRIBUTOR, INCLUDING THE NAME OF SUCH ENTITIES WITH WHICH HE OR SHE HAS A FINANCIAL RELATIONSHIP, THE NATURE OF THE RELATIONSHIP, AND THE FAIR MARKET VALUE OF ANYTHING OF ECONOMIC VALUE THE PRESENTER RECEIVED DURING THE PRECEDING TWELVE MONTHS IN CONNECTION WITH OR AS A RESULT OF SUCH RELATIONSHIP; AND

(D) SHALL DISCLOSE TO THE PROVIDER ANY INFORMATION OR WRITTEN, GRAPHIC, AUDIO, VISUAL OR ELECTRONIC MATERIALS OF ANY KIND THAT THE PRESENTER INTENDS TO COMMUNICATE AT THE CONTINUING PROFESSIONAL EDUCATION PROGRAM WHICH ARE EXEMPTED FROM THE DEFINITION OF CONTINUING PROFESSIONAL EDUCATION MATERIALS BECAUSE THEY ARE BEING DISSEMINATED BY OR ON BEHALF OF A MANUFACTURER OR DISTRIBUTOR, WHICH INFORMATION OR MATERIALS THE PRESENTER SHALL DESCRIBE WITH SPECIFICITY.

2. IN CONNECTION WITH ANY CONTINUING PROFESSIONAL EDUCATION PROGRAM CONDUCTED IN THE STATE, A PROVIDER:

(A) SHALL INFORM EVERY PRESENTER OF HIS OR HER OBLIGATIONS UNDER SUBDIVISION ONE OF THIS SECTION;

(B) SHALL ACT PRUDENTLY TO OBTAIN FROM EACH PRESENTER THE INFORMATION HE OR SHE IS REQUIRED TO DISCLOSE BY PARAGRAPHS (C) AND (D) OF SUBDIVISION ONE OF THIS SECTION; AND

(C) SHALL DISCLOSE TO ALL PERSONS ATTENDING A CONTINUING PROFESSIONAL EDUCATION PROGRAM:

(I) THE INFORMATION REQUIRED BY PARAGRAPHS (C) AND (D) OF SUBDIVISION ONE OF THIS SECTION THAT EACH PRESENTER AT SUCH PROGRAM HAS DISCLOSED TO THE PROVIDER; AND

(II) THE NATURE OF ANY SUPPORT FOR THE CONTINUING PROFESSIONAL EDUCATION PROGRAM, WHETHER MONETARY OR IN KIND, PROVIDED BY A MANUFACTURER OR DISTRIBUTOR, AND THE FAIR MARKET VALUE OF ALL SUCH SUPPORT.

S 2999-I. VIOLATIONS. THE COMMISSIONER MAY ASSESS A CIVIL PENALTY FOR VIOLATIONS OF THIS SECTION IN AN AMOUNT THAT IS, FOR A VIOLATION OF SUBDIVISION ONE OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-H OF THIS TITLE, NOT MORE THAN TWENTY-FIVE HUNDRED DOLLARS PER VIOLATION AND, FOR A VIOLATION OF SUBDIVISION TWO OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-H OF THIS TITLE, NOT MORE THAN TEN THOUSAND DOLLARS PER VIOLATION.

S 54. Section 6509 of the education law is amended by adding a new subdivision 16 to read as follows:

(16) A VIOLATION OF SUBDIVISION ONE OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-H OF THE PUBLIC HEALTH LAW.

S 55. Section 6530 of the education law is amended by adding a new subdivision 51 to read as follows:

51. A VIOLATION OF SUBDIVISION ONE OF SECTION TWENTY-NINE HUNDRED NINETY-NINE-H OF THE PUBLIC HEALTH LAW.

S 56. The public health law is amended by adding a new article 44-A to read as follows:

ARTICLE 44-A
PHARMACY BENEFIT MANAGERS

SECTION 4450. DEFINITIONS.
4451. MATTERS UNAFFECTED BY THIS ARTICLE.
4452. THE PHARMACY BENEFIT MANAGER'S GENERAL OBLIGATIONS.
4453. THE PHARMACY BENEFIT MANAGER'S DISCLOSURE OF INFORMATION TO THE HEALTH PLAN.
4454. THE PHARMACY BENEFIT MANAGER'S COMMUNICATION WITH PARTICIPANTS AND PRESCRIBERS IN CERTAIN SITUATIONS.
4455. DISTRIBUTION OF PRESCRIPTION DATA.
4456. ENFORCEMENT.

S 4450. DEFINITIONS. FOR THE PURPOSE OF THIS ARTICLE:

1. "HEALTH PLAN" MEANS A NONPROFIT HOSPITAL OR MEDICAL SERVICE ORGANIZATION, INSURER, HEALTH COVERAGE PLAN OR HEALTH MAINTENANCE ORGANIZATION LICENSED PURSUANT TO THE INSURANCE LAW; A HEALTH PROGRAM ADMINISTERED BY THE DEPARTMENT OF HEALTH, THE STATE OR A POLITICAL SUBDIVISION IN THE CAPACITY OF PROVIDER OF HEALTH COVERAGE; OR AN EMPLOYER, LABOR UNION OR OTHER GROUP OF PERSONS ORGANIZED IN THE STATE THAT PROVIDES HEALTH COVERAGE TO PARTICIPANTS WHO ARE EMPLOYED OR RESIDE IN THE STATE. "HEALTH PLAN" DOES NOT INCLUDE A HEALTH PLAN THAT PROVIDES COVERAGE ONLY FOR ACCIDENTAL INJURY, SPECIFIED DISEASE, HOSPITAL INDEMNITY, MEDICARE SUPPLEMENT, DISABILITY INCOME, LONG-TERM CARE OR OTHER LIMITED BENEFIT HEALTH INSURANCE POLICIES AND CONTRACTS.

2. "PARTICIPANT" MEANS A MEMBER, PARTICIPANT, ENROLLEE, CONTRACT HOLDER, POLICY HOLDER OR BENEFICIARY OF A HEALTH PLAN WHO RESIDES OR IS EMPLOYED IN THE STATE TO WHOM THE HEALTH PLAN PROVIDES HEALTH COVERAGE. "PARTICIPANT" INCLUDES A DEPENDENT OR OTHER PERSON PROVIDED HEALTH COVERAGE THROUGH A POLICY, CONTRACT OR PLAN FOR A PARTICIPANT.

3. "PRESCRIPTION DRUG" OR "DRUG" MEANS: (A) ARTICLES RECOGNIZED IN THE OFFICIAL UNITED STATES PHARMACOPOEIA, OFFICIAL HOMEOPATHIC PHARMACOPOEIA OF THE UNITED STATES, OR OFFICIAL NATIONAL FORMULARY;

(B) ARTICLES INTENDED FOR USE IN THE DIAGNOSIS, CURE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE IN HUMANS;

(C) ARTICLES (OTHER THAN FOOD) INTENDED TO AFFECT THE STRUCTURE OR ANY FUNCTION OF THE BODY OF HUMANS;

(D) ARTICLES INTENDED FOR USE AS A COMPONENT OF ANY ARTICLE SPECIFIED IN PARAGRAPH (A), (B) OR (C) OF THIS SUBDIVISION BUT DOES NOT INCLUDE DEVICES OR THEIR COMPONENTS, PARTS OR ACCESSORIES;
FOR WHICH A PRESCRIPTION IS REQUIRED UNDER THE FEDERAL FOOD, DRUG AND COSMETIC ACT.

4. "PRESCRIBER" MEANS A PHYSICIAN, DENTIST, PHYSICIAN ASSISTANT, SPECIALIST'S ASSISTANT, NURSE PRACTITIONER, MIDWIFE, OPTOMETRIST AND OTHER LICENSED HEALTH CARE PROVIDER AUTHORIZED UNDER TITLE EIGHT OF THE EDUCATION LAW TO PRESCRIBE DRUGS OR DEVICES, WHO IS PRACTICING IN THE STATE.

5. "PATIENT" IS A NATURAL PERSON FOR WHOM A PRESCRIBER WRITES A PRESCRIPTION FOR A PRESCRIPTION DRUG OR TO WHOM A PHARMACY DISPENSES SUCH A PRODUCT.

6. "PHARMACY BENEFIT MANAGEMENT SERVICES" MEANS THE NEGOTIATION OF THE AMOUNT TO BE PAID FOR PRESCRIPTION DRUGS BY THE HEALTH PLAN OR PARTICIPANTS IN THE STATE, THE ADMINISTRATION OR MANAGEMENT OF PRESCRIPTION DRUG BENEFITS PROVIDED BY A HEALTH PLAN FOR THE BENEFIT OF PARTICIPANTS,

OR ANY OF THE SERVICES LISTED IN PARAGRAPHS (A) THROUGH (G) OF THIS SUBDIVISION THAT ARE PROVIDED WITH REGARD TO THE ADMINISTRATION OF PARTICIPANTS' PHARMACY BENEFITS:

(A) MAIL SERVICE PHARMACY;

(B) SPECIALTY PHARMACY;

(C) CLAIMS PROCESSING, RETAIL NETWORK MANAGEMENT AND PAYMENT OF CLAIMS TO PHARMACIES FOR PRESCRIPTION DRUGS DISPENSED TO PARTICIPANTS;

(D) CLINICAL FORMULARY DEVELOPMENT AND MANAGEMENT SERVICES;

(E) REBATE CONTRACTING AND ADMINISTRATION;

(F) PATIENT COMPLIANCE, THERAPEUTIC INTERVENTION AND GENERIC SUBSTITUTION PROGRAMS; AND

(G) DISEASE MANAGEMENT PROGRAMS.

7. "PHARMACY BENEFIT MANAGER" IS A PERSON OR ENTITY THAT PROVIDES PHARMACY BENEFIT MANAGEMENT SERVICES TO A HEALTH PLAN.

8. "AFFILIATE" MEANS A CORPORATION OR OTHER BUSINESS ENTITY A MAJORITY OF WHOSE SHARES IS OWNED OR CONTROLLED BY SHAREHOLDERS, DIRECTORS OR OFFICERS OF ANOTHER CORPORATION OR OTHER BUSINESS ENTITY, WHO OWN OR CONTROL A MAJORITY OF THE SHARES OF THE OTHER CORPORATION OR OTHER BUSINESS ENTITY.

9. "COVERED" WHEN USED IN CONNECTION WITH A DRUG, DISPENSED PRESCRIPTION, GOOD OR SERVICE, REFERS TO A DRUG, DISPENSED PRESCRIPTION, GOOD OR SERVICE IN CONNECTION WITH WHICH THE PHARMACY BENEFIT MANAGER PROVIDES OR OFFERS TO PROVIDE PHARMACY BENEFIT MANAGEMENT SERVICES TO A HEALTH PLAN.

10. "PAYMENT" MEANS ANYTHING OF VALUE A PHARMACY BENEFIT MANAGER RECEIVES FROM ANY ENTITY, INCLUDING AN AFFILIATE BUT EXCLUDING THE HEALTH PLAN THAT CONTRACTS WITH IT FOR PHARMACY BENEFIT MANAGEMENT SERVICES, IN CONNECTION WITH A COVERED DRUG, COVERED DISPENSED PRESCRIPTION, COVERED GOOD OR COVERED SERVICE, OR ANY OTHER ASPECT OF THE PHARMACY BENEFIT MANAGER'S BUSINESS FAIRLY ATTRIBUTABLE TO THE PHARMACY BENEFIT MANAGEMENT SERVICES IT PROVIDES TO THE HEALTH PLAN.

11. "NET PRICE" OR "NET COST" MEANS THE PRICE PAID AFTER DEDUCTING ALL DISCOUNTS, REBATES, CHARGEBACKS AND ANY OTHER PRICE CONCESSION OR PAYMENT CONTINGENT ON A PURCHASE, BUT EXCLUDES ANY AMOUNT PAID TO A PHARMACY AS A DISPENSING FEE.

12. "SWITCH", AS IN "DRUG SWITCH" OR "SWITCH A PRESCRIPTION", MEANS AN ATTEMPT BY A PHARMACY BENEFIT MANAGER OR BY A PHARMACY OR OTHER ENTITY AT THE REQUEST OR ON BEHALF OF THE PHARMACY BENEFIT MANAGER TO CHANGE THE DRUG PRESCRIBED FOR A PARTICIPANT WHEN (A) SUCH ATTEMPT IS PART OF A CONCERTED EFFORT BY THE PHARMACY BENEFIT MANAGER TO EFFECT SUCH A CHANGE FOR MULTIPLE PARTICIPANTS BASED EITHER ON CLINICAL CONSIDERATIONS THAT ARE NOT SPECIFIC TO SUCH INDIVIDUAL PARTICIPANTS OR ON THE ECONOMIC VALUE OF THE SWITCH TO THE PHARMACY BENEFIT MANAGER AND (B) THE ATTEMPT WOULD NOT SUBSTITUTE A LOWER OR EQUALLY PRICED THERAPEUTICALLY EQUIVALENT DRUG. "LOWER OR EQUALLY PRICED" MEANS THE PARTICIPANT'S CO-PAYMENT OR CO-INSURANCE AMOUNT.

13. "THERAPEUTICALLY EQUIVALENT DRUGS" MEAN DRUGS IDENTIFIED AS BEING THERAPEUTICALLY EQUIVALENT TO EACH OTHER ON THE LIST REQUIRED BY PARAGRAPH (O) OF SUBDIVISION ONE OF SECTION TWO HUNDRED SIX OF THIS CHAPTER.

14. A "BRAND NAME DRUG" MEANS A DRUG MARKETED UNDER A PROPRIETARY, TRADEMARK-PROTECTED NAME.

15. A "GENERIC DRUG" MEANS THE SAME AS A BRAND NAME DRUG IN ACTIVE INGREDIENTS, DOSAGE, SAFETY, STRENGTH, ROUTE OF ADMINISTRATION, QUALITY, PERFORMANCE, AND INTENDED USE, BUT WHICH IS NOT MARKETED UNDER A PROPRIETARY, TRADEMARK-PROTECTED NAME.

16. "PHARMACY CATEGORIES" MEAN CHAIN RETAIL PHARMACIES (FOUR OR MORE STORES), INDEPENDENT RETAIL PHARMACIES (THREE OR FEWER STORES), PHARMACIES IN FOOD STORES, PHARMACIES IN MASS MERCHANDISE STORES, MAIL-SERVICE PHARMACIES, SPECIALTY PHARMACIES (RETAIL AND MAIL-SERVICE COMBINED), AND OTHER PHARMACIES.

17. "DRUG CATEGORIES" MEANS SINGLE-SOURCE BRAND NAME DRUG, MULTI-SOURCE BRAND NAME DRUG AND GENERIC DRUG.

S 4451. MATTERS UNAFFECTED BY THIS ARTICLE. 1. NOTHING IN THIS ARTICLE SHALL ALTER THE RELATIONSHIP BETWEEN A HEALTH PLAN AND ITS PARTICIPANTS OR BETWEEN A HEALTH PLAN AND ANY ENTITY THAT, WITH RESPECT TO A SPECIFIC ACTIVITY, QUALIFIES AS A FIDUCIARY OF THE HEALTH PLAN UNDER THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT.

2. THIS ARTICLE DOES NOT CREATE ANY OBLIGATION FOR A HEALTH PLAN TO DISCLOSE ANY INFORMATION TO ANY OF ITS PARTICIPANTS.

3. NOTHING IN THIS ARTICLE AFFECTS ANY CIVIL OR CRIMINAL PROCEEDINGS THAT MAY BE BROUGHT IN CONNECTION WITH MATTERS WITHIN THE SCOPE OF THIS ARTICLE.

S 4452. THE PHARMACY BENEFIT MANAGER'S GENERAL OBLIGATIONS. A PHARMACY BENEFIT MANAGER:

1. SHALL PERFORM ITS DUTIES IN CONNECTION WITH PHARMACY BENEFIT MANAGEMENT SERVICES IT PROVIDES TO A HEALTH PLAN OR PARTICIPANTS IN THE STATE WITH CARE, SKILL, PRUDENCE AND DILIGENCE;

2. SHALL NOT INITIATE A DRUG SWITCH FOR THE PARTICIPANTS OF A HEALTH PLAN FOR WHICH IT PROVIDES PHARMACY BENEFIT MANAGEMENT SERVICES EXCEPT PURSUANT TO THE HEALTH PLAN'S WRITTEN APPROVAL OR AGREEMENT TO SWITCHING THE SPECIFIC DRUGS. THE HEALTH PLAN'S AGREEMENT OR APPROVAL OF A DRUG SWITCH SHALL NOT RELIEVE THE PHARMACY BENEFIT MANAGER OF ANY RESPONSIBILITIES PERTAINING TO SUCH DRUG SWITCH UNDER THIS ARTICLE; AND

3. SHALL NOT PAY AN AFFILIATED ENTITY MORE FOR ANY COVERED DRUG, COVERED DISPENSED PRESCRIPTION, COVERED GOOD OR COVERED SERVICE THAN IT PAYS SIMILARLY SITUATED ENTITIES FOR THE SAME DRUG, DISPENSED PRESCRIPTION, GOOD OR SERVICE ON BEHALF OF THE SAME HEALTH PLAN. A SIMILARLY SITUATED PHARMACY IS A PHARMACY IN THE SAME PHARMACY CATEGORY.

S 4453. THE PHARMACY BENEFIT MANAGER'S DISCLOSURE OF INFORMATION TO THE HEALTH PLAN. 1. CONFIDENTIALITY. THE PHARMACY BENEFIT MANAGER MAY DESIGNATE INFORMATION IT DISCLOSES TO A HEALTH PLAN AS CONFIDENTIAL, AND THE HEALTH PLAN SHALL NOT RE-DISCLOSE SUCH INFORMATION TO OTHER ENTITIES EXCEPT TO AGENTS OR INDEPENDENT CONTRACTORS WITH WHOM THE HEALTH PLAN CONTRACTS TO ADMINISTER THE PHARMACY BENEFIT OR AUDIT SUCH ADMINISTRATION, PROVIDED SUCH AGENT OR INDEPENDENT CONTRACTOR PREVIOUSLY CERTIFIES THAT IT WILL NOT DISCLOSE SUCH CONFIDENTIAL INFORMATION TO ANY OTHER PERSON OR ENTITY. WITH RESPECT TO DOCUMENTS DISCLOSED TO A HEALTH PLAN THAT ARE SUBJECT TO ARTICLE SIX OF THE PUBLIC OFFICERS LAW, THE PHARMACY BENEFIT MANAGER SHALL NOT DESIGNATE AS "CONFIDENTIAL" ANY DOCUMENT TO WHICH THE PUBLIC WOULD HAVE ACCESS UNDER SAID LAW, AND THE PROVISIONS OF ARTICLE SIX OF THE PUBLIC OFFICERS LAW SHALL APPLY TO THE DOCUMENTS DISCLOSED TO SUCH A HEALTH PLAN. THE APPLICABILITY OF ARTICLE SIX OF THE PUBLIC OFFICERS LAW TO A HEALTH PLAN'S RECORDS DOES NOT AFFECT THE PHARMACY BENEFIT MANAGER'S OBLIGATION UNDER THIS ARTICLE TO DISCLOSE DOCUMENTS TO THE HEALTH PLAN.

2. DISCLOSURE IN CONNECTION WITH CONTRACT NEGOTIATIONS. PRIOR TO ENTERING INTO ITS INITIAL CONTRACT AND EACH SUBSEQUENT CONTRACT OR CONTRACT AMENDMENT WITH A HEALTH PLAN, THE PHARMACY BENEFIT MANAGER SHALL PROVIDE TO THE HEALTH PLAN IN WRITING EACH CATEGORY OF INFORMATION DESCRIBED IN PARAGRAPHS (A) THROUGH (C) OF THIS SUBDIVISION:

(A) A DESCRIPTION OF ALL PHARMACY BENEFIT MANAGEMENT SERVICES AND COVERED GOODS IT OFFERS TO PROVIDE THE HEALTH PLAN AND THE NET COST FOR EACH SUCH SERVICE OR GOOD;

(B) THE METHODOLOGY, WITH CLEARLY DEFINED TERMINOLOGY, THE PHARMACY BENEFIT MANAGER PROPOSES TO USE TO DISTINGUISH AMONG DRUGS, SUCH AS A METHODOLOGY BASED ON DRUG CATEGORY, FOR THE PURPOSE OF DETERMINING THE COST OF A DISPENSED PRESCRIPTION TO THE HEALTH PLAN OR THE PARTICIPANT'S CO-PAYMENT OR CO-INSURANCE AMOUNT FOR A DISPENSED PRESCRIPTION; AND

(C) A COMPLETE DESCRIPTION OF THE DESIGN AND OPERATION OF ANY FORMULARY THE PHARMACY BENEFIT MANAGER RECOMMENDS THAT THE HEALTH PLAN ADOPT.

3. INITIAL AND PERIODIC DISCLOSURE. (A) PRIOR TO ENTERING INTO ITS INITIAL CONTRACT WITH A HEALTH PLAN AND ANNUALLY THEREAFTER UNTIL THE PHARMACY BENEFIT MANAGER DISCONTINUES PROVIDING PHARMACY BENEFIT MANAGEMENT SERVICES TO THE HEALTH PLAN, THE PHARMACY BENEFIT MANAGER SHALL FULLY DISCLOSE TO THE HEALTH PLAN (I) THE CONTENT OF ALL CONTRACTS AND OTHER AGREEMENTS IT DIRECTLY OR INDIRECTLY HAS WITH, AND ALL PAYMENTS IT RECEIVES FROM, A DRUG MANUFACTURER, LABELER OR OTHER THIRD-PARTY IN CONNECTION WITH ANY PHARMACY BENEFIT MANAGEMENT SERVICE IT PROVIDES TO THE HEALTH PLAN, INCLUDING BUT NOT LIMITED TO COVERED DRUGS, COVERED DISPENSED PRESCRIPTIONS, COVERED GOODS, COVERED SERVICES, PROMOTING OR MARKETING ANY DRUG OR DRUG SWITCHES AND (II) THE PERCENTAGE OF ALL SUCH PAYMENTS RETAINED BY THE PHARMACY BENEFIT MANAGER OR DISTRIBUTED TO THE HEALTH PLAN.

(B) IN DISCLOSING PRIOR TO THE INITIAL CONTRACT THE VALUE OF A CATEGORY OF PAYMENT DESCRIBED IN SUBPARAGRAPH (I) OF PARAGRAPH (A) OF THIS SUBDIVISION OR THE PERCENTAGE OF SUCH PAYMENT RETAINED BY THE PHARMACY BENEFIT MANAGER OR DISTRIBUTED TO THE HEALTH PLAN AS DESCRIBED IN SUBPARAGRAPH (II) OF PARAGRAPH (A) OF THIS SUBDIVISION, THE PHARMACY BENEFIT MANAGER SHALL ESTIMATE THE VALUE BASED ON CONTRACTS THE EXECUTION OF WHICH IS CONTINGENT ON THE PHARMACY BENEFIT MANAGER CONTRACTING WITH THE HEALTH PLAN TO WHICH THE INFORMATION IS BEING DISCLOSED AND ON THE PHARMACY BENEFIT MANAGER'S EXISTING CONTRACTS WITH OTHER HEALTH PLANS, AND, WHERE RELEVANT, ON THE NEGOTIATING HEALTH PLAN'S PAST OR EXPECTED DRUG UTILIZATION. FOR SUBSEQUENT REPORTING PERIODS, THE PHARMACY BENEFIT MANAGER SHALL DISCLOSE THE ACTUAL VALUE OF EACH PAYMENT CATEGORY AND THE PERCENTAGE OF EACH SUCH CATEGORY THAT THE PHARMACY BENEFIT MANAGER RETAINED AND THE PERCENTAGE IT PAID TO OR PASSED THROUGH TO THE NEGOTIATING HEALTH PLAN.

4. DISCLOSURE DURING A CONTRACT PERIOD. (A) THE PHARMACY BENEFIT MANAGER SHALL PROVIDE TO THE HEALTH PLAN IN WRITING THE INFORMATION REQUIRED BY SUBPARAGRAPHS (I) THROUGH (VII) OF THIS PARAGRAPH ON A QUARTERLY BASIS DURING THE OPERATION OF THE CONTRACT BETWEEN THE PHARMACY BENEFIT MANAGER AND THE HEALTH PLAN: (I) THE HEALTH PLAN'S PARTICIPANTS' ACTUAL UTILIZATION OF DRUGS BY NATIONAL DRUG CODE (NDC) DIRECTORY NUMBER; (II) EVERY ACTIVITY, POLICY OR PRACTICE OF THE PHARMACY BENEFIT MANAGER THAT DIRECTLY OR INDIRECTLY PRESENTS ANY ACTUAL OR POTENTIAL CONFLICT OF INTEREST WITH THE HEALTH PLAN; (III) ANY INCREASE IN THE NET PRICE TO THE HEALTH PLAN FOR ANY COVERED DRUG AND THE REASON FOR SUCH INCREASE; (IV) ANY INCREASE IN THE DISPENSING FEE PAID TO ANY PHARMACY AND THE REASON FOR SUCH INCREASE; (V) ALL CONTRACTS AND OTHER AGREEMENTS ENTERED INTO DURING THE REPORTED QUARTER BETWEEN THE PHARMACY BENEFIT MANAGER AND ANY PHARMACY THAT IS WITHIN THE PHARMACY NETWORK IDENTIFIED BY THE PHARMACY BENEFIT MANAGER AT WHICH THE HEALTH PLAN'S PARTICIPANTS MAY FILL COVERED PRESCRIPTIONS, INCLUDING PHARMACIES AFFILIATED WITH THE PHARMACY BENEFIT MANAGER; (VI) ALL CONTRACTS AND OTHER AGREEMENTS THAT PERTAIN TO ANY COVERED DRUG OR COVERED DISPENSED PRESCRIPTION ENTERED

INTO DURING THE REPORTED QUARTER BETWEEN THE PHARMACY BENEFIT MANAGER AND ANY MANUFACTURER, LABELER, REPACKAGER OR DISTRIBUTOR OF A DRUG OR ANY OTHER THIRD-PARTY, INCLUDING ANY ENTITY ACTING ON BEHALF OF SUCH MANUFACTURER, LABELER, REPACKAGER, DISTRIBUTOR OR THIRD-PARTY; (VII) DOCUMENTS SUFFICIENT FOR THE HEALTH PLAN TO DETERMINE WHETHER ANY COVERED DISPENSED PRESCRIPTION FILLED WITH A REPACKAGED DRUG, INCLUDING A DRUG REPACKAGED BY AN AFFILIATE OF THE PHARMACY BENEFIT MANAGER, HAD EITHER A HIGHER NET COST TO THE HEALTH PLAN OR A HIGHER CO-PAYMENT OR CO-INSURANCE AMOUNT TO THE PARTICIPANT THAN ANY THERAPEUTICALLY EQUIVALENT DRUG AVAILABLE ON THE DATE THE PRESCRIPTION WAS FILLED. UPON THE HEALTH PLAN'S REQUEST, THE PHARMACY BENEFIT MANAGER SHALL PROVIDE DOCUMENTATION SUPPORTING THE REASON FOR ANY INCREASE IN NET PRICE OR THE REASON FOR ANY INCREASE IN DISPENSING FEE.

(B) DURING THE TIME A PHARMACY BENEFIT MANAGER PROVIDES PHARMACY BENEFIT MANAGEMENT SERVICES TO A HEALTH PLAN, UPON THE HEALTH PLAN'S DEMAND, THE PHARMACY BENEFIT MANAGER SHALL PROMPTLY:

(I) PROVIDE THE HEALTH PLAN WITH ACCESS TO ALL FINANCIAL, UTILIZATION, PRICING AND CLAIMS INFORMATION AND DOCUMENTS PERTAINING TO ANY ASPECT OF THE PHARMACY BENEFIT MANAGER'S BUSINESS THAT IS FAIRLY ATTRIBUTABLE TO THE PHARMACY BENEFIT MANAGEMENT SERVICES IT PROVIDES TO THE HEALTH PLAN, INCLUDING ELECTRONIC CLAIMS DATA FOR EACH SEPARATE CLAIM; AND

(II) ALLOW THE HEALTH PLAN TO CONDUCT ANNUAL AUDITS OF THOSE ASPECTS OF THE PHARMACY BENEFIT MANAGER'S BUSINESS THAT ARE FAIRLY ATTRIBUTABLE TO THE PHARMACY BENEFIT MANAGEMENT SERVICES IT PROVIDES TO THE HEALTH PLAN. THE PHARMACY BENEFIT MANAGER SHALL ALLOW THE HEALTH PLAN TO CONDUCT SUCH AUDITS ITSELF OR BY A CERTIFIED PUBLIC ACCOUNTING FIRM OF THE HEALTH PLAN'S CHOOSING THAT WILL CONDUCT THE AUDIT IN CONFORMANCE WITH ACCEPTED AUDITING PROCEDURES AND STANDARDS.

5. THE DEPARTMENT MAY PROMULGATE REGULATIONS THAT SET OUT THE NATURE, CONTENT AND FORMAT OF THE DISCLOSURES REQUIRED BY THIS SECTION.

S 4454. THE PHARMACY BENEFIT MANAGER'S COMMUNICATION WITH PARTICIPANTS AND PRESCRIBERS IN CERTAIN SITUATIONS. 1. NOTIFYING THE PATIENT OF A PROPOSED DRUG SWITCH. BEFORE A PHARMACY BENEFIT MANAGER, OR A PHARMACY OR OTHER ENTITY AT THE REQUEST OR ON BEHALF OF A PHARMACY BENEFIT MANAGER, REQUESTS A PRESCRIBER TO SWITCH A PRESCRIPTION FOR A PARTICIPANT OF A HEALTH PLAN, THE PHARMACY BENEFIT MANAGER, PHARMACY OR OTHER ENTITY SHALL NOTIFY IN WRITING THE PATIENT AND, IF RELEVANT, THE PATIENT'S GUARDIAN OF THIS INTENTION. SUCH NOTICE SHALL BE SENT TO THE PATIENT AND, IF RELEVANT, THE PATIENT'S GUARDIAN IN A MANNER REASONABLY CALCULATED TO REACH THE PATIENT AND, IF RELEVANT, THE PATIENT'S GUARDIAN NOT LESS THAN TWO BUSINESS DAYS BEFORE THE PRESCRIBER IS CONTACTED CONCERNING THE PROPOSED DRUG SWITCH. SUCH NOTICE SHALL NOT CONTAIN ANY FALSE OR MISLEADING INFORMATION ABOUT THE ORIGINALLY PRESCRIBED OR THE PROPOSED SUBSTITUTION DRUGS, INCLUDING THEIR RELATIVE COST TO THE PARTICIPANT.

2. INFORMATION TO BE PROVIDED TO A PRESCRIBER WHEN A DRUG SWITCH IS REQUESTED. WHEN A PHARMACY BENEFIT MANAGER, OR A PHARMACY OR OTHER ENTITY AT THE REQUEST OR ON BEHALF OF A PHARMACY BENEFIT MANAGER, REQUESTS A PRESCRIBER TO SWITCH A PRESCRIPTION THE PRESCRIBER HAS WRITTEN FOR A PARTICIPANT, IT SHALL PROVIDE THE PRESCRIBER WITH ALL OF THE FINANCIAL AND CLINICAL INFORMATION THE PRESCRIBER NEEDS TO DETERMINE WHETHER THE DRUG SWITCH IS IN THE PATIENT'S BEST INTERESTS.

3. CONTINUING OBLIGATIONS. (A) NOTHING CONTAINED IN THIS ARTICLE RELIEVES A PRESCRIBER OF ANY OBLIGATION THE PRESCRIBER MAY OTHERWISE HAVE TO DISCUSS WITH THE PATIENT THE RISKS AND BENEFITS OF A PRESCRIBED DRUG OR TO OBTAIN THE PATIENT'S CONSENT TO TREATMENT WITH A SPECIFIC DRUG, OR RELIEVES A PHARMACIST OF ANY OBLIGATION THE PHARMACIST MAY

OTHERWISE HAVE TO ALERT THE PATIENT OR PRESCRIBER TO ANY SAFETY OR EFFICACY CONCERNS RAISED BY DISPENSING A PARTICULAR DRUG TO THE INDIVIDUAL PATIENT.

(B) A PHARMACY BENEFIT MANAGER SHALL NOT TAKE ANY ACTION THAT WOULD RENDER IT LESS LIKELY THAT A PHARMACY WILL SUBSTITUTE A GENERIC DRUG WHEN REQUIRED TO DO SO BY SECTION SIXTY-EIGHT HUNDRED SIXTEEN-A OF THE EDUCATION LAW.

4. RECORD RETENTION. A PHARMACY BENEFIT MANAGER, OR A PHARMACY OR OTHER ENTITY ACTING AT THE PHARMACY BENEFIT MANAGER'S REQUEST OR ON ITS BEHALF, WHICH NOTIFIES A PATIENT AND, IF RELEVANT, THE PATIENT'S GUARDIAN OF ITS INTENTION TO CONTACT A PRESCRIBER TO SWITCH A DRUG OR REQUESTS THE PRESCRIBER TO SWITCH A PRESCRIPTION, SHALL MAINTAIN FOR THREE YEARS WRITTEN OR ELECTRONIC DOCUMENTATION OF SUCH CONTACT. UPON REQUEST, THE PHARMACY BENEFIT MANAGER SHALL MAKE SUCH DOCUMENTATION PROMPTLY AVAILABLE TO THE HEALTH PLAN OR THE DEPARTMENT.

5. DISEASE OR TREATMENT INFORMATION. PHARMACY BENEFIT MANAGERS SHALL ENSURE THAT EVERY WRITTEN OR ELECTRONIC DOCUMENT CONTAINING INFORMATION ABOUT A DISEASE, CONDITION OR TREATMENT FOR A DISEASE OR CONDITION THAT IT PROVIDES DIRECTLY OR INDIRECTLY TO ANY PARTICIPANT IS NOT FALSE OR MISLEADING AND DISCLOSES ANY SUPPORT OR INVOLVEMENT OF A DRUG OR DEVICE MANUFACTURER OR LABELER IN THE DEVELOPMENT, WRITING, OR DISTRIBUTION OF SUCH MATERIALS.

S 4455. DISTRIBUTION OF PRESCRIPTION DATA. 1. A PHARMACY BENEFIT MANAGER SHALL OBTAIN A HEALTH PLAN'S WRITTEN AGREEMENT BEFORE IT DISCLOSES ANY INFORMATION CONCERNING DISPENSED PRESCRIPTIONS COVERED BY THE HEALTH PLAN OR THE HEALTH PLAN'S DRUG-UTILIZATION OR CLAIMS DATA FOR COVERED DRUGS OR COVERED DISPENSED PRESCRIPTIONS TO AN ENTITY OTHER THAN THE HEALTH PLAN, AN ENTITY THAT QUALIFIES IN CONNECTION WITH THE DISCLOSURE OF SUCH INFORMATION AS THE HEALTH PLAN'S FIDUCIARY UNDER THE FEDERAL EMPLOYEE RETIREMENT INCOME SECURITY ACT, THE HEALTH PLAN'S SPONSOR, A PARTICIPANT WITH RESPECT TO HIS OR HER INFORMATION, A PRESCRIBER WITH THE PATIENT'S CONSENT, OR A GOVERNMENT AGENCY AUTHORIZED TO RECEIVE SUCH INFORMATION. SUCH WRITTEN AGREEMENT IS REQUIRED REGARDLESS OF WHETHER THE INFORMATION IS AGGREGATED OR IS IDENTIFIABLE BY INDIVIDUAL OR CATEGORY OF PARTICIPANT OR PRESCRIBER. WHEN THE HEALTH PLAN'S AGREEMENT TO THE DISCLOSURE OF SUCH INFORMATION IS REQUIRED BY THIS SECTION, THE PHARMACY BENEFIT MANAGER'S REQUEST FOR SUCH APPROVAL SHALL INCLUDE ALL THE INFORMATION REQUIRED BY PARAGRAPHS (A) THROUGH (D) OF THIS SUBDIVISION:

(A) THE IDENTITY OF THE ENTITY TO WHICH THE INFORMATION WILL BE PROVIDED;

(B) THE SPECIFIC, ITEMIZED CATEGORIES OF INFORMATION THAT WILL BE PROVIDED;

(C) THE SPECIFIC PRACTICES ACTUALLY IN OPERATION TO PROTECT THE PRIVACY OF THE HEALTH PLAN'S PARTICIPANTS; AND

(D) THE AMOUNT OF ANY PAYMENTS PAID OR PROVIDED TO THE PHARMACY BENEFIT MANAGER BY OR ON BEHALF OF THE ENTITY THAT SEEKS SUCH INFORMATION AND THE PURPOSE OF SUCH PAYMENTS THAT HAVE BEEN OR WILL BE PAID OR PROVIDED TO THE PHARMACY BENEFIT MANAGER.

2. A PHARMACY BENEFIT MANAGER VIOLATES THIS ARTICLE WHEN IT DISCLOSES INFORMATION FOR WHICH THIS SECTION REQUIRES THE HEALTH PLAN'S PRIOR WRITTEN AGREEMENT WITHOUT FIRST OBTAINING SUCH WRITTEN PERMISSION.

3. THE PHARMACY BENEFIT MANAGER AND THE HEALTH PLAN SHALL RETAIN FOR FIVE YEARS THE DOCUMENTATION OF THE PHARMACY BENEFIT MANAGER'S REQUEST AND THE HEALTH PLAN'S AGREEMENT THAT THE INFORMATION DESCRIBED IN SUBDIVISION ONE OF THIS SECTION MAY BE PROVIDED.

S 4456. ENFORCEMENT. 1. ANY HEALTH PLAN THAT HAS BEEN INJURED BY REASON OF A PHARMACY BENEFIT MANAGER'S VIOLATION OF ANY PROVISION OF THIS ARTICLE MAY BRING AN ACTION IN THE NAME OF THE HEALTH PLAN FOR EQUITABLE RELIEF AND TO RECOVER THE HEALTH PLAN'S ACTUAL DAMAGES AND A CIVIL PENALTY TO BE PAID TO THE HEALTH PLAN NOT TO EXCEED THREE TIMES SUCH ACTUAL DAMAGES.

2. ANY PHARMACY BENEFIT MANAGER THAT IS INJURED BY THE DISCLOSURE BY A HEALTH PLAN, A HEALTH PLAN'S AGENT OR INDEPENDENT CONTRACTOR OR A HEALTH PLAN'S CERTIFIED PUBLIC ACCOUNTING FIRM, OF INFORMATION THE PHARMACY BENEFIT MANAGER DESIGNATED AS CONFIDENTIAL PURSUANT TO SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED FIFTY-THREE OF THIS ARTICLE AND THAT IS NOT SUBJECT TO DISCLOSURE UNDER ARTICLE SIX OF THE PUBLIC OFFICERS LAW, SHALL HAVE A CAUSE OF ACTION IN THE NAME OF THE PHARMACY BENEFIT MANAGER FOR EQUITABLE RELIEF AND TO RECOVER THE PHARMACY BENEFIT MANAGER'S ACTUAL DAMAGES AND A CIVIL PENALTY NOT TO EXCEED THREE TIMES SUCH ACTUAL DAMAGES.

3. UPON DEMAND, A PHARMACY BENEFIT MANAGER SHALL PROVIDE THE DEPARTMENT WITH ACCESS, AT TIMES AND LOCATIONS THAT ARE CONVENIENT TO THE DEPARTMENT, TO THE RECORDS, BOOKS AND OTHER DOCUMENTS OF THE PHARMACY BENEFIT MANAGER AND ITS AFFILIATES WHICH PERTAIN TO THE PHARMACY BENEFIT MANAGER'S COMPLIANCE WITH THIS ARTICLE. THE OFFICERS, AGENTS AND EMPLOYEES OF THE PHARMACY BENEFIT MANAGER AND ITS AFFILIATES SHALL FACILITATE AND AID IN THE DEPARTMENT'S EXAMINATION OF SUCH RECORDS, BOOKS AND OTHER DOCUMENTS.

4. THE COMMISSIONER MAY ASSESS A CIVIL PENALTY FOR VIOLATIONS OF THIS ARTICLE IN AN AMOUNT OF NOT MORE THAN FIFTY THOUSAND DOLLARS PER VIOLATION.

S 57. Intentionally omitted.

S 58. Clauses (ii) and (iii) of subparagraph 1 and subparagraphs 3 and 4 of paragraph (a) of subdivision 1 of section 366 of the social services law, subparagraph 1 as amended by section 60 of part C of chapter 58 of the laws of 2008, subparagraph 3 as amended by chapter 309 of the laws of 1996, subparagraph 4 as amended by chapter 1080 of the laws of 1974, are amended to read as follows:

(ii) such person [may have resources up to the amount specified in subparagraph four of paragraph (a) of subdivision two of this section] SHALL NOT BE SUBJECT TO A RESOURCE TEST;

(iii) a person whose income [and resources are] IS within the [limits] LIMIT set forth in [clauses] CLAUSE (i) [and (ii)] of this subparagraph shall be deemed to have unmet needs for purposes of the eligibility requirements of the safety net program as it existed on the first day of November, nineteen hundred ninety-seven;

(3) is a child under the age of twenty-one years receiving care (A) away from his own home in accordance with title two of article six of this chapter; (B) during the initial thirty days of placement with the division for youth pursuant to section 353.3 of the family court act; (C) in an authorized agency when placed pursuant to section seven hundred fifty-six or 353.3 of the family court act; or (D) in residence at a division foster family home or a division contract home, and has not, according to the criteria promulgated by the department, sufficient income [and resources], including available support from his parents, to meet all costs of required medical care and services available under this title; or

(4) is receiving care, in the case of and in connection with the birth of an out of wedlock child, in accordance with title two of article six of this chapter, and has not, according to the criteria promulgated by

the department, sufficient income [and resources], including available support from responsible relatives, to meet all costs of required medical care and services available under this title; or

S 59. Subparagraphs 5, 6 and 8 of paragraph (a) of subdivision 1 of section 366 of the social services law, subparagraph 5 as amended by section 55 of part B of chapter 436 of the laws of 1997, subparagraph 6 as amended by chapter 710 of the laws of 1988 and subparagraph 8 as amended by section 60 of part C of chapter 58 of the laws of 2008, are amended and a new subparagraph 5-a is added to read as follows:

(5) although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has [not, according to the criteria and standards established by this article or by action of the department, sufficient] income and resources, including available support from responsible relatives, [to meet all the costs of medical care and services available under this title,] THAT DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION, and is (i) [under the age of twenty-one years, or] sixty-five years of age or older, or certified blind or certified disabled or (ii) [a spouse of a cash public assistance recipient living with him or her and essential or necessary to his or her welfare and whose needs are taken into account in determining the amount of his or her cash payment or (iii)] for reasons other than income or resources[: (A)], is eligible for federal supplemental security income benefits and/or additional state payments[, or (B) would meet the eligibility requirements of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six]; or

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

(6) is a resident of a home for adults operated by a social services district or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, OR IN THE CASE OF A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER, CERTIFIED BLIND, OR CERTIFIED DISABLED, SUFFICIENT INCOME and resources, including available support from responsible relatives, to meet all the costs of required medical care and services available under this title; or

(8) is a member of a family which contains a dependent child living with a caretaker relative, which has net available income not in excess of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, to be increased annually by the same percentage as the percentage increase in the federal consumer price index[, and which has net available resources not in excess of the amount specified in subparagraph four of paragraph (a) of subdivision two of this section]; for purposes of this subparagraph, the net avail-

able income [and resources] of a family shall be determined using the methodology of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven, except that no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; for purposes of this subparagraph, the term dependent child means a person under twenty-one years of age who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health; or

S 59-a. Subparagraph 10 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 1 of part E of chapter 57 of the laws of 2000, is amended to read as follows:

(10) is a child who is under twenty-one years of age, who is not living with a caretaker relative, who has net available income not in excess of the income standards of the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven[, and who has net available resources not in excess of one thousand dollars]; for purposes of this subparagraph, the child's net available income [and resources] shall be determined using the methodology of the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, except that [(i) there shall be disregarded an additional amount of resources equal to the difference between the applicable resource standard of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven and one thousand dollars and (ii)] no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; or

S 59-b. Paragraph (i) of subdivision 1 of section 369-ee of the social services law is REPEALED.

S 59-c. The opening paragraph of paragraph (b) of subdivision 2 of section 369-ee of the social services law, as amended by section 45-d of part C of chapter 58 of the laws of 2008, is amended to read as follows:

Subject to the provisions of paragraph (d) of this subdivision, in order to establish [income] eligibility under this subdivision, WHICH SHALL BE DETERMINED WITHOUT REGARD TO RESOURCES, an individual shall provide such documentation as is necessary and sufficient to initially, and annually thereafter, determine an applicant's eligibility for coverage under this title. Such documentation shall include, but not be limited to the following, if needed to verify eligibility:

S 59-d. Paragraph (c) of subdivision 2 of section 369-ee of the social services law is REPEALED.

S 60. Subdivision 1 and paragraph (a) of subdivision 2 of section 366-a of the social services law, subdivision 1 as amended by chapter 532 of the laws of 1972 and paragraph (a) of subdivision 2 as added by section 51 of part A of chapter 1 of the laws of 2002, are amended to read as follows:

1. Any person requesting medical assistance may make application therefor in person, through another in his behalf or by mail to the social services official of the county, city or town, or to the service officer of the city or town in which the applicant resides or is found. In addition, in the case of a person who is sixty-five years of age or older and is a patient in a state hospital for tuberculosis or for the mentally disabled, applications may be made to the department or to a

social services official designated as the agent of the department. Notwithstanding any provision of law to the contrary, [in accordance with department regulations, when an application is made by mail,] a personal interview [shall be conducted] with the applicant or with the person who made application [in] ON his OR HER behalf [when the applicant cannot be interviewed due to his physical or mental condition] SHALL NOT BE REQUIRED AS PART OF A DETERMINATION OF INITIAL OR CONTINUING ELIGIBILITY PURSUANT TO THIS TITLE.

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

S 61. Paragraph (a) of subdivision 5 of section 369-ee of the social services law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

(a) [Personal interviews, pursuant to section three hundred sixty-six-a of this chapter, may be required upon initial application only and may be conducted in community settings.] A PERSONAL INTERVIEW WITH THE APPLICANT OR WITH THE PERSON WHO MADE APPLICATION ON HIS OR HER BEHALF SHALL NOT BE REQUIRED AS PART OF A DETERMINATION OF INITIAL OR CONTINUING ELIGIBILITY PURSUANT TO THIS TITLE. Recertification of eligibility shall take place on no more than an annual basis [and shall not require a personal interview]. Nothing herein shall abridge the participant's obligation to report changes in residency, financial circumstances or household composition.

S 62. Section 23-a of part B of chapter 436 of the laws of 1997, constituting the welfare reform act of 1997, is amended to read as follows:

S 23-a. Notwithstanding any contrary provision thereof, section 266 of chapter 83 of the laws of 1995 shall apply to applicants for or recipients of public assistance and care[, including medical assistance]; provided, however, that [with respect to medical assistance, such section shall apply only to persons who are subject to the photograph identification requirements established by the commissioner of health for] SUCH SECTION SHALL NOT APPLY TO the medical assistance program.

S 63. Subparagraph 8 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(8) is a member of a family which contains a dependent child living with a caretaker relative, which has: (I) SUBJECT TO THE APPROVAL OF THE

FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOME NOT IN EXCESS OF ONE HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, net available income not in excess of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, to be increased annually by the same percentage as the percentage increase in the federal consumer price index, and which has net available resources not in excess of the amount specified in subparagraph four of paragraph (a) of subdivision two of this section; for purposes of this subparagraph, the net available income and resources of a family shall be determined using the methodology of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven, except that no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; for purposes of this subparagraph, the term dependent child means a person under twenty-one years of age who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health; or

S 64. Paragraph (a) of subdivision 1 of section 366 of the social services law is amended by adding a new subparagraph 8-a to read as follows:

(8-A) IS AN INDIVIDUAL WHO IS AT LEAST NINETEEN BUT UNDER TWENTY-ONE YEARS OF AGE AND IS A MEMBER OF A HOUSEHOLD WHICH HAS GROSS INCOME NOT IN EXCESS OF ONE HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A HOUSEHOLD OF THE SAME SIZE; OR

S 65. Paragraph (p) of subdivision 4 of section 366 of the social services law, as added by chapter 651 of the laws of 1990, subparagraph 2 as amended by section 97 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

(p) (1) Children who are at least one year of age but younger than [six] NINETEEN years of age who are not otherwise eligible for medical assistance and whose families have: (I) SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOMES NOT IN EXCESS OF ONE HUNDRED SIXTY PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, NET incomes equal to or less than one hundred thirty-three percent of the federal income official poverty line (as defined and annually revised by the federal office of management and budget) for a family of the same size as the families that include the children shall be eligible for medical assistance and shall remain eligible therefor as provided in subparagraph three of this paragraph.

(2) For purposes of determining eligibility for medical assistance under this paragraph, family income shall be determined by use of the same methodology used to determine eligibility for the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six provided, however, that costs incurred for medical or

remedial care shall not be considered and resources available to such families 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.

(3) An eligible child who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains six years of age, and who, but for attaining such age, would remain eligible for medical assistance under this paragraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

S 66. Paragraph (q) of subdivision 4 of section 366 of the social services law is REPEALED.

S 67. Subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by chapter 419 of the laws of 2000, is amended to read as follows:

(v) (A) in the case of a parent or stepparent of a child under the age of twenty-one who lives with such child, has gross family income equal to or less than the applicable percent of the federal income official poverty line (as defined and updated by the United States Department of Health and Human Services) for a family of the same size; for purposes of this clause, the applicable percent effective as of:

(I) January first, two thousand one, is one hundred twenty percent; and

(II) October first, two thousand one, is one hundred thirty-three percent; and

(III) October first, two thousand two, is one hundred fifty percent; [or] AND

(IV) APRIL FIRST, TWO THOUSAND TEN, IS ONE HUNDRED SIXTY PERCENT; OR

(B) in the case of an individual WHO IS AT LEAST TWENTY-ONE YEARS OF AGE AND who is not a parent or stepparent living with his or her child under the age of twenty-one, has gross family income equal to or less than one hundred percent of the federal income official poverty line (as defined and updated by the United States Department of Health and Human Services) for a family of the same size[.]; OR

(C) IN THE CASE OF AN INDIVIDUAL WHO IS AT LEAST NINETEEN BUT UNDER TWENTY-ONE YEARS OF AGE AND WHO IS NOT A PARENT OR STEPPARENT LIVING WITH HIS OR HER CHILD UNDER THE AGE OF TWENTY-ONE, HAS GROSS FAMILY INCOME EQUAL TO OR LESS THAN ONE HUNDRED SIXTY PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE; OR

(D) IS NOT DESCRIBED IN CLAUSE (A), (B) OR (C) OF THIS SUBPARAGRAPH AND HAS GROSS FAMILY INCOME EQUAL TO OR LESS THAN TWO HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE; PROVIDED, HOWEVER, THAT ELIGIBILITY UNDER THIS CLAUSE IS SUBJECT TO SOURCES OF FEDERAL AND NON-FEDERAL FUNDING FOR SUCH PURPOSE DESCRIBED IN SECTION SIXTY-SEVEN-A OF THE CHAPTER OF THE LAWS OF TWO THOUSAND NINE THAT ADDED THIS CLAUSE OR AS MAY BE AVAILABLE UNDER THE WAIVER AGREEMENT ENTERED INTO WITH THE FEDERAL GOVERNMENT UNDER SECTION ELEVEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, AS JOINTLY DETERMINED BY THE COMMISSIONER AND THE DIRECTOR OF THE DIVISION OF THE BUDGET. IN NO CASE SHALL STATE FUNDS BE UTILIZED TO SUPPORT THE NON-FEDERAL SHARE OF EXPENDITURES PURSUANT TO THIS SUBPARAGRAPH, PROVIDED HOWEVER THAT THE COMMISSIONER MAY DEMONSTRATE TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES THE EXISTENCE OF NON-FEDERALLY

PARTICIPATING STATE EXPENDITURES AS NECESSARY TO SECURE FEDERAL FUNDING UNDER AN ELEVEN HUNDRED FIFTEEN WAIVER FOR THE PURPOSES HEREIN. ELIGIBILITY UNDER THIS CLAUSE MAY BE PROVIDED TO RESIDENTS OF ALL COUNTIES OR, AT THE JOINT DISCRETION OF THE COMMISSIONER AND THE DIRECTOR OF THE DIVISION OF THE BUDGET, A SUBSET OF COUNTIES OF THE STATE.

S 67-a. Notwithstanding any contrary provision of law, the commissioner of health is authorized to enter into an agreement with the United States department of health and human services establishing a waiver agreement pursuant to section 1115 of the federal social security act which may include the redirection of such Medicaid payments described below, or a portion thereof, and the utilization of such funds to expand coverage under the family health plus program to families with gross income equal to or less than 200 percent of the federal poverty level, as provided in clause (D) of subparagraph (v) of paragraph (a) of subdivision two of section 369-ee of the social services law. Such waiver may include the following:

1. Notwithstanding any inconsistent provisions of sections 211, 212, 213 and 214 of chapter 474 of the laws of 1996, as amended, sections 13, 14, 18 and 21 of part B of chapter 1 of the laws of 2002, as amended, and sections 12, 14, 15 and 22 of part A of chapter 1 of the laws of 2002, as amended, or any other contrary provision of law, and subject to the availability of federal financial participation and the receipt of all necessary federal approvals, Medicaid payments authorized pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, but not including any payments to general hospitals operated by the state of New York or the university of the state of New York, sections 13 and 14 of part B of chapter 1 of the laws of 2002, and sections 12 and 14 of part A of chapter 1 of the laws of 2002, shall be in accord with the provisions of this section.

2. Social services districts which elect to participate in the program for such expanded family health plus coverage may have the non-federal share of the payment amounts described in subdivision one of this section, or a portion thereof, redirected by the commissioner of health to support the non-federal share of payments associated with such expanded family health plus coverage. Such elections shall be irrevocable and applicable to all future periods. Such elections by each social services district shall be subject to the approval of the commissioner of health and with the consent of the public hospitals which are located within each such social services district and which are otherwise eligible to receive such redirected payments.

3. The non-federal share payment obligations of social services districts that elect to participate in such expanded family health plus coverage shall be established at 50 percent of the amount of final reconciled Medicaid payments authorized pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, as amended, for the social services district for the year two years prior to the social services district's election to participate and shall not be subject to further adjustment. Further non-federal share payment obligations of social services districts that elect to participate in such expanded family health plus coverage shall be established as follows: (a) 50 percent of the amount actually expended in state fiscal year 2008-2009 for Medicaid payments authorized pursuant to section 12 of part A of chapter 1 of the laws of 2002 and pursuant to section 13 of part B of chapter 1 of the laws of 2002, and, (b) 50 percent of the amount actually expended in state fiscal year 2004-2005 for Medicaid payments authorized pursuant to section 14 of part A of

chapter 1 of the laws of 2002, and pursuant to section 14 of part B of chapter 1 of the laws of 2002.

4. For electing social services districts, the portion of each such payment obligation to be utilized for such expanded family health plus coverage shall be determined by the commissioner of health.

5. Payments to public general hospitals, other than those operated by the state of New York or the state university of New York, pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, sections 13 and 14 of part B of chapter 1 of the laws of 2002 and sections 12 and 14 of part A of chapter 1 of the laws of 2002, located in electing social services districts, shall be reduced to an amount that can be supported by the non-federal share payment obligations of such social services districts as reduced by the portion of such payment obligations to be utilized for expanded family health plus coverage as described above.

S 67-b. Notwithstanding any contrary provision of law, the commissioner of health is authorized to enter into a waiver agreement with the United States department of health and human services pursuant to section 1115 of the federal social security act to utilize federal funds available to the state under its federal disproportionate share hospital allotment pursuant to section 1923(f) of the federal social security act, that are projected to be in excess of the amounts necessary to fully fund existing state authorized disproportionate share hospital programs, to provide funding for expanded coverage under the family health plus program as provided in clause (D) of subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law.

S 68. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by section 28 of part E of chapter 63 of the laws of 2005, is amended to read as follows:

(iii) does not have equivalent health care coverage under insurance or equivalent mechanisms, as defined by the commissioner in consultation with the superintendent of insurance[, and is not a federal, state, county, municipal or school district employee that is eligible for health care coverage through his or her employer];

S 69. Intentionally omitted.

S 70. Intentionally omitted.

S 71. Intentionally omitted.

S 72. Intentionally omitted.

S 73. Subdivision 9 of section 2510 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D) FOR PERIODS ON OR AFTER JULY FIRST, TWO THOUSAND NINE, AMOUNTS AS FOLLOWS:

(I) NO PAYMENTS ARE REQUIRED FOR ELIGIBLE CHILDREN WHOSE FAMILY GROSS HOUSEHOLD INCOME IS LESS THAN ONE HUNDRED SIXTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL AND FOR ELIGIBLE CHILDREN WHO ARE AMERICAN INDIANS OR ALASKAN NATIVES, AS DEFINED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WHOSE FAMILY GROSS HOUSEHOLD INCOME IS LESS THAN TWO HUNDRED FIFTY-ONE PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL; AND

(II) FIFTEEN DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN ONE HUNDRED SIXTY PERCENT AND TWO HUNDRED TWENTY-TWO PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN FORTY-FIVE DOLLARS PER MONTH PER FAMILY; AND

(III) TWENTY-FIVE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN TWO HUNDRED TWENTY-THREE

PERCENT AND TWO HUNDRED FIFTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN SEVENTY-FIVE DOLLARS PER MONTH PER FAMILY; AND

(IV) THIRTY-FIVE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN TWO HUNDRED FIFTY-ONE PERCENT AND THREE HUNDRED PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN ONE HUNDRED FIVE DOLLARS PER MONTH PER FAMILY;

(V) FIFTY-FIVE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN THREE HUNDRED ONE PERCENT AND THREE HUNDRED FIFTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN ONE HUNDRED SIXTY-FIVE DOLLARS PER MONTH PER FAMILY; AND

(VI) SEVENTY-FIVE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN THREE HUNDRED FIFTY-ONE PERCENT AND FOUR HUNDRED PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN TWO HUNDRED TWENTY-FIVE DOLLARS PER MONTH PER FAMILY.

S 74. Clause (iii) of subparagraph 2 of paragraph (b) of subdivision 2 of section 366 of the social services law, as added by chapter 170 of the laws of 1994, subclause (B) as amended by chapter 656 of the laws of 1997, is amended to read as follows:

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, the department must not consider as available income or resources the corpus or income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust fund are established solely for the benefit of individuals who are disabled as such term is defined in section 1614(a)(3) of the federal social security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and [to the extent that amounts remaining in the individual's account are not retained by the trust] PROVIDED THAT upon the death of the individual, the state will receive all [such remaining amounts up to] AMOUNTS REMAINING IN THE INDIVIDUAL'S ACCOUNT THAT ARE NOT RETAINED BY THE TRUST OR NINETY PERCENT OF THE TOTAL AMOUNT REMAINING IN THE INDIVIDUAL'S TRUST ACCOUNT, WHICHEVER IS GREATER, BUT NOT TO EXCEED the total value of all medical assistance paid on behalf of such individual. Notwithstanding any law to the contrary, a not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as trustee of a trust for persons with disabilities established pursuant to this subclause, provided that a trust company, as defined in subdivision seven of section one hundred-c of the banking law, acts as co-trustee.

S 75. Subdivision 12 of section 367-a of the social services law, as amended by section 63-a of part C of chapter 58 of the laws of 2007, is amended to read as follows:

12. Prior to receiving medical assistance under subparagraphs twelve and thirteen of paragraph (a) of subdivision one of section three

hundred sixty-six of this title, a person whose net available income is at least one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, must pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium shall be [twenty-five dollars for an individual who is otherwise eligible for medical assistance under such subparagraphs, and fifty dollars for a couple, both of whom are otherwise eligible for medical assistance under such subparagraphs] AS FOLLOWS: (A) FOR AN INDIVIDUAL OR MARRIED COUPLE WHO ARE OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPHS AND WHOSE NET AVAILABLE INCOME IS AT LEAST ONE HUNDRED FIFTY PERCENT BUT DOES NOT EXCEED ONE HUNDRED EIGHTY-FIVE PERCENT OF THE APPLICABLE FEDERAL INCOME OFFICIAL POVERTY LINE FOR A HOUSEHOLD OF THE SAME SIZE, TWENTY-FIVE DOLLARS PER MONTH FOR AN INDIVIDUAL AND FIFTY DOLLARS PER MONTH FOR A COUPLE; (B) FOR AN INDIVIDUAL OR MARRIED COUPLE WHO ARE OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPHS AND WHOSE NET AVAILABLE INCOME IS GREATER THAN ONE HUNDRED EIGHTY-FIVE PERCENT BUT DOES NOT EXCEED TWO HUNDRED TWENTY PERCENT OF THE APPLICABLE FEDERAL INCOME OFFICIAL POVERTY LINE FOR A HOUSEHOLD OF THE SAME SIZE, FIFTY DOLLARS PER MONTH FOR AN INDIVIDUAL AND ONE HUNDRED DOLLARS PER MONTH FOR A COUPLE; AND (C) FOR AN INDIVIDUAL OR MARRIED COUPLE WHO ARE OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPHS AND WHOSE NET AVAILABLE INCOME IS GREATER THAN TWO HUNDRED TWENTY PERCENT BUT DOES NOT EXCEED TWO HUNDRED FIFTY PERCENT OF THE APPLICABLE FEDERAL INCOME OFFICIAL POVERTY LINE FOR A HOUSEHOLD OF THE SAME SIZE, SEVENTY-FIVE DOLLARS PER MONTH FOR AN INDIVIDUAL AND ONE HUNDRED FIFTY DOLLARS PER MONTH FOR A COUPLE. FOR PURPOSES OF THIS SUBDIVISION, HOUSEHOLD SIZE SHALL BE DETERMINED BY THE SAME METHODOLOGY USED FOR DETERMINING ELIGIBILITY FOR FEDERAL SUPPLEMENTAL SECURITY BENEFITS UNDER TITLE XVI OF THE FEDERAL SOCIAL SECURITY ACT. No premium shall be required from a person whose net available income is less than one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services.

S 76. Subdivision 1 of section 104-b of the social services law, as amended by chapter 271 of the laws of 1965 and such section as renumbered by chapter 550 of the laws of 1971, is amended to read as follows:

1. If a recipient of public assistance and care shall have a right of action, suit, claim, counterclaim or demand against another on account of any personal injuries suffered by such recipient, then THE PLEADINGS IN SUCH ACTION, SUIT, CLAIM, COUNTERCLAIM OR DEMAND SHALL CONTAIN A DEMAND FOR MEDICAL EXPENSES INCURRED BY THE RECIPIENT AS A DIRECT OR INDIRECT RESULT OF THOSE PERSONAL INJURIES, AND the [public welfare official for the public welfare] SOCIAL SERVICES OFFICIAL AND SOCIAL SERVICES district providing such assistance and care shall have a lien for such amount as may be fixed by the [public welfare] SOCIAL SERVICES official not exceeding, however, the total amount of such assistance and care furnished by such [public welfare] SOCIAL SERVICES official on and after the date when such injuries were incurred. IN ALL SUCH CASES, NOTICE OF THE PLEADINGS SHALL BE SERVED UPON THE SOCIAL SERVICES DISTRICT THAT HAS PROVIDED OR IS PROVIDING SUCH ASSISTANCE AND CARE, OR UPON THE DEPARTMENT OF HEALTH.

The [welfare] commissioner OF HEALTH shall endeavor to ascertain whether such person, firm or corporation alleged to be responsible for such injuries is insured with a liability insurance company, as the case may be, and the name thereof.

S 77. Section 104-b of the social services law is amended by adding a new subdivision 1-a to read as follows:

1-A. NO RIGHT OF ACTION, SUIT, CLAIM, COUNTERCLAIM OR DEMAND AGAINST ANOTHER ON ACCOUNT OF PERSONAL INJURIES SUFFERED BY A RECIPIENT OF PUBLIC ASSISTANCE AND CARE SHALL BE SETTLED WITHOUT THE APPROVAL OF THE SOCIAL SERVICES DISTRICT THAT HAS PROVIDED OR IS PROVIDING SUCH ASSISTANCE AND CARE, OR THE DEPARTMENT OF HEALTH. UNLESS WAIVED IN WHOLE OR IN PART BY THE DISTRICT OR DEPARTMENT, ANY SUCH SETTLEMENT MUST ALLOCATE FOR MEDICAL EXPENSES A SUFFICIENT AMOUNT:

(A) TO REPAY THE MEDICAL ASSISTANCE PROGRAM IN FULL, IF THE TOTAL AMOUNT OF MEDICAL ASSISTANCE PROVIDED TO THE RECIPIENT DOES NOT EXCEED ONE-THIRD OF THE GROSS PROCEEDS OF THE SETTLEMENT; OR

(B) TO REPAY THE MEDICAL ASSISTANCE PROGRAM AN AMOUNT EQUAL TO ONE-THIRD OF THE GROSS PROCEEDS OF THE SETTLEMENT, IF THE TOTAL AMOUNT OF MEDICAL ASSISTANCE PROVIDED TO THE RECIPIENT EXCEEDS SUCH AMOUNT.

S 78. Subdivision 8 of section 2511 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D)(I) EFFECTIVE APRIL FIRST, TWO THOUSAND NINE, PAYMENT FOR MARKETING AND FACILITATED ENROLLMENT ACTIVITIES SET FORTH IN SUBDIVISION NINE OF THIS SECTION AND INCLUDED IN SUBSIDY PAYMENTS MADE TO APPROVED ORGANIZATIONS PROVIDING SUCH SERVICES PURSUANT TO A CONTRACT WITH THE STATE SHALL BE LIMITED TO AN AMOUNT DETERMINED ANNUALLY BY THE COMMISSIONER.

(II) SUCH SUBSIDY PAYMENTS SHALL BE ADJUSTED BY THE COMMISSIONER TO REMOVE ANY COSTS OF APPROVED ORGANIZATIONS IN EXCESS OF THE AMOUNT DETERMINED IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH BASED ON COST REPORTS SUBMITTED TO THE DEPARTMENT BY APPROVED ORGANIZATIONS.

S 79. Subdivision 8 of section 2510 of the public health law, as amended by chapter 2 of the laws of 1998, is amended to read as follows:

8. "Subsidy payment" means a payment made to an approved organization for the cost of covered health care services coverage to an eligible child or children, THE AMOUNT OF WHICH SHALL BE DETERMINED SOLELY BY THE COMMISSIONER.

S 80. Subdivision 5 of section 2511 of the public health law, as amended by section 34 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

5. Notwithstanding any inconsistent provisions of subdivision two of this section, an individual who meets the criteria of paragraphs (b) and (c) of subdivision two of this section but not the criteria of paragraph (a) of such subdivision may be enrolled for covered health care services, provided however, that an approved organization shall not be eligible to receive a subsidy payment for providing coverage to such individuals. The cost of coverage shall be determined by the commissioner[, in consultation with the superintendent] and shall be no more than the cost of providing such coverage.

S 81. Paragraph (b) of subdivision 7 of section 2511 of the public health law, as amended by chapter 923 of the laws of 1990, is amended to read as follows:

(b) The commissioner, in consultation with the superintendent, shall make a determination whether to approve, disapprove or recommend modification of the proposal. In order for a proposal to be approved by the commissioner, the proposal must also be approved by the superintendent with respect to the provisions of subparagraphs (viii) through (X) AND (xii) of paragraph (a) of this subdivision.

S 82. Intentionally omitted.

S 83. Intentionally omitted.

S 84. Intentionally omitted.

S 85. Intentionally omitted.

S 86. Section 2801-a of the public health law is amended by adding a new subdivision 16 to read as follows:

16. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF HOSPITALS THE FOLLOWING APPLICATION FEE:

(I) FOR GENERAL HOSPITALS:	$3,000
(II) FOR NURSING HOMES:	$3,000
(III) FOR SAFETY NET DIAGNOSTIC AND TREATMENT CENTERS AS DEFINED IN PARAGRAPH (C) OF THIS SUBDIVISION:	$1,000
(IV) FOR ALL OTHER DIAGNOSTIC AND TREATMENT CENTERS:	$2,000

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A HOSPITAL SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE.

(C) THE COMMISSIONER MAY DESIGNATE A DIAGNOSTIC AND TREATMENT CENTER OR PROPOSED DIAGNOSTIC AND TREATMENT CENTER AS A "SAFETY NET DIAGNOSTIC AND TREATMENT CENTER" IF IT IS OPERATED OR PROPOSES TO BE OPERATED BY A NOT-FOR-PROFIT CORPORATION OR LOCAL HEALTH DEPARTMENT; PARTICIPATES OR INTENDS TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM; DEMONSTRATES OR PROJECTS THAT A SIGNIFICANT PERCENTAGE OF ITS VISITS, AS DETERMINED BY THE COMMISSIONER, WERE BY UNINSURED INDIVIDUALS; AND PRINCIPALLY PROVIDES PRIMARY CARE SERVICES AS DEFINED BY THE COMMISSIONER.

(D) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION FOR ESTABLISHMENT OF A HOSPITAL APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE CAPITAL COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. THE COST OF SUCH FEES AND CHARGES SHALL NOT BE SUBJECT TO REIMBURSEMENT CEILING OR OTHER PENALTIES USED BY THE COMMISSIONER FOR THE PURPOSE OF ESTABLISHING REIMBURSEMENT RATES PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 87. Subdivision 7 of section 2802 of the public health law, as amended by section 1 of part C of chapter 1 of the laws of 2002, is amended to read as follows:

7. (A) The commissioner shall charge to applicants for construction of hospitals the following fees and charges for administrative services so as to recover departmental costs in performing these functions. Each applicant for construction of a hospital shall pay to the department an application fee of [one thousand two hundred fifty dollars] TWO THOUSAND DOLLARS, PROVIDED, HOWEVER, THAT DIAGNOSTIC AND TREATMENT CENTERS DESIGNATED BY THE COMMISSIONER AS SAFETY NET DIAGNOSTIC AND TREATMENT CENTERS, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL PAY A FEE OF ONE THOUSAND TWO HUNDRED FIFTY DOLLARS.

(B) At such time as the commissioner's written approval OF THE CONSTRUCTION is granted, each applicant shall pay [an] THE FOLLOWING additional fee [of forty-five hundredths of one percent of the total capital value of the application, provided that only those applications requiring review by the State Hospital Review and Planning Council shall be subject to such fee.]:

(I) FOR HOSPITAL, NURSING HOME AND DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS THAT REQUIRE APPROVAL BY THE COUNCIL, THE ADDITIONAL FEE

SHALL BE FIFTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION, PROVIDED HOWEVER THAT APPLICATIONS FOR CONSTRUCTION OF A SAFETY NET DIAGNOSTIC AND TREATMENT CENTER, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL BE SUBJECT TO A FEE OF FORTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION; AND

(II) FOR HOSPITAL, NURSING HOME AND DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS THAT DO NOT REQUIRE APPROVAL BY THE COUNCIL, THE ADDITIONAL FEE SHALL BE THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION, PROVIDED HOWEVER THAT SAFETY NET DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL BE SUBJECT TO A FEE OF TWENTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(C) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH REDUCED FEES FOR APPLICATIONS SUBJECT TO LIMITED REVIEW, AS DESCRIBED IN REGULATION, THAT DO NOT REQUIRE REVIEW BY THE COUNCIL.

(D) The fees and charges paid by an applicant pursuant to this subdivision for any application for construction of a hospital approved in accordance with this section shall be deemed allowable capital costs in the determination of reimbursement rates established pursuant to this article. The cost of such fees and charges shall not be subject to reimbursement ceiling or other penalties used by the commissioner for the purpose of establishing reimbursement rates pursuant to this article. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

S 88. Section 3605 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE LICENSURE OF HOME CARE SERVICES AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 89. Section 3606 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF CERTIFIED HOME HEALTH AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS.

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A CERTIFIED HOME HEALTH AGENCY SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION THIRTY-SIX HUNDRED SIX-A OF THIS ARTICLE.

(C) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 90. Section 3606-a of the public health law is amended by adding a new subdivision 9 to read as follows:

9. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR CONSTRUCTION OF CERTIFIED HOME HEALTH AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS. EACH SUCH APPLICANT SHALL, AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF THE CONSTRUCTION IS GRANTED, PAY AN ADDITIONAL FEE

OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(B) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 91. Section 3610 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE AUTHORIZATION OR CONSTRUCTION OF LONG TERM HOME HEALTH CARE PROGRAMS AN APPLICATION FEE OF TWO THOUSAND DOLLARS. EACH SUCH APPLICANT SHALL, AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF A CONSTRUCTION APPLICATION IS GRANTED, PAY AN ADDITIONAL FEE OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(B) THE FEES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 92. Section 3611-a of the public health law, as added by chapter 959 of the laws of 1984, is amended to read as follows:

S 3611-a. Change in the operator or owner. 1. Any change in the person who, or ANY TRANSFER, ASSIGNMENT, OR OTHER DISPOSITION OF AN INTEREST OR VOTING RIGHTS OF TEN PERCENT OR MORE, OR ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION WHICH RESULTS IN THE OWNERSHIP OR CONTROL OF AN INTEREST OR VOTING RIGHTS OF TEN PERCENT OR MORE, IN A LIMITED LIABILITY COMPANY OR A partnership which is the operator of a licensed home care services agency or a certified home health agency shall be approved by the public health council in accordance with the provisions of subdivision four of section three thousand six hundred five of this [chapter] ARTICLE relative to licensure or subdivision two of section three thousand six hundred six of this [chapter] ARTICLE relative to certificate of approval, EXCEPT THAT:

(A) PUBLIC HEALTH COUNCIL APPROVAL SHALL BE REQUIRED ONLY WITH RESPECT TO THE PERSON, OR THE MEMBER OR PARTNER THAT IS ACQUIRING THE INTEREST OR VOTING RIGHTS; AND

(B) WITH RESPECT TO CERTIFIED HOME HEALTH AGENCIES, SUCH CHANGE SHALL NOT BE SUBJECT TO THE PUBLIC NEED ASSESSMENT DESCRIBED IN PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION THREE THOUSAND SIX HUNDRED SIX OF THIS ARTICLE.

(C) NO PRIOR APPROVAL OF THE PUBLIC HEALTH COUNCIL SHALL BE REQUIRED WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION OF:

(I) AN INTEREST OR VOTING RIGHTS TO ANY PERSON PREVIOUSLY APPROVED BY THE PUBLIC HEALTH COUNCIL FOR THAT OPERATOR; OR

(II) AN INTEREST OR VOTING RIGHTS OF LESS THAN TEN PERCENT IN THE OPERATOR. HOWEVER, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST NINETY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNER OR MEMBER COMPLETES AND FILES WITH THE PUBLIC HEALTH COUNCIL NOTICE ON FORMS TO BE DEVELOPED BY THE PUBLIC HEALTH COUNCIL, WHICH SHALL DISCLOSE SUCH INFORMATION AS MAY REASONABLY BE NECESSARY FOR THE PUBLIC HEALTH COUNCIL TO DETERMINE WHETHER IT SHOULD BAR THE TRANS-

ACTION. SUCH TRANSACTION WILL BE FINAL AS OF THE INTENDED EFFECTIVE DATE UNLESS, PRIOR THERETO, THE PUBLIC HEALTH COUNCIL SHALL STATE SPECIFIC REASONS FOR BARRING SUCH TRANSACTIONS UNDER THIS PARAGRAPH AND SHALL NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

2. Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a licensed home care services agency or a certified home health agency, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of more than ten percent of the stock or voting rights thereunder of such corporation by any person shall be subject to approval by the public health council in accordance with the provisions of subdivision four of section three thousand six hundred five of this [chapter] ARTICLE relative to licensure or subdivision two of section three thousand six hundred six of this [chapter] ARTICLE relative to certificate of approval , EXCEPT THAT:

(A) PUBLIC HEALTH COUNCIL APPROVAL SHALL BE REQUIRED ONLY WITH RESPECT TO THE PERSON OR ENTITY ACQUIRING SUCH STOCK OR VOTING RIGHTS; AND

(B) WITH RESPECT TO CERTIFIED HOME HEALTH AGENCIES, SUCH CHANGE SHALL NOT BE SUBJECT TO THE PUBLIC NEED ASSESSMENT DESCRIBED IN PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION THREE THOUSAND SIX HUNDRED SIX OF THIS ARTICLE. In the absence of such approval, the license or certificate of approval shall be subject to revocation or suspension.

(C) NO PRIOR APPROVAL OF THE PUBLIC HEALTH COUNCIL SHALL BE REQUIRED WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION OF AN INTEREST OR VOTING RIGHTS TO ANY PERSON PREVIOUSLY APPROVED BY THE PUBLIC HEALTH COUNCIL FOR THAT OPERATOR. HOWEVER, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNER OR MEMBER COMPLETES AND FILES WITH THE PUBLIC HEALTH COUNCIL NOTICE ON FORMS TO BE DEVELOPED BY THE PUBLIC HEALTH COUNCIL, WHICH SHALL DISCLOSE SUCH INFORMATION AS MAY REASONABLY BE NECESSARY FOR THE PUBLIC HEALTH COUNCIL TO DETERMINE WHETHER IT SHOULD BAR THE TRANSACTION. SUCH TRANSACTION WILL BE FINAL AS OF THE INTENDED EFFECTIVE DATE UNLESS, PRIOR THERETO, THE PUBLIC HEALTH COUNCIL SHALL STATE SPECIFIC REASONS FOR BARRING SUCH TRANSACTIONS UNDER THIS PARAGRAPH AND SHALL NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

3. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR A CHANGE IN OPERATOR OR OWNER OF A LICENSED HOME CARE SERVICES AGENCY OR A CERTIFIED HOME HEALTH AGENCY AN APPLICATION FEE IN THE AMOUNT OF TWO THOUSAND DOLLARS.

(B) THE FEES PAID BY CERTIFIED HOME HEALTH AGENCIES PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 93. Section 4004 of the public health law is amended by adding a new subdivision 5 to read as follows:

5. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF A HOSPICE AN APPLICATION FEE IN THE AMOUNT OF TWO THOUSAND DOLLARS.

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A HOSPICE SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION FOUR THOUSAND SIX OF THIS ARTICLE.

(C) ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 94. Section 4006 of the public health law is amended by adding a new subdivision 9 to read as follows:

9. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR CONSTRUCTION OF A HOSPICE AN APPLICATION FEE OF TWO THOUSAND DOLLARS.

(B) AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF THE CONSTRUCTION IS GRANTED, EACH SUCH APPLICANT SHALL PAY AN ADDITIONAL FEE OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(C) ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUND - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 95. The opening paragraph of paragraph (s) of subdivision 1 of section 2807-m of the public health law, as amended by section 16 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

"Adjustment amount" means an amount determined for each teaching hospital FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE by:

S 96. Paragraph (b) of subdivision 2 of section 2807-m of the public health law, as amended by chapter 1 of the laws of 1999, is amended to read as follows:

(b) [Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH regional pool shall be distributed on a monthly basis to teaching general hospitals for costs associated with graduate medical education provided by such teaching general hospitals in accordance with the distribution methodology set forth in subdivision three of this section; provided however, teaching general hospitals with a resident count of zero as of July first of the year preceding the distribution period shall not be eligible for distributions pursuant to this section. General hospitals may elect to have their distribution paid through the consortium.

S 97. Paragraphs (a), (c), (e) and (f) and the opening paragraphs of paragraphs (b) and (d) of subdivision 3 of section 2807-m of the public health law, paragraph (a) and the opening paragraph of paragraph (b) as added by chapter 639 of the laws of 1996, paragraph (c) as amended by chapter 419 of the laws of 2000, the opening paragraph of paragraph (d) as amended by section 17 of part B of chapter 58 of the laws of 2008, paragraph (e) as amended by section 11 of part OO of chapter 57 of the laws of 2008 and paragraph (f) as amended by section 13 of part E of chapter 63 of the laws of 2005, are amended to read as follows:

(a) Distributions to teaching general hospitals shall be made from the regional pools described in subdivision two of this section for each period PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, less amounts set aside pursuant to subdivision five of this section. To be eligible to participate in distributions pursuant to this section, a teaching general hospital and consortium must be in compliance with graduate medical education reporting requirements set forth in subdivision four of this section.

[Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH teaching general hospital in a region shall have a proxy calculated for its graduate medical education costs as follows:

(c) [A] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, A distribution amount for each teaching general hospital shall be calculated from the applicable regional pool described in subdivision two of this section as adjusted pursuant to paragraph (d) of this subdivision

based upon its percentage of the regional total of the graduate medical education proxies, except that for purposes of this paragraph the statewide amount used to compute such distribution amounts shall be four hundred ninety million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand two and two hundred forty-five million dollars for the period January first, two thousand three through June thirtieth, two thousand three, less amounts set aside each period pursuant to subdivision seven of this section.

[Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraph (c) of this subdivision adjusted by a reduction amount that is determined as follows:

(e) Effective April first, two thousand four THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, the distribution amount calculated pursuant to paragraphs (c) and (d) of this subdivision for each non-public teaching general hospital shall be reduced by the amount calculated and included in rates pursuant to paragraph (d) of subdivision twenty-five of section twenty-eight hundred seven-c of this article.

(f) Effective January first, two thousand five THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraphs (c), (d) and (e) of this subdivision and reduced by its adjustment amount calculated pursuant to paragraph [(1)] (S) of subdivision one of this section and, for distributions for the period January first, two thousand five through December thirty-first, two thousand five, further reduced by its extra reduction amount calculated pursuant to paragraph [(m)] (T) of subdivision one of this section.

S 98. The opening paragraph of paragraph (b), paragraph (c), the opening paragraphs of paragraphs (d) and (e) and paragraphs (f) and (g) of subdivision 5-a of section 2807-m of the public health law, the opening paragraph of paragraph (b), paragraph (c), the opening paragraph of paragraph (e), and paragraphs (f) and (g) as added by section 75-c of part C of chapter 58 of the laws of 2008 and the opening paragraph of paragraph (d) as amended by section 15 of part OO of chapter 57 of the laws of 2008, are amended to read as follows:

Empire clinical research investigator program (ECRIP) and other graduate medical education reforms. [Thirty-one] THIRTY million FOUR HUNDRED THOUSAND dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and seven million [seven hundred fifty] SIX HUNDRED thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be available for distribution as follows:

(c) Ambulatory care training. [Five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, [five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand

ten through December thirty-first, two thousand ten, and one million two hundred [fifty] TWENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to sponsoring institutions to be directed to support clinical training of medical students and residents in free-standing ambulatory care settings, including community health centers and private practices. Such funding shall be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be distributed to sponsoring institutions in each region pursuant to a request for application or request for proposal process with preference being given to sponsoring institutions which provide training in sites located in underserved rural or inner-city areas and those that include medical students in such training.

[Two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, [two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, and [five] FOUR hundred NINETY thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner as follows:

[Five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [five] FOUR million NINE HUNDRED THOUSAND dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and one million two hundred [fifty] TWENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner as follows:

(f) Study on physician workforce. [Six] FIVE hundred NINETY thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, and one hundred [fifty] FORTY-EIGHT thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter

into agreements with one or more organizations to conduct such study based on a request for proposal process.

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

S 99. Subdivision 7 of section 2807-m of the public health law, as amended by section 75-d of part C of chapter 58 of the laws of 2008, is amended to read as follows:

7. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, up to one million dollars for the period January first, two thousand through December thirty-first, two thousand, one million six hundred thousand dollars annually for the periods January first, two thousand one through December thirty-first, two thousand [ten,] EIGHT, ONE MILLION FIVE HUNDRED THOUSAND DOLLARS ANNUALLY FOR THE PERIODS JANUARY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN, and [four] THREE hundred SEVENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of expanding community-based training of medical students. In addition, one million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, and two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of post-secondary training of health care professionals who will achieve specific program outcomes within the New York state area health education center program. The New York state area health education center program shall report to the commissioner on an annual basis regarding the use of funds for each purpose in such form and manner as specified by the commissioner.

S 100. Paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 22 of part A of chapter 58 of the laws of 2007, subparagraphs (viii), (ix) and (xii) as amended by section 14 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) funds shall be accumulated in regional professional education pools established by the commissioner or the healthcare reform act

(HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, for distribution in accordance with section twenty-eight hundred seven-m of this article, in the following amounts:

(i) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

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

(iv) four hundred ninety-four million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand three,

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

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

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

(viii) four hundred seventy million dollars [annually] for the period January first, two thousand seven through December thirty-first, two thousand [ten] SEVEN, [and]

(ix) [one hundred seventeen] FOUR HUNDRED FORTY-SIX MILLION SIX HUNDRED THOUSAND DOLLARS FOR THE PERIOD JANUARY FIRST, TWO THOUSAND EIGHT THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT,

(X) FORTY-SEVEN MILLION TWO HUNDRED TEN THOUSAND DOLLARS FOR THE PERIOD JANUARY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN; AND

(XI) ELEVEN million [five] EIGHT hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

[(x)] (XII) provided, however, FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph may be reduced by the commissioner in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the graduate medical education program established pursuant to section twenty-eight hundred seven-m of this article;

[(xi)] (XIII) provided further, however, FOR PERIODS PRIOR TO JULY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph shall be reduced by an amount equal to the total actual distribution reductions for all facilities pursuant to paragraph (e) of subdivision three of section twenty-eight hundred seven-m of this article; and

[(xii)] (XIV) provided further, however, FOR PERIODS PRIOR TO JULY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-m of this article.

S 101. Section 2807-k of the public health law is amended by adding a new subdivision 5-b to read as follows:

5-B. 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 NINE, FUNDS AVAILABLE PURSUANT TO PARAGRAPH (A-1) OF SUBDIVISION FOUR OF THIS SECTION AND AN ADDITIONAL TWO HUNDRED EIGHTY-THREE MILLION DOLLARS AS IS OTHERWISE AVAILABLE FOR DISTRIBUTION PURSUANT TO THIS SECTION, SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED ON AN ANNUAL BASIS IN ACCORDANCE WITH THE FOLLOWING:

(A) DISTRIBUTIONS PURSUANT TO THIS SUBDIVISION SHALL BE LIMITED TO GENERAL HOSPITALS WHICH ARE TEACHING HOSPITALS AS DEFINED IN APPLICABLE REGULATIONS.

(B) FOR THE PURPOSES OF DISTRIBUTIONS IN ACCORDANCE WITH THIS SUBDIVISION, EACH ELIGIBLE FACILITY'S RELATIVE UNCOMPENSATED CARE NEED AMOUNT SHALL BE DETERMINED UTILIZING THE METHODOLOGY SET FORTH IN PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION.

(C) DISTRIBUTIONS MADE PURSUANT TO THIS SUBDIVISION REMAIN SUBJECT TO THE PROVISIONS OF PARAGRAPH (D) OF SUBDIVISION FIVE-A OF THIS SECTION.

S 102. Paragraph (c) of subdivision 5-a of section 2807-k of the public health law, as added by section 28-b of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(c) For the purposes of distributions in accordance with paragraphs (a) and (b) of this subdivision, each facility's relative uncompensated care need amount shall be determined [by multiplying reported inpatient and outpatient units of service from the calendar year two years prior to the distribution year, but excluding referred ambulatory services units of service, for all uninsured patients by the applicable Medicaid rates, but not including prospective rate adjustments and rate add-ons, in effect for the calendar year two years prior to the distribution year for such services, provided, however, that for distributions on and after January first, two thousand ten, each facility's uncompensated need amount shall be reduced by the sum of all payment amounts collected from such patients. The total uncompensated care need for each facility subject to paragraph (a) or (b) of this subdivision shall then be adjusted by application of the nominal need scale set forth in subdivision five of this section.] IN ACCORDANCE WITH THE FOLLOWING:

(I) INPATIENT UNITS OF SERVICES FOR ALL UNINSURED PATIENTS FROM THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, BUT EXCLUDING REFERRED AMBULATORY UNITS OF SERVICES, SHALL BE MULTIPLIED BY THE APPLICABLE MEDICAID INPATIENT RATES IN EFFECT FOR SUCH PRIOR YEAR, BUT NOT INCLUDING PROSPECTIVE RATE ADJUSTMENTS AND RATE ADD-ONS, PROVIDED, HOWEVER, THAT FOR DISTRIBUTIONS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN, THE UNCOMPENSATED AMOUNT FOR INPATIENT SERVICES SHALL UTILIZE THE INPATIENT RATES IN EFFECT AS OF JULY FIRST OF THE PRIOR YEAR;

(II) OUTPATIENT UNITS OF SERVICE FOR ALL UNINSURED PATIENTS FROM THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, INCLUDING EMERGENCY DEPARTMENT SERVICES AND AMBULATORY SURGERY SERVICES, BUT EXCLUDING REFERRED AMBULATORY SERVICES UNITS OF SERVICE, SHALL BE MULTIPLIED BY MEDICAID OUTPATIENT RATES THAT REFLECT THE EXCLUSIVE UTILIZATION OF THE AMBULATORY PATIENT GROUPS (APG) RATE-SETTING METHODOLOGY AS SET FORTH IN REGULATIONS PROMULGATED PURSUANT TO SUBDIVISION TWO-A OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE, AS IN EFFECT FOR THE DISTRIBUTION YEAR, PROVIDED FURTHER, HOWEVER, THAT FOR THOSE SERVICES FOR WHICH APG RATES ARE NOT AVAILABLE THE APPLICABLE MEDICAID OUTPATIENT RATE

SHALL BE THE RATE IN EFFECT FOR THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR;

(III) THE UNCOMPENSATED CARE NEED FOR EACH FACILITY FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN SHALL BE REDUCED BY THE SUM OF ALL PAYMENT AMOUNTS COLLECTED FROM SUCH PATIENTS; AND

(IV) THE TOTAL UNCOMPENSATED CARE NEED FOR EACH FACILITY SUBJECT TO THIS SUBDIVISION SHALL THEN BE ADJUSTED BY APPLICATION OF THE NOMINAL NEED SCALE SET FORTH IN SUBDIVISION FIVE OF THIS SECTION.

S 103. Section 2807-p of the public health law is amended by adding a new subdivision 10 to read as follows:

10. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER IS AUTHORIZED TO SEEK A WAIVER FROM THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, OR SUCH OTHER FEDERAL LAW PROVISION AS MAY BE DEEMED APPROPRIATE, SEEKING FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS MADE PURSUANT TO THIS SECTION, IN WHICH CASE THE STATE FUNDING MADE AVAILABLE PURSUANT TO THIS SECTION SHALL BE UTILIZED AS THE NON-FEDERAL SHARE OF SUCH PAYMENTS. TO THE EXTENT AS MAY BE REQUIRED, PAYMENTS MADE PURSUANT TO THIS SECTION AND IN ACCORDANCE WITH THIS SUBDIVISION, MAY BE DEEMED TO BE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS IN ACCORDANCE WITH THE PROVISIONS OF THE FEDERAL SOCIAL SECURITY ACT.

(B) IF FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS MADE PURSUANT TO THIS SECTION ARE MADE AVAILABLE IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBDIVISION, FREE-STANDING CLINICS LICENSED SOLELY PURSUANT TO ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW SHALL ALSO BE DEEMED ELIGIBLE FOR PARTICIPATION IN SUCH PAYMENTS TO THE SAME DEGREE AND IN ACCORDANCE WITH THE SAME DISTRIBUTION METHODOLOGY OTHERWISE PROVIDED IN THIS SECTION, PROVIDED, HOWEVER, THAT ONLY THOSE UNITS OF SERVICE PROVIDED BY SUCH FREE-STANDING CLINICS THAT CONSTITUTE MEDICAL SERVICES THAT ARE OTHERWISE ELIGIBLE FOR CONSIDERATION FOR MEDICAID PAYMENTS SHALL BE REFLECTED IN DISTRIBUTIONS MADE PURSUANT TO THIS SECTION, AND FURTHER PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, REQUIRE SUCH CLINICS, AS A CONDITION OF RECEIVING SUCH DISTRIBUTIONS, TO PROVIDE REPORTS AND DATA TO THE DEPARTMENT AS THE COMMISSIONER DEEMS NECESSARY TO ADEQUATELY IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION WITH REGARD TO SUCH CLINICS.

S 104. Subdivision 3 of section 241 of the elder law is amended to read as follows:

3. "Income" shall mean "household gross income" as defined in the real property tax circuit breaker credit program, pursuant to subparagraph (C) of paragraph one of subsection (e) of section six hundred six of the tax law, but only shall include the income of program applicants and spouses and shall exclude the income of other members of the household; PROVIDED, HOWEVER, THAT THE PANEL MAY ADOPT POLICIES TO EXCLUDE FROM INCOME CERTAIN NON-RECURRING ITEMS THAT WOULD ACT TO ARTIFICIALLY INFLATE THE AVAILABILITY OF FUNDS TO MEET CURRENT NEEDS INCLUDING, BUT NOT LIMITED TO, A RETIREE'S PREVIOUS YEAR'S WAGES, AND NON-RECURRING DISTRIBUTIONS FROM AN INDIVIDUAL RETIREMENT ACCOUNT.

S 105. Subdivision 1 of section 241 of the elder law, as amended by section 29 of part A of chapter 58 of the laws of 2008, is amended to read as follows:

1. "Covered drug" shall mean a drug dispensed subject to a legally authorized prescription pursuant to section sixty-eight hundred ten of the education law, and insulin, an insulin syringe, or an insulin

needle. Such term shall not include: (a) any drug determined by the commissioner of the federal food and drug administration to be ineffective or unsafe; (b) any drug dispensed in a package, or form of dosage or administration, as to which the commissioner of health finally determines in accordance with the provisions of section two hundred fifty-two of this title that a less expensive package, or form of dosage or administration, is available that is pharmaceutically equivalent and equivalent in its therapeutic effect for the general health characteristics of the eligible program participant population; (c) any device for the aid or correction of vision; (d) any drug, including vitamins, which is generally available without a physician's prescription; [and] (e) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food and drug administration; [and] (f) a brand name drug for which a multisource therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the elderly pharmaceutical insurance coverage program, provided, however, that the elderly pharmaceutical insurance coverage panel is authorized to exempt, for good cause shown, any brand name drug from such restriction, and provided further that such restriction shall not apply to any drug that is included on the preferred drug list under section two hundred seventy-two of the public health law or is in the clinical drug review program under section two hundred seventy-four of the public health law to the extent that the preferred drug program and the clinical drug review program are applied to the elderly pharmaceutical insurance coverage program pursuant to section two hundred seventy-five of the public health law, or to any drug covered under a program participant's Medicare part D or other primary insurance plan; AND (G) ANY DRUG EXCLUDED FROM COVERAGE BY THE MEDICAL ASSISTANCE PROGRAM ESTABLISHED UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. Any of the drugs enumerated in the preceding sentence shall be considered a covered drug or a prescription drug for purposes of this article if it is added to the preferred drug list under article two-A of the public health law. For the purpose of this title, except as otherwise provided in this section, a covered drug shall be dispensed in quantities no greater than a thirty day supply or one hundred units, whichever is greater. In the case of a drug dispensed in a form of administration other than a tablet or capsule, the maximum allowed quantity shall be a thirty day supply; the panel is authorized to approve exceptions to these limits for specific products following consideration of recommendations from pharmaceutical or medical experts regarding commonly packaged quantities, unusual forms of administration, length of treatment or cost effectiveness. In the case of a drug prescribed pursuant to section thirty-three hundred thirty-two of the public health law to treat one of the conditions that have been enumerated by the commissioner of health pursuant to regulation as warranting the prescribing of greater than a thirty day supply, such drug shall be dispensed in quantities not to exceed a three month supply.

S 106. The opening paragraph of paragraph (f) and paragraph (h) of subdivision 3 of section 242 of the elder law, as added by section 3 of part B of chapter 58 of the laws of 2007, are amended to read as follows:

As a condition of continued eligibility for benefits under this title, if a program participant is eligible for Medicare part D drug coverage under section 1860D of the federal social security act, the participant

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

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

(i) application for the premium and cost-sharing subsidies, AND THE MEDICARE SAVINGS PROGRAMS, on behalf of eligible program participants;

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

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

S 107. Paragraph (c) of subdivision 3 of section 242 of the elder law, as amended by section 4 of part A of chapter 58 of the laws of 2005, is amended to read as follows:

(c) The fact that some of an individual's prescription drug expenses are paid or reimbursable under the provisions of the medicare program shall not disqualify an individual, if he or she is otherwise eligible, from receiving assistance under this title. [In such cases, the state shall pay the portion of the cost of those prescriptions for qualified drugs for which no payment or reimbursement is made by the medicare program or any federally funded prescription drug benefit, less the participant's co-payment required on the amount not paid by the medicare program.] HOWEVER, EXCEPT FOR DRUGS EXCLUDED FROM MEDICARE COVERAGE IN ACCORDANCE WITH SECTION EIGHTEEN HUNDRED SIXTY-D-2 OF THE FEDERAL SOCIAL SECURITY ACT, SUCH ASSISTANCE SHALL BE LIMITED TO PRESCRIPTION DRUGS COVERED BY THE INDIVIDUAL'S MEDICARE PLAN. IN SUCH CASES, THE STATE SHALL COVER THE AMOUNT THAT IS THE RESPONSIBILITY OF THE INDIVIDUAL UNDER THE MEDICARE PLAN BENEFIT, SUBJECT TO THE INDIVIDUAL'S COST-SHARING RESPONSIBILITY UNDER SECTIONS TWO HUNDRED FORTY-SEVEN OR TWO HUNDRED FORTY-EIGHT OF THIS TITLE ON SUCH AMOUNT. In addition, the participant registration fee charged to eligible program participants for comprehensive coverage pursuant to section two hundred forty-seven of this title shall be waived for the portion of the annual coverage period that the participant is also enrolled as a transitional assistance beneficiary in the medicare prescription drug discount card program, authorized pursuant to title XVIII of the federal social security act, provided that: (i) any sponsor of such drug discount card program has signed an agreement to complete coordination of benefit functions with EPIC, and has been endorsed by the EPIC panel; or (ii) any exclusive sponsor of such drug discount card program authorized pursuant to title XVIII of the federal social security act that limits the participants to the medicare prescription drug discount card program sponsored by such exclusive sponsor, shall coordinate benefits available under such discount card

program with EPIC. [The participant registration fee charged to eligible program participants for comprehensive coverage pursuant to section two hundred forty-seven of this title shall be waived for the portion of the annual coverage period that the participant is also enrolled as a full subsidy individual in a prescription drug or MA-PD plan under Part D of title XVIII of the federal social security act.]

S 107-a. Paragraph (g) of subdivision 3 of section 242 of the elder law, as added by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(g) The elderly pharmaceutical insurance coverage program is authorized and directed to conduct an enrollment program to facilitate, in as prompt and streamlined a fashion as possible, the enrollment into Medicare part D of program participants who are required by the provisions of this section to enroll in part D. [Provided, however, that a participant shall not be prevented from receiving his or her drugs immediately at the pharmacy under the elderly pharmaceutical insurance coverage program as a result of such participant's enrollment in Medicare part D.]

S 108. Subdivision 6 of section 250 of the elder law is REPEALED.

S 109. The opening paragraph of subdivision 2 and paragraph (b) of subdivision 3 of section 247 of the elder law are amended to read as follows:

Eligible individuals electing to meet the requirements of this subdivision shall pay a quarterly registration fee in a manner and form determined by the executive director; at the option of the participant, the registration fee may be paid annually in a lump sum upon the beginning of the annual coverage period. No eligible individual electing to meet the requirements of this subdivision shall have his OR HER participation in the program lapse by virtue of non-payment of the applicable registration fee unless the contractor has provided notification of the amount and due date thereof, and more than thirty days have elapsed since the due date of the individual's registration fee. The registration fee to be charged to eligible program participants for comprehensive coverage under this option shall be in accordance with the following schedule, EXCEPT THAT SUCH FEE SHALL BE WAIVED FOR PARTICIPANTS WITH INCOME AT OR BELOW ONE HUNDRED FIFTY PERCENT OF THE OFFICIAL POVERTY LINE MAINTAINED BY THE FEDERAL SECRETARY OF HEALTH AND HUMAN SERVICES:

(b) The point of sale co-payment amounts which are to be charged eligible program participants shall be in accordance with the following schedule:

For each prescription of covered drugs costing $15.00 or less.....$3.00
For each prescription of covered drugs costing $15.01 to $35.00...$7.00
For each prescription of covered drugs costing $35.01 [to $55.00..$15.00
For each prescription of covered drugs costing $55.01] or more....[$20.00] $15.00

S 110. Subdivision 2 of section 241 of the elder law, as amended by section 13 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

2. "Provider pharmacy" shall mean a pharmacy registered in the state of New York pursuant to section sixty-eight hundred eight of the education law, A NON-RESIDENT ESTABLISHMENT REGISTERED PURSUANT TO SECTION SIXTY-EIGHT HUNDRED EIGHT-B OF THE EDUCATION LAW, or a pharmacy registered in a state bordering the state of New York when certified as necessary by the executive director pursuant to section two hundred fifty-three of this title, for which an agreement to provide pharmacy

services for purposes of this program pursuant to section two hundred forty-nine of this title is in effect.

S 111. Subdivision 1 of section 249 of the elder law is amended to read as follows:

1. The state shall offer an opportunity to participate in this program to all provider pharmacies as defined in section two hundred forty-one of this title, PROVIDED, HOWEVER, THAT THE PARTICIPATION OF PHARMACIES REGISTERED IN THE STATE PURSUANT TO SECTION SIXTY-EIGHT HUNDRED EIGHT-B OF THE EDUCATION LAW SHALL BE LIMITED TO STATE ASSISTANCE PROVIDED UNDER THIS TITLE FOR PRESCRIPTION DRUGS COVERED BY A PROGRAM PARTICIPANT'S MEDICARE OR OTHER DRUG PLAN.

S 112. Paragraph (e) of subdivision 3 of section 242 of the elder law, as amended by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(e) As a condition of continued eligibility for benefits under this title, if a program participant's income indicates that the participant could be eligible for an income-related subsidy under section 1860D-14 of the federal social security act BY EITHER APPLYING FOR SUCH SUBSIDY OR BY ENROLLING IN A MEDICARE SAVINGS PROGRAM AS A QUALIFIED MEDICARE BENEFICIARY (QMB), A SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB), OR A QUALIFYING INDIVIDUAL (QI), a program participant is required to provide[, and to authorize the elderly pharmaceutical insurance coverage program to obtain,] any information or documentation required to establish the participant's eligibility for such subsidy, AND TO AUTHORIZE THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM TO APPLY ON BEHALF OF THE PARTICIPANT FOR THE SUBSIDY OR THE MEDICARE SAVINGS PROGRAM. The elderly pharmaceutical insurance coverage program shall make a reasonable effort to notify the program participant of his or her need to provide any of the above required information. After a reasonable effort has been made to contact the participant, a participant shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the participant's coverage may be terminated.

S 113. Section 2807-j of the public health law is amended by adding a new subdivision 13 to read as follows:

13. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE, EACH THIRD PARTY PAYOR WHICH HAS ENTERED INTO AN ELECTION AGREEMENT WITH THE COMMISSIONER PURSUANT TO SUBDIVISION FIVE OF THIS SECTION SHALL, AS A CONDITION OF SUCH ELECTION, PAY TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE, A PERCENTAGE SURCHARGE EQUAL TO THE SURCHARGE PERCENT SET FORTH IN PARAGRAPH (C) OF SUBDIVISION TWO OF THIS SECTION FOR THE SAME PERIOD AND APPLIED TO ALL PAYMENTS MADE BY SUCH THIRD PARTY PAYORS FOR PATIENT CARE SERVICES PROVIDED WITHIN THE STATE BY PHYSICIANS IN PHYSICIAN OFFICES OR IN URGENT CARE FACILITIES THAT ARE NOT OTHERWISE LICENSED PURSUANT TO THIS ARTICLE AND WHICH ARE BILLED AS SURGERY OR RADIOLOGY SERVICES IN ACCORDANCE WITH THE CURRENT PROCEDURE TERMINOLOGY, FOURTH EDITION, AS PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION.

(B) SUCH PAYMENTS SHALL BE MADE AND REPORTED AT THE SAME TIME AND IN THE SAME MANNER AS THE PAYMENTS AND REPORTS WHICH ARE OTHERWISE SUBMITTED BY EACH THIRD PARTY PAYOR TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE IN ACCORDANCE WITH THIS SECTION. SUCH PAYMENTS SHALL BE SUBJECT TO AUDIT BY THE COMMISSIONER IN THE SAME MANNER AS THE OTHER PAYMENTS OTHERWISE SUBMITTED AND REPORTED PURSUANT TO THIS SECTION. THE COMMISSIONER MAY TAKE ALL MEASURES TO COLLECT DELINQUENT PAYMENTS DUE PURSUANT

TO THIS SUBDIVISION AS ARE OTHERWISE PERMITTED WITH REGARD TO DELINQUENT PAYMENTS DUE PURSUANT TO OTHER SUBDIVISIONS OF THIS SECTION.

(C) SURCHARGES PURSUANT TO THIS SUBDIVISION SHALL NOT APPLY TO PAYMENTS MADE BY THIRD PARTY PAYORS FOR SERVICES PROVIDED TO PATIENTS INSURED BY MEDICAID OR BY THE CHILD HEALTH PLUS PROGRAM OR TO ANY PATIENT IN A CATEGORY THAT IS EXEMPT FROM SURCHARGE OBLIGATIONS ASSESSED PURSUANT TO SUBDIVISIONS ONE THROUGH TWELVE OF THIS SECTION.

S 114. Paragraph (b) of subdivision 1-a of section 2807-s of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

(b) "Specified third-party payors", for purposes of this section and sections twenty-eight hundred seven-j and twenty-eight hundred seven-t of this article, shall include corporations organized and operating in accordance with article forty-three of the insurance law, organizations operating in accordance with the provisions of article forty-four of this chapter, self-insured funds and administrators acting on behalf of self-insured funds, and commercial insurers [licensed to do business in this state and] authorized to write accident and health insurance and whose policy provides coverage on an expense incurred basis. Specified third-party payors, for purposes of this section, shall not include governmental agencies or providers of coverage pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law.

S 115. Paragraph (j) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

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

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

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

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

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

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

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

(viii) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand seven through December thir-

ty-first, two thousand seven, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research; AND

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

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

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

(xii) up to twenty-three million five hundred thirty-seven thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven].

S 116. Paragraph (b) of subdivision 2 of section 367-a of the social services law, as amended by section 58 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(b) Any inconsistent provision of this chapter or other law notwithstanding, upon furnishing assistance under this title to any applicant or recipient of medical assistance, the local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or [third party reimbursement] REIMBURSEMENT FROM LIABLE THIRD PARTIES, INCLUDING BUT NOT LIMITED TO HEALTH INSURERS, SELF-INSURED PLANS, GROUP HEALTH PLANS, SERVICE BENEFIT PLANS, MANAGED CARE ORGANIZATIONS, PHARMACY BENEFIT MANAGERS, OR OTHER PARTIES THAT ARE, BY STATUTE, CONTRACT, OR AGREEMENT, LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE. For purposes of this section, the term medical support shall mean the right to support specified as support for the purpose of medical care by a court or administrative order. The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing such insurance, nor shall such right of subrogation attach to any benefits which may be claimed by a social services official or the department, by agreement or other established procedure, directly from an insurance carrier. No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. The local social services district or the department shall also notify the carrier when the exercise of subrogation rights has terminated because a person is no longer receiving assistance under this title. Such carrier shall establish mechanisms to maintain the confidentiality of all individually identifiable information or records. Such carrier shall limit the use of such information or record to the specific purpose for which such disclosure is made, and shall not further disclose such information or records.

S 117. Paragraph (a) of subdivision 11 of section 367-a of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(a) Any inconsistent provisions of this title or other law notwithstanding, no health insurer, [health maintenance organization] SELF-IN-

SURED PLAN, MANAGED CARE ORGANIZATION, PHARMACY BENEFIT MANAGER, or other [entity providing medical benefits] PARTY THAT IS, BY STATUTE, CONTRACT, OR AGREEMENT, LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE, employer or organization who has a plan, including an employee retirement income security act or service benefit plan, providing care and other medical benefits for persons, whether by insurance or otherwise, shall exclude a person from eligibility, coverage or entitlement to medical benefits by reason of the eligibility of such person for medical assistance under this title, or by reason of the fact that such person would, except for such plan, be eligible for benefits under this title.

S 118. Paragraph 2 of subsection (b) of section 313 of the insurance law is amended to read as follows:

(2) Notwithstanding any provisions of this section to the contrary, in case of an examination or appraisal of [a domestic] AN AUTHORIZED insurer made within this state, the traveling and living expense of the person or persons making the examination shall be considered a cost of operation, as referred to in section three hundred thirty-two of this article and not an expense of examination.

S 119. Section 332 of the insurance law, subsection (a) as amended by chapter 61 of the laws of 1989, is amended to read as follows:

S 332. Assessments to defray [operating] expenses of department. (a) [The] FOR PURPOSES OF THIS SECTION, THE expenses of the department, excluding the expenses of the supervision of employee welfare funds, SHALL INCLUDE ALL APPROPRIATIONS WHETHER ADMINISTERED BY THE DEPARTMENT OR SUBALLOCATED TO ANOTHER STATE DEPARTMENT, BOARD, OR AGENCY, for any fiscal year, including all direct and indirect costs, as approved by the director of the budget and audited by the comptroller, except as otherwise provided by sections one hundred fifty-one and two hundred twenty-eight of the workers' compensation law and by section sixty of the volunteer firefighters' benefit law, shall be assessed by the superintendent pro rata upon all [domestic] AUTHORIZED insurers [and all licensed United States branches of alien insurers domiciled in this state within the meaning of paragraph four of subsection (b) of section seven thousand four hundred eight of this chapter], in proportion to the gross direct premiums and other considerations, written or received by them in this state during the calendar year ending December thirty-first immediately preceding the end of the fiscal year for which the assessment is made (less return premiums and considerations thereon) for policies or contracts of insurance covering property or risks resident or located in this state the issuance of which policies or contracts requires a license from the superintendent; and the superintendent shall levy and collect such assessments and pay the same into the state treasury, subject to the provisions of section one hundred twenty-one of the state finance law and subsection (b) [hereof] OF THIS SECTION.

(b) For each fiscal year commencing on or after April first, nineteen hundred eighty-three, a partial payment shall be made by each insurer subject to this section in a sum equal to twenty-five per centum of the annual expenses assessed upon it for the fiscal year as estimated by the superintendent. Such payment shall be made on March tenth of the preceding fiscal year and on June tenth, September tenth and December tenth of each year, or at such other dates as the director of the budget may prescribe. [Provided, however, that the payment due March tenth, nineteen hundred eighty-three for the fiscal year beginning April first, nineteen hundred eighty-three shall not be required to be paid until June tenth, nineteen hundred eighty-three.] The balance of assessments

for the fiscal year shall be paid upon determination of the actual amount due in accordance with the provisions of this section. Any overpayment of annual assessment resulting from complying with the requirements of this subsection shall be refunded or at the option of the assessed applied as a credit against the assessment for the succeeding fiscal year. The partial payment schedule provided for herein shall not be applicable to any insurer whose annual assessment pursuant to this section for the fiscal year is estimated to be less than one hundred dollars and such insurers shall make a single annual payment on or before September thirtieth of the fiscal year.

S 120. Subparagraphs (vi), (vii) and (viii) of paragraph (uu) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, are amended to read as follows:

(vi) [nine] SEVEN million [five] EIGHT hundred THIRTY-THREE thousand THREE HUNDRED THIRTY-THREE dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and [two million] THREE HUNDRED THIRTY-THREE THOUSAND THREE HUNDRED THIRTY-THREE dollars shall be available for telemedicine demonstration programs FOR THE PERIOD JANUARY FIRST, TWO THOUSAND NINE THROUGH MARCH FIRST, TWO THOUSAND NINE;

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

(viii) [two] ONE million [three] EIGHT hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[, of which one million eight hundred seventy-five thousand dollars] shall be available for disease management demonstration programs [and five hundred thousand dollars shall be available for telemedicine demonstration programs].

S 121. Section 3621 of the public health law is REPEALED.

S 122. Paragraph 1 of subsection (g) of section 2101 of the insurance law, as amended by chapter 301 of the laws of 2008, is amended to read as follows:

(1) The term "independent adjuster" means any person, firm, association or corporation who[,] or [which,] THAT for money, commission or any other thing of value, acts [in this state] on behalf of an insurer in the work of investigating and adjusting claims arising under insurance contracts issued by such insurer and who performs such duties required by such insurer as are incidental to such claims; ANY PERSON, FIRM, ASSOCIATION OR CORPORATION WHO OR THAT FOR MONEY, COMMISSION OR ANY OTHER THING OF VALUE, PAYS CLAIMS ON BEHALF OF AN INSURER; and [also includes] any person who for compensation or anything of value investigates and adjusts claims on behalf of any independent adjuster, except that such term shall not include:

(A) any officer, director or regular salaried employee of an authorized insurer or entity licensed pursuant to article forty-four of the public health law providing comprehensive health service plans (as used in this paragraph, a "health maintenance organization"), or any manager thereof, individual or corporate, or the manager, agent or general agent of any department thereof, individual or corporate, or attorney in fact of any reciprocal insurer or Lloyds underwriter, or marine underwriting

office, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

(B) any officer, director or regular salaried employee of an insurer authorized to write accident and health insurance, a corporation licensed under article forty-three of this chapter (collectively, as used in this paragraph, a "health insurer") or a health maintenance organization, or any manager thereof, individual or corporate, when the claim to be adjusted is issued [or administered] by another health insurer or health maintenance organization within the same holding company system as the health insurer or health maintenance organization adjusting the claim;

(C) [any officer, director or regular salaried employee of an article fifteen holding company or a controlled person within such holding company system providing administrative services within that holding company, or any manager thereof, individual or corporate, when the claim to be adjusted is submitted for payment under a health benefit plan that is issued or administered by a health insurer or health maintenance organization within that same holding company system;

(D)] any officer, director or regular salaried employee of an authorized insurer that is licensed to write the kind of insurance to be adjusted, or any manager thereof, individual or corporate, when the claim to be adjusted is pursuant to a policy that is issued [or administered] by another insurer within the same holding company system as the authorized insurer adjusting the claim, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

[(E)] (D) any officer, director or regular salaried employee of an authorized life insurance company, or any manager thereof, individual or corporate, or the manager, agent or general agent of any department thereof, individual or corporate, when the claim to be adjusted is submitted under an insurance contract issued by another insurer and the claim: (i) is within the scope of a contract of reinsurance between the two insurers for all of the underlying risks and none of the underlying risks are later reinsured back to the ceding insurer OR AN AFFILIATE, PARENT OR SUBSIDIARY OF THE CEDING INSURER; and (ii) relates to a kind of insurance that the authorized life insurance company adjusting the claim is licensed to write;

(E) ANY OFFICER, DIRECTOR OR REGULAR SALARIED EMPLOYEE OF A LICENSED INDEPENDENT ADJUSTER WHO DOES NOT INVESTIGATE OR ADJUST CLAIMS;

(F) any adjustment bureau or association owned and maintained by insurers to adjust or investigate losses, or any regular salaried employee or manager thereof who devotes substantially all of his time to the business of such bureau or association, unless acting as an auto body repair estimator as defined in subsection (j) of this section;

(G) any licensed agent of an authorized insurer who adjusts losses for such insurer solely under policies issued through his or its agency, provided the agent receives no compensation for such services in excess of fifty dollars per loss adjusted;

(H) any licensed attorney at law of this state;

(I) any average adjuster or adjuster of maritime losses; or

(J) any agent or other representative of an insurer authorized to issue life and annuity contracts, provided he receives no compensation for such services.

S 123. The insurance law is amended by adding a new section 9112 to read as follows:

S 9112. FEE ON INSURANCE CLAIMS PROCESSED BY AN INDEPENDENT ADJUSTER. (A) AN INDEPENDENT ADJUSTER SHALL PAY A FEE OF ONE DOLLAR PER CLAIM FOR

EACH INSURANCE CLAIM OVER TWENTY DOLLARS IN VALUE THAT IT INVESTIGATES, ADJUSTS OR PAYS IN THIS STATE. THE FEE SHALL BE PAID ON A MONTHLY BASIS TO THE COMMISSIONER OF HEALTH OR THE COMMISSIONER OF HEALTH'S DESIGNEE FOR DEPOSIT INTO THE HEALTH CARE REFORM ACT RESOURCES FUND AUTHORIZED BY SECTION NINETY-TWO-DD OF THE STATE FINANCE LAW. THE COMMISSIONER OF HEALTH MAY PERMIT AN INDEPENDENT ADJUSTER THAT HAS AT LEAST TWELVE FULL MONTHS OF PAYMENT EXPERIENCE TO MAKE ANNUAL, RATHER THAN MONTHLY PAYMENTS, BASED ON AN ANNUAL DEMONSTRATION BY THE INDEPENDENT ADJUSTER THROUGH THE ADJUSTERS PRIOR YEARS' PAYMENTS UNDER THIS SECTION THAT ITS PAYMENTS ARE NOT EXPECTED TO EXCEED TWENTY-FIVE THOUSAND DOLLARS ANNUALLY.

(B) FEES PAID PURSUANT TO THIS SECTION SHALL BE SUBJECT TO AUDIT AND COLLECTION BY THE COMMISSIONER OF HEALTH IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION EIGHT-A OF SECTION TWENTY-EIGHT HUNDRED SEVEN-J OF THE PUBLIC HEALTH LAW.

(C) IF MORE THAN ONE INDEPENDENT ADJUSTER IS INVOLVED IN INVESTIGATING, ADJUSTING OR PAYING A CLAIM ON BEHALF OF AN INSURER, THE ADJUSTERS MAY ENTER INTO AN APPORTIONMENT AGREEMENT TO SATISFY THE PAYMENT OBLIGATIONS OF THIS SECTION. AGGREGATE PAYMENTS MUST TOTAL ONE HUNDRED PERCENT OF THE AMOUNT DUE. APPORTIONMENT AGREEMENTS AND ANY MODIFICATIONS, AMENDMENTS OR TERMINATIONS THEREOF MUST BE IN WRITING, SIGNED BY ALL PARTIES AND RETAINED FOR A PERIOD OF NOT LESS THAN SIX YEARS AFTER TERMINATION OF THE AGREEMENT. THE INDEPENDENT ADJUSTER SHALL MAKE THE AGREEMENT AVAILABLE TO THE COMMISSIONER OF HEALTH UPON REQUEST FOR AUDIT VERIFICATION PURPOSES.

(D) THE FEE REQUIRED BY SUBSECTION (A) OF THIS SECTION SHALL NOT BE ASSESSED UPON INSURANCE CLAIMS INVESTIGATED, ADJUSTED OR PAID IN CONJUNCTION WITH:

(1) PART A OR B OF TITLE XVIII OF THE SOCIAL SECURITY ACT;

(2) TITLE XIX OF THE SOCIAL SECURITY ACT;

(3) THE FEDERAL EMPLOYEE HEALTH BENEFITS ACT, CHAPTER 5 U.S. CODE, SECTION 8901-8913;

(4) THE CHILD HEALTH INSURANCE PROGRAM AUTHORIZED BY SECTION TWENTY-FIVE HUNDRED ELEVEN OF THE PUBLIC HEALTH LAW;

(5) THE FAMILY HEALTH PLUS PROGRAM AUTHORIZED BY SECTION THREE HUNDRED SIXTY-NINE-EE OF THE SOCIAL SERVICES LAW;

(6) CLAIMS ARISING UNDER AN INSURANCE CONTRACT ISSUED BY AN INSURER SUBJECT TO THE FRANCHISE TAX ON GROSS DIRECT PREMIUMS PURSUANT TO ARTICLE THIRTY-THREE OF THE TAX LAW;

(7) CLAIMS ARISING UNDER AN INSURANCE CONTRACT ISSUED BY AN INSURER LICENSED UNDER ARTICLE FORTY-THREE, FORTY-FIVE, FORTY-SEVEN OR SIXTY-SEVEN OF THIS CHAPTER OR THE STATE INSURANCE FUND;

(8) CLAIMS ARISING UNDER A CONTRACT ISSUED BY A LICENSED HEALTH MAINTENANCE ORGANIZATION PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW;

(9) CLAIMS ARISING UNDER A CONTRACT ISSUED BY A CHARITABLE ANNUITY SOCIETY THAT COMPLIES WITH THE REQUIREMENTS OF SECTION ONE THOUSAND ONE HUNDRED TEN OF THIS CHAPTER; OR

(10) CLAIMS ARISING UNDER AN INSURANCE POLICY, WHERE THE GROSS PREMIUM IS TAXABLE PURSUANT TO SUBSECTION (D) OF SECTION TWO THOUSAND ONE HUNDRED EIGHTEEN OF THIS CHAPTER.

S 123-a. Subdivision 1 of section 2807-y of the public health law, as added by section 67 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

1. For periods on and after January first, two thousand five, the commissioner is authorized to contract with the article forty-three

insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the allowances [and], assessments AND FEES established pursuant to:

(a) subdivision eighteen of section twenty-eight hundred seven-c of this article;

(b) section twenty-eight hundred seven-j of this article;

(c) section twenty-eight hundred seven-s of this article;

(d) section twenty-eight hundred seven-t of this article;

(e) section twenty-eight hundred seven-v of this article;

(f) section twenty-eight hundred seven-d of this article;

(g) section thirty-six hundred fourteen-a of this chapter; [and]

(h) section three hundred sixty-seven-i of the social services law[.]; AND

(I) SECTION NINE THOUSAND ONE HUNDRED TWELVE OF THE INSURANCE LAW.

S 123-b. Subdivision 8-a of section 2807-j of the public health law is amended by adding a new paragraph (g) to read as follows:

(G) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTION ONE HUNDRED TWELVE OR ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW OR ANY OTHER LAW, AT THE DISCRETION OF THE COMMISSIONER WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, CONTRACTS IN EFFECT AS OF APRIL FIRST, TWO THOUSAND NINE FOR THE PURPOSE OF CONDUCTING AUDITS OF PAYOR AND PROVIDER COMPLIANCE WITH THE REQUIREMENTS OF THIS SECTION AND SECTIONS TWENTY-EIGHT HUNDRED SEVEN-S AND TWENTY-EIGHT HUNDRED SEVEN-T OF THIS ARTICLE MAY BE AMENDED AS NECESSARY FOR THE PURPOSE OF CONDUCTING PAYOR COMPLIANCE AUDITS WITH REGARD TO THE REQUIREMENTS OF SUBDIVISION THIRTEEN OF THIS SECTION AND SECTION NINE THOUSAND ONE HUNDRED TWELVE OF THE INSURANCE LAW.

S 124. Paragraph (kk) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

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

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

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

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

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

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

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

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

(viii) [up to five hundred fifty-one million dollars for the period] WITHIN AMOUNTS APPROPRIATED ON AND AFTER January first, two thousand nine [through December thirty-first, two thousand nine;

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

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

S 125. Paragraphs (a) and (b) of subdivision 2 of section 480-a of the tax law, as added by chapter 190 of the laws of 1990, are amended to read as follows:

(a) (I) Every retail dealer and every person owning or, if the owner is not the operator, then any person operating one or more vending machines through which cigarettes or tobacco products are sold in this state, who is required under section eleven hundred thirty-six of this chapter to file a return for the quarterly period ending on the last day of August, nineteen hundred ninety or for the quarterly period ending on the last day of August in any year thereafter, [shall] MUST file an application for registration under this section with [such] THAT quarterly return, in such form as shall be prescribed by the commissioner [of taxation and finance].

(II) Each retail dealer [shall] MUST pay an application fee with [such] THE quarterly return [of one hundred dollars] DESCRIBED BY SUBPARAGRAPH (I) OF THIS PARAGRAPH for each retail place of business in this state through which it sells cigarettes or tobacco products, WHICH IS BASED ON GROSS SALES OF THAT PLACE OF BUSINESS DURING THE PREVIOUS CALENDAR YEAR. THE APPLICATION FEE IS: ONE THOUSAND DOLLARS FOR EACH RETAIL LOCATION WITH GROSS SALES TOTALING LESS THAN ONE MILLION DOLLARS; TWO THOUSAND FIVE HUNDRED DOLLARS FOR EACH RETAIL LOCATION WITH GROSS SALES TOTALING AT LEAST ONE MILLION DOLLARS BUT LESS THAN TEN MILLION DOLLARS; AND FIVE THOUSAND DOLLARS FOR EACH RETAIL LOCATION WITH GROSS SALES TOTALING AT LEAST TEN MILLION DOLLARS.

(III) Every person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state, regardless of whether located on the premises of the vending machine owner or, if the owner is not the operator, then the premises of the operator or the premises of any other person, [shall] MUST pay an application fee with [such] THE quarterly return [of twenty-five dollars] DESCRIBED BY SUBPARAGRAPH (I) OF THIS PARAGRAPH for each [such] vending machine, WHICH IS BASED ON GROSS SALES OF THAT VENDING MACHINE DURING THE PREVIOUS CALENDAR YEAR. THE APPLICATION FEE IS: TWO HUNDRED FIFTY DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING LESS THAN ONE HUNDRED THOUSAND DOLLARS; SIX HUNDRED TWENTY-FIVE DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING AT LEAST ONE HUNDRED THOUSAND DOLLARS BUT LESS THAN ONE MILLION DOLLARS; AND ONE THOUSAND TWO HUNDRED FIFTY DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING AT LEAST ONE MILLION DOLLARS. The department [shall] WILL issue a registration certificate, as prescribed by the commissioner [of taxation and finance], after receipt of a registration application and the appropriate registration fee, prior to the next succeeding January first.

(b) Every retail dealer and every person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state who commences business after the last day of August, nineteen hundred ninety, or who commences selling cigarettes or tobacco products at retail through a new or different place of business in this state after such date, or who commences selling cigarettes or tobacco products through new or different vending machines after such date, [shall] MUST file with the commissioner [of taxation and finance] an application for registration, in a form prescribed by him OR HER, at least thirty days prior to commencing [such] business or commencing [such] sales. Each [such] application [shall] MUST be accompanied by an application fee [of one hundred dollars] for each retail place of business [to be registered] and [twenty-five dollars for] each vending machine to be registered. THE AMOUNT OF THE APPLICATION FEE IS DETERMINED BY SUBPARAGRAPHS (II) AND (III) OF PARAGRAPH (A) OF THIS SUBDIVISION, EXCEPT THAT ANY RETAIL LOCATION OR VENDING MACHINE WITH ZERO DOLLARS IN GROSS SALES DURING THE PREVIOUS CALENDAR YEAR IS SUBJECT TO THE LOWEST APPLICATION FEE REQUIRED BY SUCH SUBPARAGRAPHS. The department, within ten days after receipt of an application for registration under this paragraph and payment of the proper fee for application for registration, [shall] WILL issue a registration certificate, as prescribed by the commissioner, for each retail place of business or cigarette or tobacco products vending machine registered.

S 125-a. Subdivision 3 of section 480-a of the tax law, as amended by chapter 262 of the laws of 2000, is amended to read as follows:

3. In addition to any other penalty imposed by this chapter: (a) Any retail dealer who violates the provisions of this section [shall], after due notice and an opportunity for a hearing, for a first violation [be] IS liable for a civil fine not less than five [hundred] THOUSAND dollars but not to exceed [two] TWENTY-FIVE thousand dollars and for a second or subsequent violation within three years following a prior finding of violation [be] IS liable for a civil fine not less than [one] TEN thousand dollars but not to exceed [three thousand five hundred] THIRTY-FIVE THOUSAND dollars; or

(b) Any person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state and who violates the provisions of this section [shall], after due notice and an opportunity for a hearing, for a first violation [be] IS liable for a civil fine not less than [seventy-five] SEVEN HUNDRED FIFTY dollars but not to exceed two [hundred] THOUSAND dollars and for a second or subsequent violation within three years following a prior finding of violation be liable for a civil fine not less than two [hundred] THOUSAND dollars but not to exceed six [hundred] THOUSAND dollars.

S 125-b. Section 482 of the tax law, as amended by section 3 of part RR-1 of chapter 57 of the laws of 2008, is amended to read as follows:

S 482. Deposit and disposition of revenue. (A) All taxes, fees, interest and penalties collected or received by the commissioner under this article and article twenty-A of this chapter shall be deposited and disposed of pursuant to the provisions of section one hundred seventy-one-a of this chapter. (B) From the taxes, interest and penalties collected or received by the commissioner under sections four hundred seventy-one and four hundred seventy-one-a of this article, effective on and after March first, two thousand, forty-nine and fifty-five hundredths, and effective on and after February first, two thousand two,

forty-three and seventy hundredths; and effective on and after May first, two thousand two, sixty-four and fifty-five hundredths; and effective on and after April first, two thousand three, sixty-one and twenty-two hundredths percent; and effective on and after June third, two thousand eight, seventy and sixty-three hundredths percent collected or received under [such] THOSE sections [shall] MUST be deposited to the credit of the tobacco control and insurance initiatives pool to be established and distributed by the commissioner of health in accordance with section twenty-eight hundred seven-v of the public health law. (C) FROM THE FEES COLLECTED OR RECEIVED BY THE COMMISSIONER UNDER SUBDIVISION TWO OF SECTION FOUR HUNDRED EIGHTY-A OF THIS ARTICLE, EFFECTIVE ON OR AFTER SEPTEMBER FIRST, TWO THOUSAND NINE, ANY MONIES COLLECTED OR RECEIVED UNDER THAT SECTION IN EXCESS OF THREE MILLION DOLLARS MUST BE DEPOSITED TO THE CREDIT OF THE TOBACCO CONTROL AND INSURANCE INITIATIVES POOL TO BE DISTRIBUTED BY THE COMMISSIONER OF HEALTH IN ACCORDANCE WITH SECTION TWENTY-EIGHT HUNDRED SEVEN-V OF THE PUBLIC HEALTH LAW.

S 125-c. Subdivisions (a) and (b) of section 92-dd of the state finance law, as added by section 89 of part B of chapter 58 of the laws of 2005, are amended to read as follows:

(a) On and after April first, two thousand five, such fund shall consist of the revenues heretofore and hereafter collected or required to be deposited pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, SUBDIVISIONS (B) AND (C) OF section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law.

(b) The pool administrator under contract with the commissioner of health pursuant to section twenty-eight hundred seven-y of the public health law shall continue to collect moneys required to be collected or deposited pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, and shall deposit such moneys in the HCRA resources fund. The comptroller shall deposit moneys collected or required to be deposited pursuant to SUBDIVISIONS (B) AND (C) OF section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law in the HCRA resources fund.

S 126. 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 127. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of subdivisions 4, 7, 7-a and 7-b of section 2807 of the public health law and section 18 of chapter 2 of the

laws of 1988, as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and shall, for purposes of implementing the provisions of this act, be deemed to have been without any force or effect from and after October 1, 2008 for such rates effective for the period January 1, 2008 through December 31, 2008.

S 128. 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 129. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009; provided that:

(a) sections forty-three, forty-four, seventy-four and seventy-eight through eighty-one of this act shall take effect April 1, 2009;

(b) sections forty-five and seventy-three of this act shall take effect June 1, 2009;

(c) sections two through ten, twelve through twenty-three, twenty-five through twenty-seven, sixty-two and one hundred four through one hundred twelve of this act shall take effect July 1, 2009;

(d) sections twenty-nine, thirty-eight through forty-two, forty-six, forty-seven, forty-eight and seventy-five of this act shall take effect September 1, 2009;

(e) sections fifty through fifty-nine, one hundred twenty-two and one hundred twenty-three of this act shall take effect October 1, 2009;

(f) sections sixty, sixty-one, sixty-three through sixty-seven, sixty-seven-a, seventy-seven-b, one hundred eighteen and one hundred nineteen of this act shall take effect April 1, 2010;

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

(h) section twenty-six of this act shall expire and be deemed repealed April 1, 2014;

(h-1) section one hundred twenty-five of this act applies only to fees related to applications for registration for the 2010 calendar year and thereafter;

(h-2) sections one hundred twenty-five-a, one hundred twenty-five-b, and one hundred twenty-five-c of this act shall take effect September 1, 2009.

(i) 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;

(j) 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;

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

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

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

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

(n) the amendments to section 364-f of the social services law made by section thirty of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(o) the amendments to subdivision 7 of section 274 of the public health law made by section forty-five of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(p) the amendments to paragraph (a-1) of subdivision 4 of section 365-a of the social services law made by section forty-six of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(q) the amendments to subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law made by section forty-seven of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(r) the amendments to subdivision 9 of section 367-a of the social services law made by sections forty-eight and forty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(s) section 279 of the public health law as added by section fifty of this act shall not affect the repeal of article 2-A of such law and shall be deemed repealed therewith;

(t) section sixty-eight of this act shall take effect on the same date and in the same manner as the amendments made to subparagraph (iii) of paragraph (a) of subdivision 2 of section 369-ee of the social services law by section 28 of part E of chapter 63 of the laws of 2005, takes effect;

(u) the amendments to subdivision 8 of section 2510 of the public health law made by section seventy-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(v) the amendments to subdivision 5 of section 2511 of the public health law made by section eighty of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(w) the amendments to section 2807-s of the public health law made by sections one hundred and one hundred fourteen of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(x) the amendments to paragraph (c) of subdivision 5-a of section 2807-k of the public health law made by section one hundred two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(y) the amendments to subdivision one of section 241 of the elder law made by section one hundred five of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith; and

(z) the amendments to section 2807-j of the public health law made by sections one hundred thirteen and one hundred twenty-three-b of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART D

Section 1. The legislature finds that New York leads the nation in Medicaid spending on long-term care services and that Medicaid spending on home and personal care services are among the fastest growing areas of Medicaid expenditure despite the fact that the number of beneficiaries receiving these services has not increased. Current processes for assessing the service needs of elderly and disabled beneficiaries do not consistently result in appropriate placement and services and show wide variation across the state. Current reimbursement levels and methodologies do not ensure quality or efficiency, with providers in the same community serving comparable populations receiving markedly different Medicaid payments. It is the intent of this legislation to ensure that elderly and disabled beneficiaries have access to the right level of care in the most appropriate setting; to implement transparent and accurate reimbursement systems for nursing and home care services; and to reward quality and efficiency as well as to make targeted investments to improve long-term care services.

S 1-a. Short title. This act shall be known and may be cited as "The Long-Term Care Reform Act".

S 2. Subdivision 2-b of section 2808 of the public health law is amended by adding a new paragraph (h) to read as follows:

(H) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, THIS SUBDIVISION SHALL BE NULL AND VOID AS OF MARCH FIRST, TWO THOUSAND NINE.

S 3. Section 2808 of the public health law is amended by adding a new subdivision 2-c to read as follows:

2-C. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE OPERATING COSTS OF RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR INPATIENT SERVICES PROVIDED ON AND AFTER MARCH FIRST, TWO THOUSAND NINE SHALL BE DETERMINED IN ACCORDANCE WITH THE FOLLOWING:

(I) THE OPERATING COST COMPONENT OF FACILITIES' RATES WILL BE COMPUTED ON A REGIONAL BASIS, USING ALLOWABLE OPERATING COSTS, AS DETERMINED BY THE COMMISSIONER, FROM THE TWO THOUSAND FIVE CERTIFIED COST REPORTS FROM FACILITIES ON FILE WITH THE DEPARTMENT AS OF DECEMBER FIRST, TWO THOUSAND EIGHT, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH PARAGRAPH (C) OF SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE. FOR THE PURPOSE OF THIS PARAGRAPH, THE REGIONS OF THE STATE SHALL BE AS FOLLOWS:

(A) NEW YORK CITY, CONSISTING OF THE COUNTIES OF BRONX, NEW YORK, KINGS, QUEENS AND RICHMOND;

(B) LONG ISLAND, CONSISTING OF THE COUNTIES OF NASSAU AND SUFFOLK;

(C) NORTHERN METROPOLITAN, CONSISTING OF THE COUNTIES OF COLUMBIA, DELAWARE, DUTCHESS, ORANGE, PUTNAM, ROCKLAND, SULLIVAN, ULSTER AND WESTCHESTER;

(D) NORTHEAST CONSISTING OF THE COUNTIES OF ALBANY, CLINTON, ESSEX, FULTON, GREENE, MONTGOMERY, RENSSELAER, SARATOGA, SCHENECTADY, SCHOHARIE, WARREN AND WASHINGTON;

(E) UTICA/WATERTOWN, CONSISTING OF THE COUNTIES OF FRANKLIN, HAMILTON, HERKIMER, LEWIS, OSWEGO, OTSEGO, ST. LAWRENCE, JEFFERSON, CHENANGO, MADISON AND ONEIDA;

(F) CENTRAL, CONSISTING OF THE COUNTIES OF BROOME, CAYUGA, CHEMUNG, CORTLAND, ONONDAGA, SCHUYLER, STEUBEN, TIOGA AND TOMPKINS;

(G) ROCHESTER, CONSISTING OF MONROE, ONTARIO, LIVINGSTON, SENECA, WAYNE AND YATES; AND

(H) WESTERN, CONSISTING OF THE COUNTIES OF ALLEGANY, CATTARAUGUS, CHAUTAUQUA, ERIE, GENESEE, NIAGARA, ORLEANS AND WYOMING.

(II) THE CAPITAL COMPONENT OF RATES ON AND AFTER JANUARY FIRST, TWO THOUSAND NINE SHALL FULLY REFLECT THE COST OF LOCAL PROPERTY TAXES AND PAYMENTS MADE IN LIEU OF LOCAL PROPERTY TAXES, AS REPORTED IN EACH FACILITY'S COST REPORT SUBMITTED FOR THE YEAR TWO YEARS PRIOR TO THE RATE YEAR.

(III) THE DIRECT COMPONENT OF THE OPERATING COMPONENT OF RATES SHALL BE SUBJECT TO CASE MIX ADJUSTMENT THROUGH APPLICATION OF THE MINIMUM DATA SET (MDS) CLASSIFICATION EMPLOYED BY THE FEDERAL GOVERNMENT WITH REGARD TO PAYMENTS TO SKILLED NURSING FACILITIES PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT (MEDICARE) TO REFLECT PATIENT SERVICE INTENSITY, AS MAY BE ADJUSTED BY THE COMMISSIONER. SUCH ADJUSTMENTS SHALL BE MADE SEMI-ANNUALLY IN EACH CALENDAR YEAR, AND BOTH THE ADJUSTMENTS AND THE RELATED PATIENT CLASSIFICATIONS IN EACH FACILITY SHALL BE SUBJECT TO AUDIT REVIEW IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE COMMISSIONER.

(IV) NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, RULE OR REGULATION, RATES OF PAYMENT FOR INPATIENT SERVICES PROVIDED ON AND AFTER MARCH FIRST, TWO THOUSAND NINE BY RESIDENTIAL HEALTH CARE FACILITIES SHALL, EXCEPT FOR THE ESTABLISHMENT OF ANY REGIONAL PRICES, BE CALCULATED UTILIZING ONLY THE NUMBER OF PATIENTS PROPERLY ASSESSED AND REPORTED IN EACH PATIENT CLASSIFICATION GROUP AND ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW.

(V) NOTWITHSTANDING SUBPARAGRAPH (I) OF PARAGRAPH (A) OF THIS SUBDIVISION, THE OPERATING COST COMPONENT OF THE RATES, EFFECTIVE MARCH FIRST, TWO THOUSAND NINE FOR THE FOLLOWING CATEGORIES OF FACILITIES, AS ESTABLISHED PURSUANT TO APPLICABLE REGULATIONS, SHALL REFLECT THE RATES IN EFFECT FOR SUCH FACILITIES ON DECEMBER THIRTY-FIRST, TWO THOUSAND SIX, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH PARAGRAPH (C) OF SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE: (A) AIDS FACILITIES OR DISCRETE AIDS UNITS WITHIN FACILITIES, (B) DISCRETE UNITS FOR RESIDENTS RECEIVING CARE IN A LONG-TERM INPATIENT REHABILITATION PROGRAM FOR TRAUMATIC BRAIN INJURED PERSONS, (C) DISCRETE UNITS PROVIDING SPECIALIZED PROGRAMS FOR RESIDENTS REQUIRING BEHAVIORAL INTERVENTIONS, (D) DISCRETE UNITS FOR LONG-TERM VENTILATOR DEPENDENT RESIDENTS, AND (E) FACILITIES OR DISCRETE UNITS WITHIN FACILITIES THAT PROVIDE EXTENSIVE NURSING, MEDICAL, PSYCHOLOGICAL AND COUNSELING SUPPORT SERVICES SOLELY TO CHILDREN. SUCH RATE SHALL REMAIN IN EFFECT UNTIL THE DEPARTMENT, IN CONSULTATION WITH REPRESENTATIVES OF THE NURSING HOME INDUSTRY, AS SELECTED BY THE COMMISSIONER, DEVELOPS A REGIONAL PRICING OR ALTERNATIVE METHODOLOGY FOR DETERMINING SUCH RATES.

(B) THE OPERATING COMPONENT OF RATES OF PAYMENT, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH SUBPARAGRAPH (I) OF PARAGRAPH (A) OF THIS SUBDIVISION, SHALL, BY NO LATER THAN THE TWO THOUSAND TWELVE RATE PERIOD, BE BASED ON ALLOWABLE COSTS, AS REPORTED ON ANNUAL FACILITY COST REPORTS SUBMITTED AS REQUIRED BY THE COMMISSIONER, FROM A BASE YEAR PERIOD NO EARLIER THAN THREE YEARS PRIOR TO THE INITIAL RATE YEAR. THEREAFTER, THE BASE YEAR UTILIZED FOR RATE-SETTING PURPOSES SHALL BE UPDATED TO BE CURRENT NO LESS FREQUENTLY THAN EVERY SIX YEARS; PROVIDED, HOWEVER, THAT FOR THE PURPOSES OF THIS PARAGRAPH, CURRENT SHALL MEAN THAT THE OPERATING COMPONENTS OF THE INITIAL RATE YEAR, UTILIZING SUCH UPDATED BASE YEAR, SHALL REFLECT ALLOWABLE COSTS AS REPORTED IN ANNUAL FACILITY COST REPORTS FOR PERIODS NO EARLIER THAN THREE YEARS PRIOR TO

SUCH INITIAL RATE YEAR, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH SUBPARAGRAPH (I) OF PARAGRAPH (A) OF THIS SUBDIVISION.

(C) THE OPERATING COMPONENT OF RATES MAY BE ADJUSTED TO REFLECT A PER DIEM ADD-ON, AS DETERMINED BY THE COMMISSIONER, FOR THE FOLLOWING PATIENTS: (I) EACH PATIENT WHOSE BODY MASS INDEX IS GREATER THAN THIRTY-FIVE; (II) EACH PATIENT WHO QUALIFIES UNDER THE RUG-III IMPAIRED COGNITION AND BEHAVIORAL PROBLEMS CATEGORIES, OR HAS BEEN DIAGNOSED WITH ALZHEIMER'S DISEASE OR DEMENTIA, AND IS CLASSIFIED IN THE REDUCED PHYSICAL FUNCTIONS A, B, OR C, OR IN BEHAVIORAL PROBLEMS A OR B CATEGORIES, AND HAS AN ACTIVITIES OF DAILY LIVING INDEX SCORE OF LESS THAN TEN; (III) EACH PATIENT WHO QUALIFIES FOR EXTENDED CARE AS A RESULT OF TRAUMATIC BRAIN INJURY AS DEFINED BY APPLICABLE REGULATIONS.

(D) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER MAY, SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, MAKE ADDITIONAL TRANSITION ADJUSTMENTS TO RATES OF PAYMENT FOR RESIDENTIAL HEALTH CARE FACILITIES FOR THE PERIODS BEGINNING MARCH FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN TO FACILITATE IMPROVEMENTS IN RESIDENTIAL HEALTH CARE FACILITIES OPERATIONS AND FINANCES IN ACCORDANCE WITH THE FOLLOWING:

(I) RESIDENTIAL HEALTH CARE FACILITIES ELIGIBLE FOR DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH SHALL BE THOSE NON-PUBLIC FACILITIES AND STATE OPERATED PUBLIC RESIDENTIAL HEALTH CARE FACILITIES, WHICH HAVE AN AVERAGE ANNUAL MEDICAID UTILIZATION PERCENTAGE OF FIFTY PERCENT OR GREATER, FOR THE PERIOD TWO YEARS PRIOR TO THE RATE YEAR AND WHICH, AS DETERMINED BY THE COMMISSIONER, EXPERIENCE A REDUCTION IN THEIR MEDICAID REVENUE OF A PERCENTAGE AS DETERMINED BY THE COMMISSIONER AS A RESULT OF THE APPLICATION OF REGIONAL PRICING AS DESCRIBED IN THIS SUBDIVISION.

(II) TRANSITION FUNDS DISTRIBUTED PURSUANT TO THIS PARAGRAPH SHALL BE ALLOCATED BASED ON EACH ELIGIBLE FACILITY'S RELATIVE NEED AS DETERMINED BY THE COMMISSIONER.

(III) TRANSITION FUNDING PURSUANT TO THIS PARAGRAPH SHALL BE AVAILABLE FOR THE FOLLOWING PERIODS AND IN THE FOLLOWING AMOUNTS:

(A) FOR THE PERIOD MARCH FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN, UP TO SEVENTY-FIVE MILLION DOLLARS;

(B) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, UP TO SEVENTY-FIVE MILLION DOLLARS;

(C) FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO FIFTY MILLION DOLLARS;

(D) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, UP TO TWENTY-FIVE MILLION DOLLARS.

(IV) PAYMENTS MADE PURSUANT TO THIS PARAGRAPH SHALL NOT BE SUBJECT TO RETROACTIVE ADJUSTMENT OR RECONCILIATION AND MAY BE ADDED TO RATES OF PAYMENT OR MADE AS LUMP SUM PAYMENTS.

(V) EACH RESIDENTIAL HEALTH CARE FACILITY RECEIVING FUNDS PURSUANT TO THIS PARAGRAPH SHALL, AS A CONDITION FOR ELIGIBILITY FOR SUCH FUNDS, ADOPT A RESOLUTION OF THE BOARD OF DIRECTORS OR SUBMIT A REPORT BY THE OWNER ACCEPTABLE TO THE COMMISSIONER SETTING FORTH ITS CURRENT FINANCIAL CONDITION AND A PLAN FOR REFORMING AND IMPROVING SUCH FINANCIAL CONDITION, INCLUDING ONGOING BOARD OR OWNER OVERSIGHT, AND SHALL, AFTER TWO YEARS, ISSUE A REPORT AS ADOPTED BY EACH SUCH BOARD OR ISSUE A FURTHER REPORT BY THE OWNER ACCEPTABLE TO THE COMMISSIONER SETTING FORTH WHAT PROGRESS HAS BEEN ACHIEVED REGARDING SUCH IMPROVEMENT, PROVIDED, HOWEVER, IF SUCH FURTHER REPORT IS NOT SUBMITTED TO THE COMMISSIONER, OR IF SUCH FURTHER REPORT FAILS TO SET FORTH ADEQUATE PROGRESS, AS DETERMINED BY THE COMMISSIONER, THE COMMISSIONER MAY DEEM SUCH FACILITY INELIGIBLE

FOR FURTHER DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH AND MAY REDISTRIBUTE SUCH FURTHER DISTRIBUTIONS TO OTHER ELIGIBLE FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF THIS PARAGRAPH. THE COMMISSIONER SHALL BE PROVIDED WITH COPIES OF ALL SUCH RESOLUTIONS AND REPORTS.

(E) THE COMMISSIONER MAY PROMULGATE REGULATIONS, INCLUDING EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

S 4. Subdivision 11 of section 2808 of the public health law, as amended by chapter 474 of the laws of 1996, is amended to read as follows:

11. Residential health care facility reimbursement rate promulgation. With regard to a residential health care facility, the provisions of [paragraph (a) of] subdivision seven of section twenty-eight hundred seven of this article relating to advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are based on rate appeals filed by such facility, audits, changes in patient conditions or acuity levels, the correction of errors or omissions of data or errors in the computations of such rates, the submission of cost report data from facilities without an established cost basis, the judicial annulment or invalidation of existing rates or changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of existing rates or as otherwise authorized by law. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION, AS OF MARCH FIRST, TWO THOUSAND NINE, WITH REGARD TO ADMINISTRATIVE RATE APPEALS, THE DEPARTMENT WILL ONLY REVIEW SUCH APPEALS FOR (A) THE CORRECTION OF COMPUTATIONAL ERRORS OR OMISSIONS OF DATA BY THE DEPARTMENT IN DETERMINING THE OPERATING RATE BASED UPON THE INFORMATION PROVIDED TO THE DEPARTMENT PRIOR TO THE COMPUTATION OF THE RATE, (B) CAPITAL COST REIMBURSEMENT, OR (C) SUCH REASONS AS THE COMMISSIONER DETERMINES ARE APPROPRIATE. THE DEPARTMENT WILL NOT CONSIDER ANY REVISIONS MADE TO A FACILITY'S ANNUAL COST REPORT FOR OPERATING RATE ADJUSTMENT PURPOSES LATER THAN THE DUE DATE ESTABLISHED BY THE COMMISSIONER.

S 5. Paragraph d of subdivision 20 of section 2808 of the public health law is relettered paragraph e and a new paragraph d is added to read as follows:

D. (I) CAPITAL COST REIMBURSEMENT FOR PROPRIETARY RESIDENTIAL HEALTH CARE FACILITIES. ANY PROPRIETARY FACILITY WHICH OTHERWISE WOULD BE ENTITLED TO RESIDUAL REIMBURSEMENT AS PROVIDED UNDER APPLICABLE REGULATION, MAY HAVE THE CAPITAL COST COMPONENT OF ITS RATE RECALCULATED BY THE DEPARTMENT TO TAKE INTO ACCOUNT ANY CAPITAL IMPROVEMENTS AND/OR RENOVATIONS MADE TO THE FACILITY'S EXISTING INFRASTRUCTURE FOR THE PURPOSE OF CONVERTING BEDS TO ALTERNATIVE LONG-TERM CARE USES OR PROTECTING THE HEALTH AND SAFETY OF PATIENTS, SUBJECT TO THE APPROVAL OF THE COMMISSIONER AND ALL APPLICABLE CERTIFICATE OF NEED REQUIREMENTS.

(II) THE DEPARTMENT SHALL EVALUATE THE ADEQUACY OF CURRENT CAPITAL COST REIMBURSEMENT FOR VOLUNTARY RESIDENTIAL HEALTH CARE FACILITIES.

S 6. Notwithstanding any contrary provision of law, if the commissioner of health determines that federal financial participation will not be available with regard to the provisions of subparagraph (ii) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, the commissioner of health may deem such provision null and void and instead may allocate funds pursuant to such subparagraph (ii) proportionally, based on each eligible facility's relative share of Medicaid days in the year two years prior to the distribution year.

S 7. Subdivision 21 of section 2808 of the public health law, as added by section 27 of part C of chapter 58 of the laws of 2004 and paragraphs

(a), (b), (f), (g) and (h) as amended by chapter 746 of the laws of 2004, is amended to read as follows:

21. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, PROVIDED, HOWEVER, THAT PUBLIC RESIDENTIAL HEALTH CARE FACILITIES SHALL NOT BE ELIGIBLE FOR RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE.

(b) Eligibility for such rate adjustments shall be determined on the basis of each residential health care facility's operating margin over the most recent three-year period for which financial data are available from the RHCF-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October first, two thousand four through December thirty-first, two thousand four, financial information for the calendar years two thousand through two thousand two shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.

(c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based residential health care facilities for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three year period, or an average Medicaid utilization percentage of fifty percent or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this subdivision, PROVIDED, HOWEVER, THAT FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, SUCH DISQUALIFICATION:

(I) SHALL NOT BE APPLIED SOLELY ON THE BASIS OF A FACILITY'S HAVING A POSITIVE TOTAL MARGIN IN THE MOST RECENT YEAR OF SUCH THREE-YEAR PERIOD;

(II) SHALL BE EXTENDED TO THOSE FACILITIES IN THE QUARTILE OF FACILITIES WITH THE SECOND SMALLEST NEGATIVE OPERATING MARGINS; AND

(III) SHALL ALSO BE EXTENDED TO THOSE FACILITIES WITH AN AVERAGE MEDICAID UTILIZATION PERCENTAGE OF LESS THAN SEVENTY PERCENT DURING THE MOST RECENT YEAR OF THE THREE-YEAR PERIOD.

(d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this subdivision, the commissioner shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOU-

SAND NINE, THE AMOUNT OF SUCH AVERAGE ANNUAL OPERATING LOSS SHALL BE REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH FACILITY PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION TWO-B OF THIS SECTION. For this purpose, for hospital-based residential health care facilities for which the average annual operating loss cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the residential health care facility based on the proportion the residential health care facility's total revenues for the period bears to the total revenues reported by the sponsoring hospital, AND SUCH APPORTIONED AVERAGE ANNUAL OPERATING LOSS SHALL THEN BE REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH FACILITY PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION TWO-B OF THIS SECTION.

(e) [Each] FOR PERIODS PRIOR TO APRIL FIRST, TWO THOUSAND NINE, EACH such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this subdivision by the applicable percentage shown in the tables below for the quartile within which the facility's negative operating margin for the three-year period is assigned.

i. For a facility located in a county with a total population of two hundred thousand or more as determined by the two thousand U.S. Census:

First Quartile (lowest operating margins): 30 percent
Second Quartile: 15 percent
Third Quartile: 7.5 percent

ii. For a facility located in a county with a total population of fewer than two hundred thousand as determined by the two thousand U.S. Census:

First Quartile (lowest operating margins): 35 percent
Second Quartile: 20 percent
Third Quartile: 12.5 percent

(f) The amount of any facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision shall be reduced by the facility's estimated rate year benefit of the two thousand one update to the regional input price adjustment factors authorized pursuant to FORMER subdivision seventeen of this section as amended by section 24 of part C of chapter 58 of the laws of 2004, OR AS AUTHORIZED BY SUBDIVISION SEVENTEEN-A OF THIS SECTION, AS ADDED BY SECTION 56 OF PART C OF CHAPTER 58 OF THE LAWS OF 2007, if any, PROVIDED, HOWEVER, THAT SUCH REDUCTION SHALL NOT BE APPLIED WITH REGARD TO RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE. After all other adjustments to a facility's financially disadvantaged residential health care facility distribution have been made in accordance with this subdivision, the amount of each facility's distribution shall be limited to no more than four hundred thousand dollars during the period October first, two thousand four through December thirty-first, two thousand four and [during any subsequent annual rate period], ON AN ANNUALIZED BASIS, FOR RATE PERIODS THROUGH MARCH THIRTY-FIRST, TWO THOUSAND NINE, AND NO MORE THAN ONE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE AND FOR EACH ANNUAL RATE PERIOD THEREAFTER.

(g) The adjustment made to each qualifying facility's medical assistance rate of payment determined pursuant to this article shall be calculated by dividing the facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision by the facility's total medical assistance patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October first, two thousand four through December thirty-first, two thousand four shall be calculated based on twenty-five percent of each facility's reported total medical assistance patient days as reported in the applicable two thousand two cost report. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged residential health care facility rate adjustments to eligible facilities for a rate period in accordance with this subdivision shall be thirty million dollars for the period October first, two thousand four through December thirty-first, two thousand four and thirty million dollars [for annual] ON AN ANNUALIZED BASIS FOR rate periods on and after January first, two thousand five THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT AND FORTY MILLION DOLLARS ON AN ANNUALIZED BASIS ON AND AFTER JANUARY FIRST, TWO THOUSAND NINE. The nonfederal share of such [total shall be fifteen million dollars which] RATE ADJUSTMENTS shall be paid by the state, with no local share, from allocations made pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this chapter. In the event the statewide total of the ANNUAL rate adjustments determined pursuant to paragraph (g) of this subdivision varies from [thirty million dollars] THE AMOUNTS SET FORTH IN THIS PARAGRAPH, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the total OF THE ANNUAL rate adjustments made pursuant to this subdivision is equal to [thirty million dollars] THE AMOUNTS SET FORTH IN THIS PARAGRAPH on a statewide basis.

(i) This subdivision shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate adjustments determined in accordance with this subdivision.

(J) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, RESIDENTIAL HEALTH CARE FACILITIES WHICH ARE OTHERWISE ELIGIBLE FOR RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION SHALL ALSO, AS A CONDITION FOR RECEIPT OF SUCH RATE ADJUSTMENTS, SUBMIT TO THE COMMISSIONER A WRITTEN RESTRUCTURING PLAN THAT IS ACCEPTABLE TO THE COMMISSIONER AND WHICH IS IN ACCORD WITH THE FOLLOWING:

(I) SUCH AN ACCEPTABLE PLAN SHALL BE SUBMITTED TO THE COMMISSIONER WITHIN SIXTY DAYS OF THE FACILITY'S RECEIPT OF RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION FOR A RATE PERIOD SUBSEQUENT TO MARCH THIRTY-FIRST, TWO THOUSAND EIGHT, PROVIDED, HOWEVER, THAT FACILITIES WHICH ARE ALLOCATED FOUR HUNDRED THOUSAND DOLLARS OR LESS ON AN ANNUALIZED BASIS SHALL BE REQUIRED TO SUBMIT SUCH PLANS WITHIN ONE HUNDRED TWENTY DAYS, AND FURTHER PROVIDED THAT THESE PERIODS MAY BE EXTENDED BY THE COMMISSIONER BY NO MORE THAN THIRTY DAYS, FOR GOOD CAUSE SHOWN; AND

(II) SUCH PLAN SHALL PROVIDE A DETAILED DESCRIPTION OF THE STEPS THE FACILITY WILL TAKE TO IMPROVE OPERATIONAL EFFICIENCY AND ALIGN ITS EXPENDITURES WITH ITS REVENUES, AND SHALL INCLUDE A PROJECTED SCHEDULE

OF QUANTIFIABLE BENCHMARKS TO BE ACHIEVED IN THE IMPLEMENTATION OF THE PLAN; AND

(III) SUCH PLAN SHALL REQUIRE PERIODIC REPORTS TO THE COMMISSIONER, IN ACCORDANCE WITH A SCHEDULE ACCEPTABLE TO THE COMMISSIONER, SETTING FORTH THE PROGRESS THE FACILITY HAS MADE IN IMPLEMENTING ITS PLAN; AND

(IV) SUCH PLAN MAY INCLUDE THE FACILITY'S RETENTION OF A QUALIFIED CHIEF RESTRUCTURING OFFICER TO ASSIST IN THE IMPLEMENTATION OF THE PLAN, PROVIDED, HOWEVER, THAT THIS REQUIREMENT MAY BE WAIVED BY THE COMMISSIONER, FOR GOOD CAUSE SHOWN, UPON WRITTEN APPLICATION BY THE FACILITY.

(K) IF A RESIDENTIAL HEALTH CARE FACILITY FAILS TO SUBMIT AN ACCEPTABLE RESTRUCTURING PLAN IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH (J) OF THIS SUBDIVISION, THE FACILITY SHALL, FROM THAT TIME FORWARD, BE PRECLUDED FROM RECEIPT OF ALL FURTHER RATE ADJUSTMENTS MADE PURSUANT TO THIS SUBDIVISION AND SHALL BE DEEMED INELIGIBLE FROM ANY FUTURE RE-APPLICATION FOR SUCH ADJUSTMENTS. FURTHER, IF THE COMMISSIONER DETERMINES THAT A FACILITY HAS FAILED TO MAKE SUBSTANTIAL PROGRESS IN IMPLEMENTING ITS PLAN OR IN ACHIEVING THE BENCHMARKS SET FORTH IN SUCH PLAN, THEN THE COMMISSIONER MAY, UPON THIRTY DAYS NOTICE TO THAT FACILITY, DISQUALIFY THE FACILITY FROM FURTHER PARTICIPATION IN THE RATE ADJUSTMENTS AUTHORIZED BY THIS SUBDIVISION AND THE COMMISSIONER MAY REQUIRE THE FACILITY TO REPAY SOME OR ALL OF THE PREVIOUS RATE ADJUSTMENTS.

S 8. Clause (A) of subparagraph (i) of paragraph (a) of subdivision 18 of section 2808 of the public health law, as amended by section 73-b of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(A) fifty-three million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eighty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; one hundred fifteen million eight hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; fifty-seven million nine hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty-seven million nine hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and [sixty-four] FIFTY-NINE million [eight] FOUR hundred thousand dollars for the period April first, two thousand eight through March [thirty-first] FIRST, two thousand nine [and twenty-six million two hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten and each state fiscal year thereafter].

S 9. Clause (A) of subparagraph (i) of paragraph (b) of subdivision 18 of section 2808 of the public health law, as amended by section 73-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(A) seven million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; and eight million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, eight million one hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, [seven] SIX million [three] SIX hundred NINETY thousand dollars

for the period April first, two thousand eight through March [thirty-first] FIRST, two thousand nine [and one million nine hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten and each state fiscal year thereafter].

S 9-a. Subdivision 5 of section 2808 of the public health law is amended by adding a new paragraph (c) to read as follows:

(C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION, ON AND AFTER MARCH FIRST, TWO THOUSAND NINE, NO NON-PUBLIC RESIDENTIAL HEALTH CARE FACILITY, WHETHER OPERATED AS A FOR-PROFIT FACILITY OR AS A NOT-FOR-PROFIT FACILITY, MAY WITHDRAW EQUITY OR TRANSFER ASSETS WHICH IN THE AGGREGATE EXCEED THREE PERCENT OF SUCH FACILITY'S TOTAL MEDICAID REVENUE IN THE PRIOR CALENDAR YEAR, WITHOUT THE PRIOR WRITTEN APPROVAL OF THE COMMISSIONER. THE COMMISSIONER SHALL MAKE A DETERMINATION TO APPROVE OR DISAPPROVE A REQUEST FOR WITHDRAWAL OF EQUITY OR ASSETS UNDER THIS SUBDIVISION WITHIN SIXTY DAYS OF THE DATE OF THE RECEIPT OF A WRITTEN REQUEST FROM THE FACILITY. REQUESTS SHALL BE MADE IN A FORM ACCEPTABLE TO THE DEPARTMENT BY CERTIFIED OR REGISTERED MAIL. IN ADDITION TO ANY OTHER REMEDY OR PENALTY AVAILABLE UNDER THIS CHAPTER, AND AFTER OPPORTUNITY FOR A HEARING, THE COMMISSIONER MAY REQUIRE REPLACEMENT OF THE WITHDRAWN EQUITY OR ASSETS AND MAY IMPOSE A PENALTY FOR VIOLATION OF THE PROVISIONS OF THIS SUBDIVISION IN AN AMOUNT NOT TO EXCEED TEN PERCENT OF ANY AMOUNT WITHDRAWN WITHOUT PRIOR APPROVAL.

S 10. Notwithstanding any inconsistent provision of law or regulation, effective March 1, 2009, for rates of payment by government agencies for impatient services provided by residential health care facilities, in determining the operating component of a facility's rate for care provided for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the operating component shall not reflect an occupancy factor increase.

S 11. Paragraph (a) of subdivision 1 of section 461-l of the social services law, as amended by chapter 597 of the laws of 2005, is amended to read as follows:

(a) "Assisted living program" means an entity or entities with identical ownership, which are approved to operate pursuant to subdivision three of this section and possesses a valid operating certificate as A RESIDENTIAL HEALTH CARE FACILITY ISSUED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW OR an adult care facility, other than a shelter for adults, a residence for adults or a family type home for adults, issued pursuant to this article and which possesses either: (i) a valid license as a home care services agency issued pursuant to section thirty-six hundred five of the public health law; or (ii) a valid certificate of approval as a certified home health agency issued pursuant to section thirty-six hundred six of the public health law; or (iii) valid authorization as a long term home health care program issued pursuant to section thirty-six hundred ten of the public health law.

S 12. Paragraph (c) of subdivision 1 of section 461-l of the social services law, as amended by chapter 597 of the laws of 2005, is amended to read as follows:

(c) "Eligible applicant" means:

(i) A single entity [that is]:

(A) THAT IS only: (1) a natural person [or]; (2) A partnership composed only of natural persons[,]; (3) a not-for-profit corporation[,]; (4) a public corporation[,]; (5) a business corporation other than a corporation whose shares are traded on a national securities exchange or are regularly quoted on a national over-the-counter market or a subsidiary of such a corporation or a corporation any of the

stock of which is owned by another corporation[,]; (6) a limited liability company provided that if a limited liability company has a member that is a corporation, a limited liability company or a partnership, the shareholders of the member corporation, the members of the member limited liability company, or the partners of the member partnership must be natural persons[,]; (7) a social services district; or (8) other governmental agency [which possesses or is eligible pursuant to this article to apply for an adult care facility operating certificate]; [and]

(B) THAT (1) POSSESSES OR IS ELIGIBLE PURSUANT TO THIS ARTICLE TO APPLY FOR AN ADULT CARE FACILITY OPERATING CERTIFICATE; OR (2) POSSESSES A NURSING HOME OPERATING CERTIFICATE ISSUED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW; AND

(C) THAT IS either: (1) an entity which possesses or is eligible pursuant to article thirty-six of the public health law to apply for licensure as a home care services agency; (2) an entity which possesses valid authorization as a long term home health care program; or (3) an entity which possesses a valid certificate of approval as a certified home health agency pursuant to article thirty-six of the public health law; or

(ii) One or more entities listed in subparagraph (i) of this paragraph with identical owners that, in combination, meet each of the criteria set forth by subparagraph (i) of this paragraph.

S 13. Subdivision 4 of section 461-l of the social services law, as added by chapter 165 of the laws of 1991, is amended to read as follows:

4. Revocation, suspension, limitation or annulment. Authorization to operate an assisted living program may be revoked, suspended, limited or annulled by the commissioner:

(A) in accordance with the provisions of this article if the adult care facility fails to comply with applicable provisions of this chapter or rules or regulations promulgated hereunder OR IF THE NURSING HOME FAILS TO COMPLY WITH SUCH PROVISIONS OR THE PROVISIONS OF ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW OR RULES OR REGULATIONS PROMULGATED THEREUNDER; or [by the commissioner of health]

(B) in accordance with the provisions of article thirty-six of the public health law if the licensed home care service agency, certified home health agency or long term home health care program fails to comply with the provisions of article thirty-six of the public health law or rules or regulations promulgated thereunder.

S 14. Subdivision 3 of section 461-l of the social services law is amended by adding a new paragraph (i) to read as follows:

(I) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ADD UP TO SIX THOUSAND ASSISTED LIVING PROGRAM BEDS TO THE GROSS NUMBER OF ASSISTED LIVING PROGRAM BEDS HAVING BEEN DETERMINED TO BE AVAILABLE AS OF APRIL FIRST, TWO THOUSAND NINE, PROVIDED THAT, FOR EACH ASSISTED LIVING PROGRAM BED SO ADDED, A NURSING HOME BED HAS BEEN DECERTIFIED UPON THE APPLICATION OF THE NURSING HOME OPERATOR OR THAT THE COMMISSIONER OF HEALTH HAS FOUND PURSUANT TO SUBDIVISION SIX OF SECTION TWENTY-EIGHT HUNDRED SIX OF THE PUBLIC HEALTH LAW THAT ANY ASSISTED LIVING PROGRAM BED SO ADDED WOULD SERVE AS A MORE APPROPRIATE ALTERNATIVE TO A CERTIFIED NURSING HOME BED AND HAS ACCORDINGLY LIMITED OR REVOKED THE OPERATING CERTIFICATE OF THE NURSING HOME PROVIDING THAT CERTIFIED NURSING HOME BED. THE COMMISSIONER OF HEALTH SHALL NOT BE REQUIRED TO REVIEW ON A COMPARATIVE BASIS APPLICATIONS SUBMITTED FOR ASSISTED LIVING PROGRAM BEDS MADE AVAILABLE UNDER THIS PARAGRAPH. THE COMMISSIONER OF HEALTH SHALL ONLY AUTHORIZE THE ADDITION OF SIX THOUSAND BEDS PURSUANT TO A FIVE YEAR PLAN.

S 15. Section 21 of chapter 1 of the laws of 1999 amending the public health law and other laws relating to enacting the New York Health Care Reform Act of 2000, as amended by section 8 of part A of chapter 57 of the laws of 2000, is amended to read as follows:

S 21. Notwithstanding any inconsistent provision of law, effective April 1, 2000, in determining rates of payment for residential health care facilities pursuant to section 2808 of the public health law, hospital outpatient services and diagnostic and treatment centers pursuant to section 2807 of the public health law, unless otherwise subject to the limits set forth in section 4 of chapter 81 of the laws of 1995, as amended by this act, certified home health agencies and long term home health care programs pursuant to section 3614-a of the public health law and personal care services pursuant to section 367-i of the social services law, AND FOR PERIODS ON AND AFTER MARCH 1, 2009, ADULT DAY HEALTH CARE SERVICES PROVIDED TO PATIENTS DIAGNOSED WITH AIDS AS DEFINED BY APPLICABLE REGULATIONS, the commissioner of health shall apply trend factors using the methodology described in paragraph (c) of subdivision 10 of section 2807-c of the public health law, except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. Nothing in this section is intended to reduce a change in any existing provision of law establishing maximum reimbursement rates.

S 16. Intentionally omitted.

S 17. Section 3614 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, EFFECTIVE JANUARY FIRST, TWO THOUSAND TEN, PAYMENTS BY GOVERNMENT AGENCIES FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES SHALL BE BASED ON EPISODIC PAYMENTS. IN ESTABLISHING SUCH PAYMENTS, A STATEWIDE BASE PRICE SHALL BE ESTABLISHED FOR EACH SIXTY DAY EPISODE OF CARE AND ADJUSTED BY A PROVIDER REGIONAL WAGE INDEX FACTOR AND AN INDIVIDUAL PATIENT CASE MIX INDEX. SUCH EPISODIC PAYMENTS MAY BE FURTHER ADJUSTED FOR LOW UTILIZATION CASES AND TO REFLECT A PERCENTAGE OF THE COST FOR HIGH-UTILIZATION CASES THAT EXCEED OUTLIER THRESHOLDS OF SUCH PAYMENTS. BASE YEAR EPISODIC PAYMENTS SHALL BE FURTHER ADJUSTED TO THE APPLICABLE RATE YEAR IN ACCORDANCE WITH PARAGRAPH C OF SUBDIVISION TEN OF SECTION TWO THOUSAND EIGHT HUNDRED SEVEN-C OF THIS CHAPTER.

(B) INITIAL BASE YEAR EPISODIC PAYMENTS SHALL BE BASED ON MEDICAID PAID CLAIMS, AS DETERMINED BY THE COMMISSIONER, FOR SERVICE PROVIDED BY ALL CERTIFIED HOME HEALTH AGENCIES IN THE BASE YEAR TWO THOUSAND SEVEN. SUBSEQUENT BASE YEAR EPISODIC PAYMENTS MAY BE BASED ON MEDICAID PAID CLAIMS FOR SERVICES PROVIDED BY ALL CERTIFIED HOME HEALTH AGENCIES IN A BASE YEAR SUBSEQUENT TO TWO THOUSAND SEVEN AND AS DETERMINED BY THE COMMISSIONER. IN DETERMINING CASE MIX, EACH PATIENT SHALL BE CLASSIFIED USING A SYSTEM BASED ON MEASURES INCLUDING, BUT NOT LIMITED TO, CLINICAL AND FUNCTIONAL MEASURES, AS REPORTED ON THE FEDERAL OUTCOME AND ASSESSMENT INFORMATION SET (OASIS).

(C) AS DETERMINED BY THE COMMISSIONER, AGENCIES WILL BE REQUIRED TO COLLECT AND SUBMIT ANY DATA REQUIRED TO IMPLEMENT THIS SECTION. THE COMMISSIONER MAY ADOPT REGULATIONS, INCLUDING EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

S 18. Paragraph (a) of subdivision 5 of section 3614 of the public health law, as added by chapter 884 of the laws of 1990, is amended to read as follows:

(a) During the period July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety, the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one and for each calendar year period commencing on January first thereafter, rates of payment by governmental agencies established in accordance with subdivision three of this section applicable for services provided by certified home health agencies to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for certified home health agencies which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during the base year period as used in determining such rates may include an allowance determined in accordance with this subdivision to reflect the needs of the certified home health agency for the financing of losses resulting from bad debt and the cost of charity care. Losses resulting from bad debt and the delivery of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the certified home health agency and the availability of other financial support, including state local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the certified home health agency. The bad debt and charity care allowance for a certified home health agency for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. For purposes of distribution of bad debt and charity care allowances to eligible certified home health agencies, the commissioner, in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, may limit application of a bad debt and charity care allowance to a particular home care services unit or units of service, such as nursing service. A certified home health agency applying for a bad debt and charity care allowance pursuant to this subdivision shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this subdivision, a certified home health agency shall: have professional assistance available on a seven day per week, twenty-four hour per day basis to all registered clients [and must]; demonstrate compliance with minimum charity care certification obligation levels established pursuant to rules and regulations adopted by the state hospital review and planning council and approved by the commissioner; AND PROVIDE TO THE COMMISSIONER AND MAINTAIN A COMMUNITY SERVICE PLAN WHICH OUTLINES THE AGENCY'S ORGANIZATIONAL MISSION AND COMMITMENT TO MEET THE HOME CARE NEEDS OF THE COMMUNITY, IN ACCORDANCE WITH PARAGRAPH (H) OF THIS SUBDIVISION.

S 19. Paragraph (h) of subdivision 5 of section 3614 of the public health law is relettered paragraph (i) and a new paragraph (h) is added to read as follows:

(H) COMMUNITY SERVICE PLANS. (I) THE GOVERNING BODY OF A CERTIFIED HOME HEALTH AGENCY SHALL ISSUE AN ORGANIZATIONAL MISSION STATEMENT IDEN-

TIFYING AT A MINIMUM THE POPULATIONS AND COMMUNITIES SERVED BY THE AGENCY AND THE AGENCY'S COMMITMENT TO MEETING THE HOME CARE NEEDS OF THE COMMUNITY. THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE LIMITATIONS OF AGENCY SIZE AND RESOURCES, AND ALLOW FLEXIBILITY IN COMPLYING WITH THE PROVISIONS OF THIS SECTION.

(II) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL AT LEAST ONCE EVERY THREE YEARS:

(A) REVIEW AND AMEND AS NECESSARY THE AGENCY'S MISSION STATEMENT;

(B) SOLICIT THE VIEWS OF THE COMMUNITIES SERVED BY THE AGENCY ON SUCH ISSUES AS THE AGENCY'S PERFORMANCE AND SERVICE PRIORITIES;

(C) DEMONSTRATE THE AGENCY'S OPERATIONAL AND FINANCIAL COMMITMENT TO MEETING COMMUNITY HOME CARE NEEDS, TO PROVIDE CHARITY CARE SERVICE AND TO IMPROVE ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED; AND

(D) PREPARE AND MAKE AVAILABLE TO THE PUBLIC A STATEMENT SHOWING THE PROVISION OF FREE, REDUCED CHARGE AND/OR OTHER SERVICES OF A CHARITABLE OR COMMUNITY NATURE.

(III) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL ANNUALLY MAKE AVAILABLE TO THE PUBLIC A REVIEW OF THE AGENCY'S PERFORMANCE IN MEETING THE HOME CARE NEEDS OF THE COMMUNITY, PROVIDING CHARITY CARE SERVICES, AND IMPROVING ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED.

(IV) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL FILE WITH THE COMMISSIONER ITS MISSION STATEMENT, ITS ANNUAL PERFORMANCE REVIEW, AND AT LEAST EVERY THREE YEARS A REPORT DETAILING AMENDMENTS TO THE STATEMENT REFLECTING CHANGES IN THE AGENCY'S OPERATIONAL AND FINANCIAL COMMITMENT TO MEETING THE HOME CARE NEEDS OF THE COMMUNITY, PROVIDING CHARITY CARE SERVICES, AND IMPROVING ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED.

(V) THE COMMISSIONER SHALL PROMULGATE REGULATIONS ESTABLISHING A REVISED PERCENTAGE FOR THE CHARITY CARE REQUIREMENT.

S 20. Subdivision 3 of section 367-e of the social services law, as added by chapter 622 of the laws of 1988, is amended to read as follows:

3. The commissioner shall apply for any waivers, including home and community based services waivers pursuant to section nineteen hundred fifteen-c of the social security act, necessary to implement AIDS home care programs. Notwithstanding any inconsistent provision of law but subject to expenditure limitations of this section, the commissioner, subject to the approval of the state director of the budget, may authorize the utilization of medical assistance funds to pay for services provided by AIDS home care programs in addition to those services included in the medical assistance program under section three hundred sixty-five-a of this [chapter] TITLE, so long as federal financial participation is available for such services. TOTAL MONTHLY EXPENDITURES MADE UNDER THIS TITLE FOR A PERSON RECEIVING AIDS HOME CARE PROGRAM SERVICES SHALL NOT EXCEED ONE HUNDRED PERCENT OF THE AVERAGE OF THE CURRENT MONTHLY RATES PAYABLE UNDER THIS TITLE FOR NURSING HOME SERVICES WITHIN THE APPLICABLE SOCIAL SERVICES DISTRICT. HOWEVER, IF A CONTINUING ASSESSMENT OF SUCH PERSON'S NEEDS DEMONSTRATES THAT HE OR SHE REQUIRES INCREASED SERVICES, THE SOCIAL SERVICES OFFICIAL MAY AUTHORIZE THE EXPENDITURE OF ANY AMOUNT ACCRUED UNDER THIS SECTION DURING THE PAST TWELVE MONTHS AS THE RESULT OF THE EXPENDITURES FOR THAT PERSON NOT HAVING EXCEEDED SUCH MAXIMUM AMOUNT. IF THE ASSESSMENT OF SUCH PERSON'S NEEDS DEMONSTRATES THAT HE OR SHE REQUIRES INCREASED SERVICES THE PAYMENT FOR WHICH WOULD EXCEED SUCH MONTHLY MAXIMUM, BUT IT CAN BE REASONABLY ANTICIPATED THAT TOTAL EXPENDITURES FOR REQUIRED SERVICES FOR SUCH PERSON WILL NOT EXCEED SUCH MAXIMUM CALCULATED OVER A ONE YEAR

PERIOD, THE SOCIAL SERVICES OFFICIAL MAY AUTHORIZE PAYMENT FOR SUCH SERVICES. Expenditures made under this subdivision shall be deemed payments for medical assistance for needy persons and shall be subject to reimbursement by the state in accordance with the provisions of section three hundred sixty-eight-a of this [chapter] TITLE.

S 21. Paragraph (k) of subdivision 2 of section 365-a of the social services law, as amended by chapter 659 of the laws of 1997, is amended to read as follows:

(k) care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations provided, that no such agreement shall allow for medical assistance payments on a capitated basis for nursing facility[, home care or other long term care] services of a duration and scope defined in regulations of the department of health promulgated pursuant to section forty-four hundred three-f of the public health law, unless such entity has received a certificate of authority as a managed long term care plan or is an operating demonstration or is an approved managed long term care demonstration, pursuant to such section.

S 22. Subdivision 4 of section 4403-f of the public health law is REPEALED and two new subdivisions 4 and 4-a are added to read as follows:

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

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

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

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

(B) STANDARDS ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE ADEQUATE TO PROTECT THE INTERESTS OF ENROLLEES IN MANAGED LONG TERM CARE PLANS. THE COMMISSIONER SHALL BE SATISFIED THAT THE ELIGIBLE APPLICANT IS FINANCIALLY SOUND, AND HAS MADE ADEQUATE PROVISIONS TO PAY FOR SERVICES.

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

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

S 22-a. Subdivision 6 of section 4403-f of the public health law, as added by chapter 659 of the laws of 1997, paragraph (a) as added by section 16 and paragraph (d) as amended by section 17 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

6. Approval authority. (a) An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner[, subject to any applicable evaluations, approvals, and regulations of the superintendent of insurance as stated in this section,] that the applicant complies with the operating requirements for a managed long term care plan under this section. The commissioner shall issue no more than fifty certificates of authority to managed long term care plans pursuant to this section. For purposes of issuance of no more than fifty certificates of authority, such certificates shall include those certificates issued pursuant to paragraphs (b) and (c) of this subdivision.

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner[, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance as stated in this section,] that such demonstration complies with the operating requirements for a managed long term care plan under this section. Except as otherwise expressly provided in paragraphs (d) and (e) of subdivision seven of this section, nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) An approved managed long term care demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner[, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance set forth in this section,] that such demonstration complies with the operating requirements for a managed long term care plan under this section. Notwithstanding any inconsistent provision of law to the contrary, all authority for the operation of approved managed long term care demonstrations which have not been issued a certificate of authority as a managed long term care plan, shall expire one year after the adoption of regulations implementing managed long term care plans.

(d) The majority leader of the senate and the speaker of the assembly may each designate in writing up to fifteen eligible applicants to apply to be approved managed long term care demonstrations or plans. The commissioner may designate in writing up to eleven eligible applicants to apply to be approved managed long term care demonstrations or plans.

S 22-b. Paragraph (f) of subdivision 7 of section 4403-f of the public health law, as added by chapter 659 of the laws of 1997 and as relettered by section 20 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(f) Continuation of a certificate of authority issued under this section[, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance,] shall be contingent upon satisfactory performance by the managed long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the

continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf [on] OF enrollees who are eligible to receive services under title XIX of the federal social security act.

S 22-c. Subdivision 9 of section 4403-f of the public health law, as added by chapter 659 of the laws of 1997, is amended to read as follows:

9. Reports. The department shall provide an interim report to the governor, temporary president of the senate and the speaker of the assembly on or before April first, two thousand three and a final report on or before April first, two thousand six on the results of the managed long term care plans under this section. Such results shall be based on data provided by the managed long term care plans and shall include but not be limited to the quality, accessibility and appropriateness of services; consumer satisfaction; the mean and distribution of impairment measures of the enrollees by payor for each plan; the current method of calculating premiums and the cost of comparable health and long term care services provided on a fee-for-service basis for enrollees eligible for services under title XIX of the federal social security act; and the results of periodic reviews of enrollment levels and practices. [Such reports shall contain a section prepared by the superintendent of insurance as to the results of the plans approved in accordance with this section concerning the matters regulated by the superintendent of insurance.] Such reports shall [also] provide data on the demographic and clinical characteristics of enrollees, voluntary and involuntary disenrollments from plans, utilization of services and shall examine the feasibility of increasing the number of plans that may be approved. Data collected pursuant to this section shall be available to the public in an aggregated format to protect individual confidentiality, however under no circumstance will data be released on items with cells with smaller than statistically acceptable standards.

S 23. The social services law is amended by adding a new section 367-w to read as follows:

S 367-W. REGIONAL LONG-TERM CARE ASSESSMENT CENTERS. 1. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE DEPARTMENT OF HEALTH IS AUTHORIZED TO ESTABLISH LONG-TERM CARE ASSESSMENT CENTERS TO SERVE REGIONS OF THE STATE AS MAY BE ESTABLISHED BY THE DEPARTMENT OF HEALTH, INCLUDING THE CITY OF NEW YORK, FOR THE PURPOSE OF TRANSFERRING FROM THE SOCIAL SERVICES DISTRICT TO THE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS RESPONSIBILITY FOR ACTIVITIES RELATED TO THE ASSESSMENT OF A PERSON'S NEED FOR, AND THE AUTHORIZATION OF, LONG-TERM CARE SERVICES AND PROGRAMS IDENTIFIED IN SUBDIVISIONS TWO, THREE AND FOUR OF THIS SECTION. THE DEPARTMENT IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO OPERATE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS.

2. THE REGIONAL LONG-TERM CARE ASSESSMENT CENTER SHALL HAVE RESPONSIBILITY FOR ASSESSMENT OF LONG-TERM CARE NEEDS OF AN APPLICANT FOR, OR RECIPIENT OF, MEDICAL ASSISTANCE AND FOR AUTHORIZATION OF SERVICES AND PARTICIPATION IN PROGRAMS INCLUDING: PERSONAL CARE SERVICES, INCLUDING PERSONAL EMERGENCY RESPONSE SERVICES, UNDER PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE; CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE; THE CASH AND COUNSELING DEMONSTRATION PROGRAM UNDER SECTION THREE HUNDRED SIXTY-SEVEN-V OF THIS TITLE; THE ASSISTED LIVING PROGRAM UNDER SECTION FOUR HUNDRED SIXTY-ONE-L OF THIS CHAPTER; AND PARTICIPATION IN THE LONG-TERM HOME HEALTH CARE PROGRAM UNDER SECTION THREE HUNDRED SIXTY-SEVEN-C OF THIS TITLE AND SECTION THIRTY-SIX HUNDRED SIXTEEN OF THE PUBLIC HEALTH LAW, INCLUDING THE AIDS HOME CARE PROGRAM UNDER THE PROVISIONS OF SECTION THREE HUNDRED

SIXTY-SEVEN-E OF THIS TITLE AND SECTION THIRTY-SIX HUNDRED TWENTY OF THE PUBLIC HEALTH LAW.

3. NOTWITHSTANDING ANY PROVISION OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW TO THE CONTRARY, THE REGIONAL LONG-TERM CARE ASSESSMENT CENTER SHALL HAVE RESPONSIBILITY FOR REVIEWING ASSESSMENTS TO VERIFY THAT AN INDIVIDUAL REQUIRES A NURSING HOME LEVEL OF CARE AND, AFTER CONFIRMING THAT AN ENROLLMENT IS VOLUNTARY, FOR AUTHORIZING PARTICIPATION IN A MANAGED LONG-TERM CARE PLAN OR AN APPROVED MANAGED LONG-TERM CARE DEMONSTRATION UNDER PARAGRAPH (O) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

4. THE REGIONAL LONG-TERM CARE ASSESSMENT CENTER SHALL HAVE RESPONSIBILITY FOR REVIEWING DOCUMENTATION FROM A PERSON'S PHYSICIAN AND A CERTIFIED HOME HEALTH AGENCY AND FOR MAKING THE DETERMINATION AS TO THE CONTINUING NEED FOR HOME HEALTH SERVICES BEYOND SIXTY DAYS PROVIDED BY A CERTIFIED HOME HEALTH AGENCY UNDER PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

5. THIS SECTION SHALL APPLY TO THOSE CONSUMERS WHO APPLY FOR THE SERVICES SPECIFIED IN THIS SECTION ON AND AFTER THE LATER OF JANUARY FIRST, TWO THOUSAND TEN OR THE DATE SPECIFIED IN THE CONTRACT BETWEEN THE DEPARTMENT AND THE ENTITY SELECTED TO BE A REGIONAL LONG-TERM CARE ASSESSMENT CENTER, AND SHALL APPLY TO THOSE CONSUMERS WHO ARE IN RECEIPT OF SUCH SERVICES ON SUCH LATER DATE, AND WHOSE AUTHORIZATION FOR SERVICES IS UNINTERRUPTED AFTER SUCH LATER DATE, ON AND AFTER JANUARY FIRST, TWO THOUSAND TWELVE.

6. THE COMMISSIONER OF HEALTH SHALL SUBMIT A REPORT TO THE GOVERNOR, TEMPORARY PRESIDENT OF THE SENATE AND SPEAKER OF THE ASSEMBLY NO LATER THAN JANUARY FIRST, TWO THOUSAND TWELVE, ON THE IMPLEMENTATION OF THIS SECTION. SUCH REPORT SHALL INCLUDE AN ASSESSMENT OF THE PROJECT, AN ANALYSIS OF THE LEVEL AND COSTS OF SERVICES MANAGED UNDER THE CONTRACTS, ANY RECOMMENDATIONS FOR CHANGES TO PERSONAL CARE SERVICES ASSESSMENT AND DELIVERY PROTOCOLS, ANY RECOMMENDATIONS FOR LEGISLATIVE ACTION, AND SUCH OTHER MATTERS AS MAY BE PERTINENT.

S 23-a. Section 3614 of the public health law is amended by adding a new subdivision 14 to read as follows:

14. (A) NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR RATE PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE, THE RATES OF PAYMENT PAID BY GOVERNMENTAL AGENCIES FOR HOME HEALTH CARE SERVICES TO EACH CERTIFIED HOME HEALTH AGENCY SHALL, AFTER APPLICATION OF ANY APPLICABLE ADJUSTMENTS TO THE TREND FACTORS AFFECTING SUCH RATES, BE SUBJECT TO A UNIFORM REDUCTION OF THREE AND ONE-HALF PERCENT.

(B) NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR RATE PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE, THE RATES OF PAYMENT PAID BY GOVERNMENTAL AGENCIES FOR HOME HEALTH CARE SERVICES TO EACH LONG TERM HOME HEALTH CARE PROGRAM AND EACH AIDS HOME CARE PROGRAM SHALL, AFTER APPLICATION OF ANY APPLICABLE ADJUSTMENTS TO THE TREND FACTORS AFFECTING SUCH RATES, BE SUBJECT TO A UNIFORM REDUCTION OF ONE AND ONE-HALF PERCENT.

(C) NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR RATE PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE, THE RATES OF PAYMENT PAID BY GOVERNMENTAL AGENCIES FOR PERSONAL CARE SERVICES, INCLUDING PERSONAL CARE SERVICES PROVIDED IN THOSE SOCIAL SERVICE DISTRICTS WHOSE RATES OF PAYMENT FOR

SUCH SERVICES ARE ESTABLISHED BY SUCH SOCIAL SERVICE DISTRICTS PURSUANT TO A RATE-SETTING EXEMPTION ISSUED BY THE COMMISSIONER TO SUCH SOCIAL SERVICE DISTRICTS IN ACCORDANCE WITH APPLICABLE REGULATIONS, SHALL, AFTER APPLICATION OF ANY APPLICABLE ADJUSTMENTS TO THE TREND FACTORS AFFECTING SUCH RATES, BE SUBJECT TO A UNIFORM REDUCTION OF ONE AND ONE-HALF PERCENT.

(D) UPON THE IMPLEMENTATION OF THE PROVISIONS OF SUBDIVISION TWELVE OF THIS SECTION ON JANUARY FIRST, TWO THOUSAND TEN, THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE DEEMED NULL AND VOID FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN.

S 24. Section 2808 of the public health law is amended by adding a new subdivision 25 to read as follows:

25. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A QUALITY OF CARE INCENTIVE POOL FOR ELIGIBLE RESIDENTIAL HEALTH CARE FACILITIES AND INCREASE MEDICAID RATES OF PAYMENT FOR SUCH ELIGIBLE FACILITIES FROM THIS POOL. UP TO FIFTY MILLION DOLLARS IN SUCH INCREASED MEDICAID PAYMENTS WILL BE MADE AVAILABLE FOR DISTRIBUTION FOR THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND NINE AND UP TO ONE HUNDRED TWENTY-FIVE MILLION DOLLARS WILL BE AVAILABLE FOR STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND TEN. PAYMENTS WILL BE DETERMINED BY THE COMMISSIONER BY APPLYING CRITERIA, INCLUDING, BUT NOT LIMITED TO, THE QUALITY COMPONENTS OF THE MINIMUM DATA SET REQUIRED UNDER FEDERAL LAW, STAFFING AND SURVEY INFORMATION AND OTHER FACILITY DATA.

(B) FACILITIES THAT FALL WITHIN ONE OR MORE OF THE CATEGORIES BELOW DURING A REVIEW PERIOD WILL BE EXCLUDED FROM AWARD ELIGIBILITY:

(I) ANY RESIDENTIAL HEALTH CARE FACILITY THAT IS CURRENTLY DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS A "SPECIAL FOCUS FACILITY";

(II) ANY RESIDENTIAL HEALTH CARE FACILITY FOR WHICH THE DEPARTMENT HAS ISSUED A FINDING OF IMMEDIATE JEOPARDY DURING THE MOST RECENTLY COMPLETED FEDERAL FISCAL YEAR;

(III) ANY RESIDENTIAL HEALTH CARE FACILITY THAT HAS RECEIVED A CITATION FOR SUBSTANDARD QUALITY OF CARE IN THE AREAS OF QUALITY OF LIFE, QUALITY OF CARE, RESIDENT BEHAVIOR, AND/OR FACILITY PRACTICES DURING THE MOST RECENTLY COMPLETED FEDERAL FISCAL YEAR;

(IV) ANY RESIDENTIAL HEALTH CARE FACILITY THAT IS PART OF A CONTINUING CARE RETIREMENT COMMUNITY;

(V) ANY RESIDENTIAL HEALTH CARE FACILITY THAT OPERATES AS A TRANSITIONAL CARE UNIT; AND

(VI) ANY OTHER EXCLUSIONS AS DEEMED APPROPRIATE BY THE COMMISSIONER.

(C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF ANY LAW OR REGULATION TO THE CONTRARY, IN THE EVENT THAT THE TOTAL AMOUNT OF FUNDING ALLOCATED FOR A PARTICULAR FISCAL YEAR IS NOT DISTRIBUTED, FUNDS SHALL BE RESERVED AND ACCUMULATED FROM YEAR TO YEAR SO THAT ANY FUNDS REMAINING AT THE END OF A PARTICULAR FISCAL YEAR WILL BE AVAILABLE FOR DISTRIBUTION DURING THE FOLLOWING FISCAL YEAR.

(D) THE COMMISSIONER MAY PROMULGATE ANY REGULATIONS, INCLUDING EMERGENCY REGULATIONS, NECESSARY TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

S 25. Section 3614 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. (A) SUBJECT TO THE AVAILABILITY OF FUNDS, THE COMMISSIONER SHALL ESTABLISH A QUALITY OF CARE INCENTIVE POOL OF UP TO TWENTY MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN AND UP TO TWENTY MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO

THOUSAND ELEVEN FOR PAYMENTS TO ELIGIBLE CERTIFIED HOME HEALTH AGENCIES THAT MEET QUALITY MEASURES, AS ESTABLISHED BY THE COMMISSIONER. SUCH PAYMENTS SHALL BE MADE IN THE FORM OF ADJUSTMENTS TO MEDICAL ASSISTANCE RATES OF PAYMENT FOR SERVICES PROVIDED BY ELIGIBLE CERTIFIED HOME HEALTH AGENCIES MEETING SUCH QUALITY MEASURES.

(B) TO BE ELIGIBLE FOR SUCH RATE ADJUSTMENTS, A CERTIFIED HOME HEALTH AGENCY MUST HAVE, DURING A FIFTEEN MONTH PERIOD PRIOR TO PAYMENT, PROVIDED SERVICES TO MEDICAID RECIPIENTS, AS REPORTED ON THE AGENCY'S COST REPORTS; PROVIDED, HOWEVER, THAT AN AGENCY THAT HAS CHANGED OWNERSHIP DURING THIS SAME PERIOD SHALL NOT BE ELIGIBLE. AN ELIGIBLE CERTIFIED HOME HEALTH AGENCY MUST SUBMIT SUCH REPORTS AND DATA AS THE COMMISSIONER MAY REQUIRE AND MUST NOT HAVE RECEIVED A CONDITION LEVEL DEFICIENCY OF NON-COMPLIANCE DURING THE MOST RECENTLY COMPLETED RECERTIFICATION SURVEY. THE COMMISSIONER MAY EXCLUDE ANY AGENCY FROM ELIGIBILITY FOR SUCH RATE ADJUSTMENTS ON SUCH OTHER BASIS AS THE COMMISSIONER DEEMS APPROPRIATE.

(C) THE COMMISSIONER MAY ADOPT REGULATIONS, INCLUDING EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

S 26. The public health law is amended by adding a new article 28-C-1 to read as follows:

ARTICLE 28-C-1

LONG-TERM CARE NURSING INITIATIVE DEMONSTRATION PROJECTS

SECTION 2893. LONG-TERM NURSING INITIATIVE DEMONSTRATION PROJECTS.

S 2893. LONG-TERM CARE NURSING INITIATIVE DEMONSTRATION PROJECTS. 1. SCHOLARSHIP DEMONSTRATION PROJECT. (A) ON OR AFTER APRIL FIRST, TWO THOUSAND NINE, THE COMMISSIONER, IN CONSULTATION WITH THE PRESIDENT OF THE HIGHER EDUCATION SERVICES CORPORATION, IS AUTHORIZED TO ESTABLISH SCHOLARSHIP AWARDS FOR THE PROFESSIONAL STUDY OF NURSING BY NEW YORK STATE RESIDENTS AT SCHOOLS APPROVED BY THE COMMISSIONER. EACH RECIPIENT OF A SCHOLARSHIP AWARD SHALL BE ENTITLED TO A YEARLY PAYMENT NOT TO EXCEED EIGHT THOUSAND DOLLARS OR THE ACTUAL COST OF TUITION AND OTHER RELATED EDUCATIONAL EXPENSES, WHICHEVER IS LOWER, FOR A MAXIMUM OF TWO YEARS, WHILE IN ATTENDANCE AT AN APPROVED NURSING SCHOOL. AWARDS SHALL BE CONDITIONED UPON THE AGREEMENT OF THE SCHOLARSHIP HOLDER TO PRACTICE NURSING IN THE FIELD OF LONG-TERM CARE IN NEW YORK FOR A PERIOD OF ONE YEAR FOR EACH YEAR AN AWARD IS RECEIVED, UP TO A MAXIMUM OF TWO YEARS. THE COMMISSIONER SHALL DEFINE ELIGIBILITY CRITERIA FOR THE AWARDS, INCLUDING BUT NOT LIMITED TO THE TYPE OF LONG-TERM CARE SERVICE REQUIRED.

(B) IF A RECIPIENT FAILS TO COMPLY FULLY WITH THE CONDITIONS IN PARAGRAPH (A) OF THIS SUBDIVISION, THE RECIPIENT SHALL BE RESPONSIBLE FOR REPAYMENT OF ONE HUNDRED PERCENT OF THE YEARLY PAYMENT RECEIVED FOR EACH YEAR OR PART THEREOF THAT THE RECIPIENT FAILS TO PRACTICE IN THE FIELD OF LONG-TERM CARE, PLUS INTEREST AT A RATE TO BE DETERMINED BY THE COMMISSIONER BUT NOT LESS THAN THE RATE OF INTEREST SET BY THE COMMISSIONER OF TAXATION AND FINANCE WITH RESPECT TO UNDERPAYMENTS OF PERSONAL INCOME TAX PURSUANT TO SECTION SIX HUNDRED EIGHTY-FOUR OF THE TAX LAW. ANY AMOUNT WHICH IS REQUIRED TO BE REPAID UNDER THIS SUBDIVISION SHALL BE PAID WITHIN THE FIVE-YEAR PERIOD BEGINNING ON THE DATE THAT THE RECIPIENT FAILS TO COMPLY WITH THE CONDITIONS IN PARAGRAPH (A) OF THIS SUBDIVISION. ANY REPAYMENT OBLIGATION SHALL BE CANCELED UPON THE DEATH OF THE RECIPIENT.

(C) THE COMMISSIONER MAY POSTPONE, CHANGE OR WAIVE THE SERVICE OBLIGATION AND REPAYMENT AMOUNTS SET FORTH IN PARAGRAPHS (A) AND (B) OF THIS

SUBDIVISION IN INDIVIDUAL CIRCUMSTANCES WHERE THERE IS COMPELLING NEED OR HARDSHIP.

(D) A RECIPIENT OF AN AWARD SHALL REPORT ANNUALLY, ON PRESCRIBED FORMS, AS TO THE PERFORMANCE OF THE REQUIRED SERVICES, COMMENCING WITH THE CALENDAR YEAR IN WHICH THE RECIPIENT BEGINS TO PRACTICE NURSING IN THE FIELD OF LONG-TERM CARE AND CONTINUING UNTIL THE RECIPIENT SHALL HAVE COMPLETED, OR UNTIL IT IS DETERMINED THAT HE OR SHE SHALL NOT BE OBLIGATED TO COMPLETE, THE REQUIRED SERVICES. IF THE RECIPIENT SHALL FAIL TO FILE ANY REPORT REQUIRED HEREUNDER WITHIN THIRTY DAYS OF WRITTEN NOTICE TO THE RECIPIENT, MAILED TO THE ADDRESS SHOWN ON THE LAST APPLICATION FOR AN AWARD OR LAST REPORT FILED, WHICHEVER IS LATER, A FINE OF UP TO ONE THOUSAND DOLLARS MAY BE IMPOSED. THE REPORTING REQUIREMENT MAY BE WAIVED OR EXCUSED, AND/OR ANY FINE REDUCED OR WAIVED, FOR GOOD CAUSE SHOWN.

2. LOAN REPAYMENT DEMONSTRATION PROJECT. (A) ON OR AFTER APRIL FIRST, TWO THOUSAND NINE, THE COMMISSIONER, IN CONSULTATION WITH THE PRESIDENT OF THE HIGHER EDUCATION SERVICES CORPORATION, IS AUTHORIZED TO MAKE LOAN REPAYMENT AWARDS TO INDIVIDUALS WHO PRACTICE NURSING IN THE FIELD OF LONG-TERM CARE IN NEW YORK STATE. SUCH NURSES SHALL BE ELIGIBLE FOR A YEARLY LOAN REPAYMENT AWARD OF UP TO EIGHT THOUSAND DOLLARS FOR EACH YEAR OF PRACTICE IN THE FIELD OF LONG-TERM CARE, FOR A MAXIMUM OF TWO YEARS. THE COMMISSIONER SHALL DEFINE ELIGIBILITY CRITERIA FOR THE AWARDS, INCLUDING BUT NOT LIMITED TO THE TYPE OF LONG-TERM CARE SERVICE REQUIRED.

(B) LOAN REPAYMENT AWARDS MADE PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL NOT EXCEED THE TOTAL QUALIFYING OUTSTANDING STUDENT LOAN DEBT OF THE NURSE FOR TUITION AND RELATED EDUCATIONAL EXPENSES INCURRED AT SCHOOLS APPROVED BY THE COMMISSIONER, MADE BY OR GUARANTEED BY THE FEDERAL OR STATE GOVERNMENT, OR MADE BY A LENDING OR EDUCATIONAL INSTITUTION APPROVED UNDER TITLE IV OF THE FEDERAL HIGHER EDUCATION ACT. LOAN REPAYMENT AWARDS SHALL BE USED SOLELY TO REPAY SUCH OUTSTANDING DEBT.

(C) A RECIPIENT OF AN AWARD SHALL REPORT ANNUALLY, ON PRESCRIBED FORMS, THE PERFORMANCE OF THE REQUIRED SERVICES, COMMENCING WITH THE CALENDAR YEAR IN WHICH THE RECIPIENT BEGINS TO PRACTICE NURSING IN THE FIELD OF LONG-TERM CARE UNTIL THE RECIPIENT SHALL HAVE COMPLETED, OR UNTIL IT IS DETERMINED THAT HE OR SHE SHALL NOT BE OBLIGATED TO COMPLETE, THE REQUIRED SERVICES. LOAN REPAYMENT AWARDS SHALL BE MADE YEARLY, AFTER THE RECIPIENT HAS COMPLETED EACH YEAR OF QUALIFYING PRACTICE AND FILED THE PERFORMANCE REPORT DESCRIBED HEREIN. THE REPORTING REQUIREMENT MAY BE WAIVED OR EXCUSED FOR GOOD CAUSE SHOWN.

S 27. The education law is amended by adding a new section 679-f to read as follows:

S 679-F. LONG-TERM CARE NURSING INITIATIVE DEMONSTRATION PROJECTS. 1. LONG-TERM CARE NURSING INITIATIVE SCHOLARSHIP AND LOAN-REPAYMENT AWARDS MAY BE MADE IN ACCORDANCE WITH THE STANDARDS ENUMERATED IN SECTION TWENTY-EIGHT HUNDRED NINETY-THREE OF THE PUBLIC HEALTH LAW.

2. THE PRESIDENT SHALL BE RESPONSIBLE FOR THE ADMINISTRATION OF THE AWARDS TO THE EXTENT DETERMINED IN CONSULTATION WITH THE COMMISSIONER OF HEALTH.

S 28. The social services law is amended by adding a new section 367-v to read as follows:

S 367-V. CASH AND COUNSELING DEMONSTRATION PROGRAM. 1. THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A CASH AND COUNSELING DEMONSTRATION PROGRAM FOR THE PROVISION TO UP TO ONE THOUSAND PERSONS OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES IN UP TO TEN COUNTIES CHOSEN BY THE COMMIS-

SIONER BASED UPON THE DEMOGRAPHIC AND GEOGRAPHIC FEATURES OF SUCH COUNTIES. FOR PURPOSES OF THIS SECTION, THE TERM "SELF-DIRECTED PERSONAL ASSISTANCE SERVICES" MEANS PERSONAL CARE AND RELATED SERVICES AS DEFINED IN THIS SECTION THAT ARE PROVIDED TO AN ELIGIBLE PERSON UNDER SUCH PROGRAM. THE PROGRAM PERMITS PARTICIPANTS RECEIVING SELF-DIRECTED PERSONAL ASSISTANCE SERVICES TO PLAN AND MANAGE THE SERVICES WITH COUNSELING AND MANAGEMENT SUPPORT AND TO USE THE FUNDS IN HIS OR HER INDIVIDUALIZED BUDGET TO ACQUIRE ITEMS THAT INCREASE INDEPENDENCE OR SUBSTITUTE FOR HUMAN ASSISTANCE WITH PERSONAL CARE. THE COMMISSIONER IS AUTHORIZED TO FILE SUCH STATE PLAN AMENDMENTS AND WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT AS MAY BE NEEDED TO OBTAIN FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH PROGRAM.

2. (A) ALL ELIGIBLE PERSONS, RESIDING IN THE COUNTIES IDENTIFIED IN SUBDIVISION ONE OF THIS SECTION, RECEIVING PERSONAL CARE SHALL BE PROVIDED NOTICE OF THE AVAILABILITY OF THE PROGRAM AND SHALL HAVE THE OPPORTUNITY TO APPLY FOR PARTICIPATION IN THE PROGRAM. FOR PURPOSES OF THIS SECTION, AN "ELIGIBLE PERSON" IS A PERSON EIGHTEEN YEARS OF AGE OR OLDER WHO:

(I) IS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE;

(II) IS ELIGIBLE FOR PERSONAL CARE SERVICES UNDER THIS TITLE;

(III) IS DETERMINED BY THE SOCIAL SERVICES DISTRICT, PURSUANT TO AN ASSESSMENT, AS BEING SELF-DIRECTING IN REGARD TO PARTICIPATION IN COUNSELING AND FISCAL MANAGEMENT OF THEIR PLAN AND BUDGET AND AS BEING CAPABLE TO EXERCISE CHOICE AND CONTROL OVER THE BUDGET, PLANNING AND PURCHASE OF SELF-DIRECTED PERSONAL ASSISTANCE SERVICES; AND

(IV) MEETS SUCH OTHER CRITERIA, AS MAY BE ESTABLISHED BY THE COMMISSIONER, WHICH THE COMMISSIONER DEEMS NECESSARY TO EFFECTIVELY IMPLEMENT THE OBJECTIVES OF THIS SECTION.

(B) A PERSON SHALL BE INELIGIBLE FOR PARTICIPATION IN THIS PROGRAM WHILE HE OR SHE IS RECEIVING PERSONAL CARE SERVICES, OTHER THAN PERSONAL EMERGENCY RESPONSE SERVICES, UNDER PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE; OR IS A PARTICIPANT IN EITHER THE CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE OR A HOME AND COMMUNITY-BASED WAIVER PROGRAM ESTABLISHED UNDER PARAGRAPH (C) OF SECTION NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT; OR IS AN ENROLLEE IN A MANAGED LONG-TERM CARE PLAN OR AN APPROVED MANAGED LONG-TERM CARE DEMONSTRATION UNDER PARAGRAPH (O) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

3. THE DEPARTMENT IS AUTHORIZED TO CONTRACT WITH AN ENTITY TO PROVIDE PROGRAM PARTICIPANTS WITH ASSISTANCE IN DEVELOPING A SERVICE PLAN AND AN INDIVIDUALIZED BUDGET, AND TO ASSUME RESPONSIBILITY FOR ALL TASKS RELATED TO PROCESSING TIMESHEETS AND PAYROLL FUNCTIONS.

4. (A) THE LOCAL DEPARTMENTS OF SOCIAL SERVICES IN THE TEN COUNTIES CHOSEN BY THE COMMISSIONER PURSUANT TO SUBDIVISION ONE OF THIS SECTION SHALL INFORM EACH ELIGIBLE PERSON OF OTHER FEASIBLE ALTERNATIVES INCLUDING PERSONAL CARE UNDER PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE OR THE CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE. THE RESPONSIBILITIES OF THE LOCAL DEPARTMENTS OF SOCIAL SERVICES SHALL INCLUDE, BUT ARE NOT LIMITED TO, DETERMINING WHETHER THE INDIVIDUAL IS AN ELIGIBLE PERSON; ASSESSING EACH ELIGIBLE PERSON'S FUNCTIONAL NEEDS; APPROVING THE NUMBER OF HOURS OF PERSONAL CARE SERVICES; AND, UPON DISENROLLMENT OF A PARTICIPANT FROM THIS PROGRAM, ASSISTING WITH TRANSITION TO THE PERSONAL CARE SERVICES AVAILABLE UNDER PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS

TITLE OR THE CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE IF THE PERSON IS DETERMINED TO CONTINUE TO NEED PERSONAL CARE SERVICES.

(B) THE ENTITY WITH WHICH THE DEPARTMENT HAS CONTRACTED FOR THE ADMINISTRATION OF THIS PROGRAM SHALL BE RESPONSIBLE FOR THE PERFORMANCE OF CERTAIN ACTIVITIES SUPPORTING PROGRAM PARTICIPANTS WHICH MAY INCLUDE, BUT SHALL NOT BE LIMITED TO: ASSISTING THE ELIGIBLE PERSON WITH THE DEVELOPMENT OF HIS OR HER SERVICE PLAN; PROVIDING TRAINING AND ONGOING TECHNICAL SUPPORT TO THE ELIGIBLE PERSON WITH REGARD TO THE PERFORMANCE OF HIS OR HER RESPONSIBILITIES AS A PARTICIPANT IN THE PROGRAM; PROVIDING RECORDKEEPING SERVICES; RETAINING THE FUNDS FOR THE INDIVIDUALIZED BUDGETS ESTABLISHED FOR EACH ELIGIBLE PERSON; PROCESSING EMPLOYMENT AND TAX INFORMATION; REVIEWING RECORDS TO ENSURE CORRECTNESS; WRITING AND DELIVERING PAYCHECKS; AND ASSISTING ELIGIBLE PERSONS IN OBTAINING REQUIRED INSURANCE POLICIES.

(C) THE PARTICIPANT SHALL BE RESPONSIBLE FOR: DEVELOPING A SERVICE PLAN WITH THE ASSISTANCE OF A BUDGET COUNSELOR EMPLOYED BY THE ENTITY WITH WHICH THE DEPARTMENT HAS CONTRACTED TO ADMINISTER THIS PROGRAM, WHICH SERVICE PLAN SHALL BE SUBJECT TO THE APPROVAL OF THE BUDGET COUNSELOR; DEVELOPING A JOB DESCRIPTION FOR HIS OR HER PROVIDERS; SELECTING AND EMPLOYING PROVIDERS; TRAINING PROVIDERS; ENDING THE EMPLOYMENT OF AN UNSATISFACTORY PROVIDER; AND SUBMITTING TO THE FISCAL AGENT EMPLOYED BY THE CONTRACTOR ANY INFORMATION NECESSARY FOR PROVIDER PAYMENTS, TAX REQUIREMENTS AND ANY BACKGROUND SCREENING THAT MAY BE REQUESTED BY THE PARTICIPANT. A PARTICIPANT MAY EMPLOY FAMILY MEMBERS, EXCEPT FOR A SPOUSE, PARENT OR STEP-PARENT, TO PROVIDE PERSONAL CARE OR RELATED SERVICES.

5. THIS SECTION SHALL BE EFFECTIVE IF, TO THE EXTENT THAT, AND AS LONG AS, FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR EXPENDITURES INCURRED UNDER THIS SECTION.

S 29. Section 3614 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-A. NOTWITHSTANDING SUBDIVISION ONE OF THIS SECTION, ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN, HOME HEALTH SERVICES UNDER SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW PROVIDED BY HOME HEALTH AIDES AS DEFINED IN SUBDIVISION FOUR OF SECTION THIRTY-SIX HUNDRED TWO OF THIS ARTICLE SHALL BE PROVIDED DIRECTLY BY THE CERTIFIED HOME HEALTH AGENCY PROVIDER, LONG-TERM HOME HEALTH CARE PROGRAM PROVIDER OR AIDS HOME CARE PROGRAM PROVIDER THROUGH SUCH PROVIDERS' EMPLOYEES.

S 30. Paragraph (a) of subdivision 1 of section 367-f of the social services law, as amended by section 51 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(a) "Medicaid extended coverage" shall mean eligibility for medical assistance (i) without regard to the resource requirements of section three hundred sixty-six of this title, or in the case of an individual covered under an insurance policy or certificate described in subdivision two of this section that provided a residential health care facility benefit less than three years in duration, without consideration of an amount of resources equivalent to the value of benefits received by the individual under such policy or certificate, as determined under the rules of the partnership for long-term care program[, and]; (ii) without regard to the recovery of medical assistance from the estates of individuals and the imposition of liens on the homes of persons pursuant to section three hundred sixty-nine of this title, with respect to resources exempt from consideration pursuant to subparagraph (i) of this paragraph; provided, however, that nothing [herein] IN THIS SECTION

shall prevent the imposition of a lien or recovery against property of an individual on account of medical assistance incorrectly paid; AND (III) BASED ON AN INCOME ELIGIBILITY STANDARD FOR MARRIED COUPLES EQUAL TO THE AMOUNT OF THE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE DEFINED IN PARAGRAPH (H) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SIX-C OF THIS TITLE, AND FOR SINGLE INDIVIDUALS EQUAL TO ONE-HALF OF SUCH AMOUNT; PROVIDED, HOWEVER, THAT THE COMMISSIONER OF HEALTH SHALL NOT BE REQUIRED TO IMPLEMENT THE PROVISIONS OF THIS SUBPARAGRAPH IF THE USE OF SUCH INCOME ELIGIBILITY STANDARDS WILL RESULT IN A LOSS OF FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF MEDICAID EXTENDED COVERAGE FURNISHED IN ACCORDANCE WITH SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH.

S 31. 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 32. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of subdivisions 4, 7, 7-a and 7-b of section 2807 of the public health law and section 18 of chapter 2 of the laws of 1988, as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and shall, for purposes of implementing the provisions of this act, be deemed to have been without any force or effect from and after November 1, 2007 for such rates effective for the period January 1, 2008 through December 31, 2008.

S 33. 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 34. This act shall take effect on March 1, 2009; provided, however, that:

1. section twenty-one of this act shall take effect October 1, 2009;

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

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

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

5. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

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

7. the amendments to section 4403-f of the public health law made by sections twenty-two, twenty-two-a, twenty-two-b and twenty-two-c of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith;

8. a. notwithstanding any contrary provision of law, in the event sections two and ten of this act are not enacted into law then the provisions of sections three through six, seven, eleven through fourteen, twenty-four, and twenty-six through twenty-eight of this act shall be deemed null and void and of no effect; and

b. notwithstanding any contrary provision of law, in the event sections seventeen, twenty-three and twenty-three-a of this act are not enacted into law then the provisions of sections twenty-five, and twenty-eight of this act shall be deemed null and void and of no effect;

9. the amendments to subdivision 5 of section 3614 of the public health law made by section eighteen of this act shall not affect the expiration of such subdivision and shall expire therewith;

10. the amendments to paragraph (k) of subdivision 2 of section 365-a of the social services law made by section twenty-one of this act shall not affect the expiration of such paragraph and shall expire therewith; and

11. article 28-C-1 of the public health law and section 679-f of the education law added by sections twenty-six and twenty-seven of this act shall expire April 1, 2012.

PART E

Section 1. Section 31 of part E of chapter 58 of the laws of 1998, relating to the determination of state aid for the long-term sheltered employment program, is amended to read as follows:

S 31. Notwithstanding any other provision of law to the contrary, for each state fiscal year commencing on or after April 1, 1998, up to one thousand dollars of income as determined by the commissioner of the office of mental retardation and developmental disabilities and approved by the director of the budget, provided through the long term sheltered employment program, pursuant to subdivision 2 of section 1004-a of the education law, on behalf of eligible clients, [shall] MAY be regarded as exempt income and not recognized or included in the determination of state aid granted to local governments, and the local government share of operating costs pursuant to article 41 of the mental hygiene law, PROVIDED THAT STATE FUNDING IS AVAILABLE FOR THIS PURPOSE AS CERTIFIED BY THE DIRECTOR OF THE BUDGET OR HIS OR HER DESIGNEE.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART F

Section 1. Notwithstanding the provisions of subdivision (e) of section 7.17 or section 41.55 of the mental hygiene law, or any other law to the contrary, the office of mental health is authorized to implement measures designed to ensure the efficient operation of hospitals operated by the office of mental health which may include the closure of wards, and to develop one or more transitional placement programs to

provide supervised housing, and necessary outpatient and support services to individuals with mental illness, who have been discharged from hospitals operated by the office of mental health, and who have been determined by the office of mental health to be able to be appropriately served in such less restrictive setting.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART G

Section 1. Section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, as amended by chapter 433 of the laws of 2003, is amended to read as follows:

S 9. Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local [government] GOVERNMENTAL unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except that this section shall be deemed repealed on [January 1, 2010] JANUARY 1, 2014.

S 2. Section 17-a of chapter 676 of the laws of 2002 amending the education law relating to defining the practice of psychology, as amended by chapter 419 of the laws of 2003, is amended to read as follows:

S 17-a. Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family services, or a local [government] GOVERNMENTAL unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 153 or 163 of the education law, except as otherwise provided by such articles, except that this section shall be deemed repealed on [January 1, 2010] JANUARY 1, 2014.

S 3. This act shall take effect on March 1, 2009.

PART H

Section 1. Subdivision (k) of section 10.06 of the mental hygiene law, as added by chapter 7 of the laws of 2007, is amended to read as follows:

(k) At the conclusion of the hearing, the court shall determine whether there is probable cause to believe that the respondent is a sex offender requiring civil management. If the court determines that probable cause has not been established, the court shall issue an order dismissing the petition, and the respondent's release shall be in accordance with other applicable provisions of law. If the court determines that probable cause has been established: (i) the court shall order that the respondent be committed to a secure treatment facility designated by the commissioner for care, treatment and control upon his or her release, PROVIDED, HOWEVER, THAT A RESPONDENT WHOSE RELEASE DATE HAS PASSED MAY CONSENT TO REMAIN IN AND BE CONFINED AT A FACILITY MAIN-

TAINED BY THE DEPARTMENT OF CORRECTIONAL SERVICES PENDING THE OUTCOME OF THE PROCEEDINGS UNDER THIS ARTICLE, AND PROVIDED FURTHER THAT A RESPONDENT WHO IS UNDER THE SUPERVISION OF THE DIVISION OF PAROLE AT THE TIME OF THE PROBABLE CAUSE DETERMINATION MAY, AT THE DISCRETION OF THE COURT, BE CONTINUED ON PAROLE SUPERVISION UNDER THE SAME OR MODIFIED CONDITIONS OF SUPERVISION; (ii) the court shall set a date for trial in accordance with subdivision (a) of section 10.07 of this article; [and] (iii) the respondent shall not be released FROM CUSTODY OR PAROLE SUPERVISION pending the completion of such trial; AND (IV) WHERE THE RESPONDENT HAS BEEN PLACED UNDER THE JURISDICTION OF THE DIVISION OF PAROLE, HE OR SHE MAY BE RETAKEN AND TEMPORARILY DETAINED IN ACCORDANCE WITH SUBDIVISION THREE OF SECTION TWO HUNDRED FIFTY-NINE-I OF THE EXECUTIVE LAW. WHERE A RESPONDENT IS RETAKEN AND TEMPORARILY DETAINED PURSUANT TO SUBDIVISION THREE OF SECTION TWO HUNDRED FIFTY-NINE-I OF THE EXECUTIVE LAW AND SUCH RESPONDENT HAS SATISFIED THE FULL TERM OF HIS OR HER SENTENCE OR AGGREGATED SENTENCES, THE COURT MAY THEREAFTER DIRECT THAT THE RESPONDENT REMAIN IN LOCAL CUSTODY OR BE RETURNED TO THE JURISDICTION OF THE DIVISION OF PAROLE PENDING COMPLETION OF THE TRIAL. WHERE APPROPRIATE, THE COURT MAY ORDER THAT THE RESPONDENT BE COMMITTED TO A SECURE TREATMENT FACILITY DESIGNATED BY THE COMMISSIONER FOR CARE, TREATMENT AND CONTROL PENDING COMPLETION OF THE TRIAL.

S 2. Section 10.08 of the mental hygiene law is amended by adding a new subdivision (i) to read as follows:

(I) AT ANY PROCEEDING CONDUCTED PURSUANT TO THIS ARTICLE, THE RESPONDENT OR ANY WITNESS SHALL BE PERMITTED, UPON GOOD CAUSE SHOWN, TO MAKE AN ELECTRONIC APPEARANCE IN THE COURT BY MEANS OF AN INDEPENDENT AUDIO-VISUAL SYSTEM, AS THAT TERM IS DEFINED IN SUBDIVISION ONE OF SECTION 182.10 OF THE CRIMINAL PROCEDURE LAW, FOR PURPOSES OF A COURT APPEARANCE OR FOR GIVING TESTIMONY. GOOD CAUSE SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FACT THAT A WITNESS IS CURRENTLY EMPLOYED BY THE STATE AT A SECURE TREATMENT FACILITY OR ANOTHER WORK LOCATION, UNLESS THERE ARE COMPELLING CIRCUMSTANCES REQUIRING THE WITNESS'S PERSONAL PRESENCE AT THE COURT PROCEEDING. FOR PURPOSES OF THIS SUBDIVISION, AN "ELECTRONIC APPEARANCE" MEANS AN APPEARANCE AT WHICH A PARTICIPANT IS NOT PRESENT IN THE COURT, BUT IN WHICH (I) ALL OF THE PARTICIPANTS ARE ABLE TO SEE AND HEAR THE SIMULTANEOUS REPRODUCTIONS OF THE VOICES AND IMAGES OF THE JUDGE, COUNSEL, RESPONDENT OR ANY OTHER APPROPRIATE PARTICIPANT, AND (II) COUNSEL IS PRESENT WITH THE RESPONDENT OR THE RESPONDENT AND COUNSEL ARE ABLE TO SEE AND HEAR EACH OTHER AND ENGAGE IN PRIVATE CONVERSATION. WHEN A RESPONDENT OR A WITNESS MAKES AN ELECTRONIC APPEARANCE, THE COURT STENOGRAPHER SHALL RECORD ANY STATEMENTS IN THE SAME MANNER AS IF THE RESPONDENT OR WITNESS HAD MADE A PERSONAL APPEARANCE.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART I

Section 1. Section 29.23 of the mental hygiene law is amended to read as follows:

S 29.23 Powers with respect to property of patients.

The commissioner may authorize the directors of department facilities, to receive or obtain funds or other personal property, excepting jewelry, due or belonging to a patient who has no [committee] GUARDIAN AUTHORIZED TO RECEIVE SUCH FUNDS OR PROPERTY, up to an amount or value not exceeding five thousand dollars EXCEPTING FEDERAL OR STATE BENEFITS PAID TO THE DIRECTOR AS REPRESENTATIVE PAYEE; and also from [a commit-

tee] SUCH GUARDIAN upon his discharge when the final order so provides where the balance remaining in the hands of such [committee] GUARDIAN does not exceed such amount. Such personal property, excepting jewelry, other than moneys shall be retained by the director for the benefit of the patient for whom received until sold as hereinafter provided. FEDERAL BENEFITS, INCLUDING BENEFITS FOR WHICH THERE IS A STATE SHARE, PAID TO THE DIRECTOR AS REPRESENTATIVE PAYEE, SHALL BE RETAINED BY THE DIRECTOR AND USED IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS. Such funds and the proceeds of the sale of other personal property so received shall be placed to the credit of the patient for whom received and disbursed on the order of the director, to provide, in the first instance, for luxuries, comforts, and necessities for such patient, including burial expenses, and, if funds are thereafter available, for the support of such patient. The commissioner may authorize directors, on behalf of any such patient, to give receipts, execute releases and other documents required by law or court order, to endorse checks and drafts, and to convert personal property excepting jewelry into money by sale for an adequate consideration, and to execute bills of sale or to permit such patient to do so, in order that the proceeds may be deposited to the credit of such patient in accordance with the provisions of this section.

Whenever, under the provisions of this section, the commissioner shall authorize the director of a facility in the department to receive moneys or other personal property excluding jewelry belonging to a patient which are on deposit in any bank or other institution or which are due to the person from any person or agency, such bank, institution, person, or agency shall, upon the written request of the director, forthwith turn over to such director from such moneys or personal property the amount or value hereinbefore specified. Any moneys received by the director of such facility shall be deposited by him in such bank or trust company as shall be designated by the comptroller, except that the commissioner may, in his discretion, invest so much thereof as he may deem advisable in bonds issued by the United States government or any of its agencies.

Moneys belonging to a patient received by the director of such facility pursuant to law shall be received by him in his official capacity as such director and such receipt shall be deemed an exercise or performance by him of a power and duty duly conferred by this section.

S 2. Subdivision (e) of section 33.07 of the mental hygiene law, as added by chapter 709 of the laws of 1986, is amended as follows:

(e) A mental hygiene facility which is a representative payee for a patient pursuant to designation by the social security administration or which assumes management responsibility over the funds of a patient, shall maintain such funds in [a fiduciary capacity to the patient] ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS. The commissioners of mental health and mental retardation and developmental disabilities [shall] ARE AUTHORIZED TO develop standards regarding the management of patient funds.

S 3. This act shall take effect immediately, and shall be deemed to have been in full force and effect on and after January 1, 2002.

PART J

Section 1. Subdivision (b) of section 13.17 of the mental hygiene law, as amended by section 1 of part N of chapter 57 of the laws of 2000, is amended to read as follows:

(b) There shall be in the office the developmental disabilities services offices named below serving the areas either currently or previously served by a school, for the care and treatment of the mentally retarded and developmentally disabled and for research and teaching in the science and skills required for the care and treatment of such mentally retarded and developmentally disabled:

Bernard M. Fineson Developmental Disabilities Services Office
Brooklyn Developmental Disabilities Services Office
Broome Developmental Disabilities Services Office
Capital District Developmental Disabilities Services Office
Central New York Developmental Disabilities Services Office
Finger Lakes Developmental Disabilities Services Office
Institute for Basic Research in Developmental Disabilities
Hudson Valley Developmental Disabilities Services Office
Metro New York Developmental Disabilities Services Office
Long Island Developmental Disabilities Services Office
Sunmount Developmental Disabilities Services Office
Taconic Developmental Disabilities Services Office
Western New York Developmental Disabilities Services Office
Staten Island Developmental Disabilities Services Office
[Valley Ridge Center for Intensive Treatment]

The New York State Institute for Basic Research in Developmental Disabilities is designated as an institute for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of mental retardation and developmental disabilities.

S 2. Notwithstanding any other provision of law to the contrary, the head of the office of mental retardation and developmental disabilities is authorized to consolidate the Valley Ridge Center for Intensive Treatment and the Broome Developmental Disabilities Services Office. The consolidated entity shall be known as the Broome Developmental Disabilities Services Office.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART K

Section 1. Subdivision (f) of section 19.17 of the mental hygiene law, as amended by section 3 of part E of chapter 405 of the laws of 1999, is amended to read as follows:

(f) There shall be in the office the facilities named below for the care, treatment and rehabilitation of the mentally disabled and for clinical research and teaching in the science and skills required for the care, treatment and rehabilitation of such mentally disabled.

R.E. Blaisdell Addiction Treatment Center
Bronx Addiction Treatment Center
C.K. Post Addiction Treatment Center
Creedmoor Addiction Treatment Center
Dick Van Dyke Addiction Treatment Center
Kingsboro Addiction Treatment Center
[Manhattan Addiction Treatment Center]
McPike Addiction Treatment Center
Richard C. Ward Addiction Treatment Center
J.L. Norris Addiction Treatment Center
South Beach Addiction Treatment Center
St. Lawrence Addiction Treatment Center

Stutzman Addiction Treatment Center

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART L

Section 1. Subdivision 3-b of section 1 of part C of chapter 57 of the laws of 2006, as added by section 2 of part I of chapter 58 of the laws of 2008, establishing a cost of living adjustment for designated human services programs, is amended and a new subdivision 3-b is added to read as follows:

3-B. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, BEGINNING APRIL 1, 2009 AND ENDING MARCH 31, 2010, THE COMMISSIONERS SHALL NOT INCLUDE A COLA FOR THE PURPOSE OF ESTABLISHING RATES OF PAYMENTS, CONTRACTS OR ANY OTHER FORM OF REIMBURSEMENT.

[3-b] 3-C. Notwithstanding any inconsistent provision of law, beginning April 1, [2009] 2010 and ending March 31, [2012] 2013, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006, made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART M

Section 1. Section 1 of chapter 119 of the laws of 2007, relating to directing the commissioner of mental health to study, evaluate and report on the unmet mental health service needs of traditionally underserved populations, is amended to read as follows:

Section 1. The commissioner of mental health shall [study, evaluate and report on the unmet] IDENTIFY mental health service needs AND PROBLEMS of traditionally underserved populations IN A MANNER CONSISTENT WITH THE REQUIREMENTS OF SUBDIVISION (B) OF SECTION 5.07 OF THE MENTAL HYGIENE LAW AND SHALL ALSO INCLUDE THE FOLLOWING:

A. IDENTIFYING NEEDS AND PROBLEMS WHICH MUST BE ADDRESSED DURING THE ENSUING FIVE YEARS;

B. RECOMMENDATIONS ON THE PROVISION OF STATE AND LOCAL MENTAL HEALTH SERVICES BASED ON THE DEVELOPMENT OF BEST PRACTICES BY PROGRAMS PROMOTING CULTURALLY AND LINGUISTICALLY COMPETENT MENTAL HEALTH SERVICES, INCLUDING SERVICES TO RACIAL AND ETHNIC MINORITIES;

C. REVIEW OF EFFORTS UNDERTAKEN BY THE OFFICE OF MENTAL HEALTH TO ADDRESS MENTAL HEALTH SERVICE NEEDS OF THESE POPULATIONS; AND

D. A DESCRIPTION OF THE INVOLVEMENT OF LOCAL GOVERNMENT MENTAL HEALTH AUTHORITIES IN PLANNING AND DEVELOPING MENTAL HEALTH SERVICES FOR THESE POPULATIONS.

[Such study and evaluation shall identify those populations with high rates of unmet mental health service needs, including but not limited to: racial and ethnic minorities, persons with limited English proficiency, persons with unmet housing needs, high-risk demographic populations (children, adolescents, young adults and the elderly), persons

with criminal justice contact, and those lacking sufficient mental health care coverage.] Such commissioner shall report, on or before October 1, 2010 AND ANNUALLY THEREAFTER, his or her findings and recommendations [to improve service delivery to these populations, including an analysis of promising practices that support cultural and linguistic competence in the provision of mental health services in the state. Such report shall be submitted] REQUIRED BY THIS ACT, to the governor, the temporary president of the senate, the speaker of the assembly, the chair of the senate committee on mental health and developmental disabilities and the chair of the assembly committee on mental health. SUCH REPORT SHALL BE CONSISTENT WITH THE REQUIREMENTS OF SUBDIVISION (B) OF SECTION 5.07 OF THE MENTAL HYGIENE LAW, EITHER AS A PART OF THE STATEWIDE COMPREHENSIVE FIVE-YEAR PLAN FOR THE PROVISION OF STATE AND LOCAL SERVICES FOR PERSONS WITH MENTAL ILLNESS, REQUIRED UNDER THAT SECTION, OR AS A SEPARATE DOCUMENT, AT THE DISCRETION OF THE COMMISSIONER.

S 2. Subdivision (e) of section 41.55 of the mental hygiene law, as amended by section 1 of part N-1 of chapter 63 of the laws of 2003, is amended to read as follows:

(e) The amount of community mental health support and workforce reinvestment funds for the office of mental health shall be determined in the annual budget and shall include the amount of actual state operations general fund appropriation reductions, including personal service savings and other than personal service savings directly attributed to each child and adult non-geriatric inpatient bed closure. For the purposes of this section a bed shall be considered to be closed upon the elimination of funding for such beds in the executive budget. The appropriation reductions as a result of inpatient bed closures shall be no less than seventy thousand dollars per bed on a full annual basis, as annually recommended by the commissioner, subject to the approval of the director of the budget, in the executive budget request prior to the fiscal year for which the executive budget is being submitted. [The commissioner shall report to the governor, the temporary president of the senate and the speaker of the assembly no later than October first, two thousand three, and annually thereafter, with an explanation of the methodologies used to calculate the per bed closure savings.] The methodologies shall be developed by the commissioner and the director of the budget. In no event shall the full annual value of community mental health support and workforce reinvestment programs attributable to beds closed as a result of net inpatient census decline exceed the twelve month value of the office of mental health state operations general fund reductions resulting from such census decline. Such reinvestment amount shall be made available in the same proportion by which the office of mental health's state operations general fund appropriations are reduced each year as a result of child and adult non-geriatric inpatient bed closures due to census decline.

S 3. Subdivisions (h) and (1) of section 41.55 of the mental hygiene law are REPEALED.

S 4. 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 5. Subdivision (c) of section 7.15 of the mental hygiene law is REPEALED.

S 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009; provided, however, that the amendments to section 41.55 of the mental hygiene law,

made by section two of this act, shall not affect the repeal of such section and shall be deemed repealed therewith.

PART N

Section 1. Section 3 of chapter 119 of the laws of 1997 authorizing the department of health to establish certain payments to general hospitals, as amended by section 1 of part H of chapter 57 of the laws of 2006, is amended to read as follows:

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 1997. This act shall expire April 1, [2009] 2012.

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, 2009.

PART O

Section 1. The commissioner of mental health and the city of New York are hereby authorized to extend for a period not exceeding fifty years the lease of certain portions of Ward's Island authorized by chapter 2 of the laws of 1896, as amended by chapter 380 of the laws of 1900, chapter 139 of the laws of 1908, chapter 696 of the laws of 1913, chapter 101 of the laws of 1952, chapter 491 of the laws of 1952, and chapter 524 of the laws of 1962 for the purposes of the Manhattan psychiatric center, the Kirby forensic psychiatric center and the promotion of the public health, welfare and safety.

S 2. Section 18-130 of the administrative code of the city of New York is amended by adding a new subdivision g to read as follows:

G. NOTWITHSTANDING THE PROVISIONS OF SUBDIVISIONS B, C, D, E, AND F OF THIS SECTION, OR OF ANY OTHER LAW, GENERAL, SPECIAL, OR LOCAL, IN ORDER THAT THE STATE MAY RECONSTRUCT, MODERNIZE AND REBUILD SOME OR ALL OF THE BUILDINGS AND FACILITIES OF THE MANHATTAN PSYCHIATRIC CENTER AND THE KIRBY FORENSIC PSYCHIATRIC CENTER ON WARD'S ISLAND, AND CONTINUE TO MAINTAIN SAID HOSPITALS, SO AS TO FURNISH MODERN FACILITIES FOR TREATMENT AND CARE OF MENTAL PATIENTS OF THE METROPOLITAN DISTRICT AND TO BENEFIT THE HEALTH, WELFARE AND SAFETY OF ITS RESIDENTS, THE CITY OF NEW YORK, ACTING BY THE MAYOR ALONE, IS HEREBY AUTHORIZED TO ENTER INTO AN AGREEMENT FOR THE RENEWAL OR FURTHER EXTENSION OF THE LEASE EXECUTED BETWEEN THE CITY OF NEW YORK AND THE STATE OF NEW YORK PURSUANT TO THE PROVISIONS OF CHAPTER ONE HUNDRED ONE OF THE LAWS OF NINETEEN HUNDRED SIXTY-TWO, FOR A PERIOD NOT EXCEEDING FIFTY YEARS BEYOND ITS PRESENT TERMINATION DATE WITH RESPECT TO ANY OF THE LANDS NOW OCCUPIED BY OR USED IN CONNECTION WITH THE MANHATTAN PSYCHIATRIC CENTER, THE KIRBY FORENSIC PSYCHIATRIC CENTER AND RELATED PROGRAMS. NEITHER THE PROVISIONS OF SECTION ONE HUNDRED NINETY-SEVEN-C OF THE NEW YORK CITY CHARTER, RELATING TO A UNIFORM LAND USE PROCEDURE, NOR THE PROVISIONS OF ANY OTHER LOCAL LAW OF LIKE OR SIMILAR IMPORT SHALL APPLY TO THE RENEWAL OR EXTENSION OF SAID LEASE.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

PART P

Section 1. Section 19.07 of the mental hygiene law is amended by adding a new subdivision (h) to read as follows:

(H) THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL DEVELOP AN ALCOHOL AND DRUG REHABILITATION PROGRAM, CONSISTENT WITH THE PROVISIONS OF SECTION ELEVEN HUNDRED NINETY-SIX OF THE VEHICLE AND TRAFFIC LAW FOR THE PROVISION OF CHEMICAL DEPENDENCY PREVENTION, EDUCATION, EVALUATION AND TREATMENT TO PERSONS REFERRED AS A RESULT OF A VIOLATION OF SECTIONS ELEVEN HUNDRED NINETY-TWO AND ELEVEN HUNDRED NINETY-TWO-A OF THE VEHICLE AND TRAFFIC LAW. THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL ADOPT STANDARDS, RULES AND REGULATIONS, AND ESTABLISH FEES NECESSARY TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

S 2. Subdivisions 1, 2, 3, 4 and 6 of section 1196 of the vehicle and traffic law, subdivisions 1, 2, 3 and 6 as added by chapter 47 of the laws of 1988, subdivision 4 as amended by chapter 196 of the laws of 1996, are amended to read as follows:

1. Program establishment. There is hereby established an alcohol and drug rehabilitation program within the [department of motor vehicles] OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES. The commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES shall establish, by regulation OR CONTRACT, the instructional and rehabilitative aspects of the program. Such program shall [consist of at least fifteen hours and] include, but need not be limited to, classroom instruction in areas deemed suitable by the commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES. [No person shall be required to attend or participate in such program or any aspect thereof for a period exceeding eight months except upon the recommendation of the department of mental hygiene or appropriate health officials administering the program on behalf of a municipality.]

2. Curriculum. The form, content and method of presentation of the various aspects of such program shall be established by the commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES. In the development of the form, curriculum and content of such program, the commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES may consult with the commissioner of mental health, [the director of the division of alcoholism and alcohol abuse, the director of the division of substance abuse services] THE COMMISSIONER and any other state department or agency and request and receive assistance from them. The commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES is also authorized to develop more than one curriculum and course content for such program in order to meet the varying rehabilitative needs of the participants.

3. Where available. A course in such program shall be available in at least every county in the state, except where the commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES determines that there is not a sufficient number of alcohol or drug-related traffic offenses in a county to mandate the establishment of said course, and that provisions be made for the residents of said county to attend a course in another county where a course exists.

4. Eligibility. Participation in the program shall be limited to those persons convicted of alcohol or drug-related traffic offenses or persons who have been adjudicated youthful offenders for alcohol or drug-related traffic offenses, or persons found to have been operating a motor vehicle after having consumed alcohol in violation of section eleven hundred ninety-two-a of this article, who choose to participate and who satisfy the criteria and meet the requirements for participation as established by this section and the regulations promulgated thereunder; provided, however, in the exercise of discretion, the judge imposing sentence may

prohibit the defendant from enrolling in such program. The commissioner [or deputy] OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES may exercise discretion, to reject any person from participation referred to such program and nothing herein contained shall be construed as creating a right to be included in any course or program established under this section. In addition, no person shall be permitted to take part in such program if, during the five years immediately preceding commission of an alcohol or drug-related traffic offense or a finding of a violation of section eleven hundred ninety-two-a of this article, such person has participated in a program established pursuant to this article or been convicted of a violation of any subdivision of section eleven hundred ninety-two of this article other than a violation committed prior to November first, nineteen hundred eighty-eight, for which such person did not participate in such program. In the exercise of discretion, the commissioner [or a deputy] OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES shall have the right to expel any participant from the program who fails to satisfy the requirements for participation in such program or who fails to satisfactorily participate in or attend any aspect of such program. Notwithstanding any contrary provisions of this chapter, satisfactory participation in and completion of a course in such program shall result in the termination of any sentence of imprisonment that may have been imposed by reason of a conviction therefor; provided, however, that nothing contained in this section shall delay the commencement of such sentence.

6. Fees. The commissioner OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES shall establish a schedule of fees to be paid by or on behalf of each participant in the program, and may, from time to time, modify same. Such fees shall defray the ongoing expenses of the program. Provided, however, that pursuant to an agreement with the [department] OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, a municipality, department thereof, or other agency may conduct a course in such program with all or part of the expense of such course and program being borne by such municipality, department or agency. In no event shall such fee be refundable, either for reasons of the participant's withdrawal or expulsion from such program or otherwise.

S 3. Paragraph (d) of subdivision 7 of section 1196 of the vehicle and traffic law, as amended by chapter 309 of the laws of 1996, is amended to read as follows:

(d) The commissioner shall require applicants for a conditional license to pay a fee of seventy-five dollars for processing costs. Such fees assessed under this subdivision shall be paid to the commissioner for deposit to the general fund and shall be in addition to any fees established by the commissioner OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES pursuant to subdivision six of this section to defray the costs of the alcohol and drug rehabilitation program.

S 4. Notwithstanding any other provision of this act, the commissioner of motor vehicles and the commissioner of the office of alcoholism and substance abuse services shall enter into an agreement whereby the department of motor vehicles will continue to operate the alcohol and drug rehabilitation program pursuant to section eleven hundred ninety-six of the vehicle and traffic law until October 1, 2009 whereupon the commissioner of alcoholism and substance abuse services shall have promulgated all rules and regulations necessary to implement the provisions of this act.

S 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after March 1, 2009.

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

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