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

S. 6608 A. 9708

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

January 19, 2010

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 insurance law, the state finance law, the elder law and the county law, in relation to the early intervention program for infants and toddlers with disabilities and their families; to amend the public health law, in relation to requiring physicians to register and maintain an account with the department of health's health provider network; to amend the public health law and the state finance law, in relation to cardiac service information; to amend the public health law, in relation to the health information technology demonstration program; to amend part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to eligible programs; and to repeal certain provisions of the public health law, the state finance law, section 1 of chapter 462 of the laws of 1996, relating to establishing a quality incentive payment program, and the elder law relating thereto (Part A); to amend the public health law, in relation to the assessment of general hospitals, Medicaid rates of reimbursement general hospital indigent care pools, and preferred drug programs; 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 the social services law and the public health law, in relation to prescription drug coverage for needy persons; to amend the public health law, in relation to funds for tobacco control and insurance initiative pools, and health care initiatives pools; to amend the general business law and the social services law, in relation to authorizing moneys paid in advance for funeral merchandise or services for family members; to amend the social services law, in relation to authorizing the commissioner of health to assume responsibility for transportation costs; to amend the public health law, in relation to covering medically necessary ortho-

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

LBD12671-01-0

dontia, covering persons declaring to be a citizen for child health insurance; to amend the public health law, the social services law and the tax law, in relation to imposing parental fees in the early intervention program; to amend the public health law and the social services law, in relation to establishing express lane eligibility for child health insurance and co-payments for certain individuals enrolled in family health plus plans; to amend the public health law and the education law, in relation to interactions between pharmaceutical companies and health care professionals; to amend the public health law, in relation to general hospital reimbursement rate periods; to amend the public health law, in relation to a physician loan repayment program and in relation to transitional care units; to amend part B of chapter 58 of the laws of 2005, amending the public health law and other laws relating to implementing the state fiscal plan for the 2005-2006 state fiscal year, in relation to the expiration thereof; to amend the social services law, in relation to eligibility for medical assistance; to amend the public health law, in relation to general hospital reimbursement rate periods; to amend the social services law, in relation to coverage of certain treatment for individuals at risk of substance abuse; to amend section 17 of part C of chapter 58 of the laws of 2005 amending the public health law and other laws relating to implementing the state fiscal plan for the 2005-2006 state fiscal year, in relation to extending coverage for specialty outpatient services; to amend the public health law, in relation to violations of health laws or regulations, penalties and injunctions; to amend part C of chapter 58 of the laws of 2005 amending the tax law and other laws relating to implementing the state fiscal plan for the 2005-06 state fiscal year, in relation to Medicaid fraud and abuse; to amend the public health law, in relation to audits of service providers; to amend the public health law, in relation to hospital mortgage loan construction; to amend chapter 392 of the laws of 1973 constituting the New York medical care facilities finance agency act, in relation to special hospital project bonds and secured hospital projects reserve funds and appropriations; to amend the social services law, in relation to documentation and eligibility under the medical assistance program; permitting the commissioner of health to enter into contracts for the purpose of conducting audits of hospital costs; to amend the public health law, in relation to reimbursements to certain diagnostic and treatment and ambulatory care centers; to amend the social services law, in relation to providing smoking cessation counseling services to adolescents to the age of nineteen; to amend part A of chapter 57 of the laws of 2006 amending the social services law relating to medically fragile children, in relation to the effectiveness of provisions; to amend the social services law, in relation to participation in certain federal medical assistance programs; to amend chapter 33 of the laws of 1998 amending the social services law relating to authorizing payment of Medicare part B premiums for certain Medicaid recipients, in relation to making the provisions of such chapter permanent; to repeal paragraph (f) of subdivision 9 of section 367-a of the social services law relating to payment of prescription drugs; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend the public health law and the social services law, in relation to residential health care facilities; to amend chapter 58 of the laws of 2009, amending the public health law and other laws relating to Medicaid reimbursements to residential health care facilities inpatient

services, in relation to such reimbursements; to amend chapter 109 of the laws of 2006, amending the social services law and other laws relating to Medicaid reimbursement rate settings, in relation to such rate settings; to amend the social services law, in relation to personal care services and the nursing home transition and diversion program; to amend the social services law, in relation to creating the county long term care financing demonstration program; to amend the public health law, in relation to requiring a study of resident data, in relation to matters regarding fiscal solvency, in relation to certificates of authority, in relation to reporting requirements and in relation to the voluntary residential health care facility right-sizing demonstration program (Part C); to amend the insurance law, in relation to prior approval of health insurance premium rates (Part D); 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 E); to repeal chapter 119 of the laws of 2007, directing the commissioner of mental health to study, evaluate and report on the unmet mental health service needs of traditionally underserved populations (Part F); to amend the mental hygiene law, in relation to electronic court appearance in relation to article 10 of the mental hygiene law (Part G); in relation to authorizing the office of mental health to close patient wards and establish transitional placement programs, notwithstanding the provisions of section 7.17 or section 41.55 of the mental hygiene law; to amend chapter 62 of the laws of 2003 amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to the effectiveness thereof; to amend the mental hygiene law, in relation to community mental health support and workforce reinvestment program; and repealing certain provisions of the mental hygiene law relating thereto (Part H); in relation to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs (Part I); to amend the mental hygiene law, in relation to payments made by the office of mental retardation and developmental disabilities and the office of mental health to operators of family care homes and to increasing the number of days that substitute caretakers may be provided to family care homes by the office of mental retardation and developmental disabilities and the office of mental health, and in relation to payments made to the operators of community residential facilities for the needs of persons with mental retardation or other developmental disabilities residing therein (Part J); to amend the mental hygiene law, in relation to discrete units of a hospital or other facility possessing an operating certificate for the purpose of providing residential or non-residential chemical dependence services (Part K); to amend the mental hygiene law and the vehicle and traffic law, in relation to the transfer of the alcohol and drug rehabilitation program from the department of motor vehicles to the office of alcoholism and substance abuse services (Part L); to amend the mental hygiene law, in relation to unified services; and repealing certain provisions of such law relating thereto (Part M); and to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in

relation to foregoing such adjustment during the 2010-2011 state fiscal year (Part N)

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 2010-2011 state fiscal year. Each component is wholly contained within a Part identified as Parts A through N. 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 reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph (a) of subdivision 3 of section 2559 of the public health law, as amended by chapter 231 of the laws of 1993, is amended to read as follows:

(a) [Providers of] PAYMENT FOR early intervention services and transportation services shall in the first instance and where [applicable] AVAILABLE, [seek payment] BE SOUGHT from all third party payors including governmental agencies prior to claiming payment from a given municipality for services rendered to eligible children[, provided that]. EXCEPT AS PROVIDED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, for the purpose of seeking payment from the medical assistance program or from other third party payors, 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 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.

(I) EARLY INTERVENTION PROGRAM PROVIDERS WHO RECEIVED PAYMENT OF FIVE HUNDRED THOUSAND DOLLARS OR MORE AS DETERMINED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH FOR EARLY INTERVENTION SERVICES PROVIDED TO ELIGIBLE CHILDREN THAT WERE COVERED SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM, SHALL IN THE FIRST INSTANCE AND WHERE AVAILABLE, SEEK PAYMENT FROM THE MEDICAL ASSISTANCE PROGRAM OR AN INSURANCE POLICY OR PLAN FOR THOSE CHILDREN COVERED UNDER BOTH THE MEDICAL ASSISTANCE PROGRAM AND AN INSURANCE POLICY OR PLAN, PRIOR TO CLAIMING PAYMENT FROM A MUNICIPALITY FOR SERVICES RENDERED TO SUCH CHILDREN.

(II) THE COMMISSIONER SHALL DETERMINE WHICH PROVIDERS RECEIVED PAYMENT OF FIVE HUNDRED THOUSAND DOLLARS OR MORE FOR EARLY INTERVENTION SERVICES THAT WERE COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM BASED UPON THE MOST RECENT YEAR FOR WHICH COMPLETE INFORMATION EXISTS. THE COMMISSIONER SHALL NOTIFY A PROVIDER AT LEAST THIRTY DAYS PRIOR TO THE DATE THE PROVIDER SHALL BE REQUIRED TO BILL FOR SERVICES IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH.

(III) PARENTS SHALL PROVIDE AND MUNICIPALITIES SHALL OBTAIN INFORMATION ON ANY PLAN OF INSURANCE UNDER WHICH AN ELIGIBLE CHILD HAS COVERAGE.

S 2. 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 to read as follows:

S 3235-a. Payment for early intervention services. (a) No policy of accident and health insurance, including contracts issued pursuant to article forty-three of this chapter, shall exclude coverage for otherwise covered services [solely on the basis that the services constitute early intervention program services] THAT ARE PROVIDED UNDER THE EARLY INTERVENTION PROGRAM under title two-A of article twenty-five of the public health law.

(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] A SERVICE THAT IS PROVIDED TO AN INSURED UNDER THE early intervention program [service], such coverage 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 COVERED SERVICES PROVIDED UNDER THE early intervention [services] PROGRAM. However, any visits used for COVERED SERVICES PROVIDED UNDER THE early intervention program [services] shall not reduce the number of visits otherwise available under the policy or contract for such services. WHERE SUCH POLICY OR CONTRACT PROVIDES COVERAGE FOR A SERVICE PROVIDED TO THE INSURED UNDER THE EARLY INTERVENTION PROGRAM, THE INDIVIDUALIZED FAMILY SERVICES PLAN AS DEFINED IN SECTION TWENTY-FIVE HUNDRED FORTY-ONE OF THE PUBLIC HEALTH LAW AND CERTIFIED BY THE EARLY INTERVENTION OFFICIAL OR SUCH OFFICIAL'S DESIGNEE, SHALL BE DEEMED TO MEET ANY PRECERTIFICATION, PREAUTHORIZATION AND MEDICAL NECESSITY REQUIREMENTS IMPOSED ON BENEFITS UNDER THE POLICY OR CONTRACT, PROVIDED, HOWEVER, THAT THE EARLY INTERVENTION OFFICIAL SHALL REMOVE OR REDACT ANY INFORMATION CONTAINED ON THE INSURED'S INDIVIDUALIZED FAMILY SERVICE PLAN THAT IS NOT REQUIRED BY THE INSURER FOR PAYMENT PURPOSES. PAYMENT FOR A SERVICE COVERED UNDER THE POLICY OR CONTRACT THAT IS PROVIDED UNDER THE EARLY INTERVENTION PROGRAM SHALL BE AT RATES ESTABLISHED BY THE COMMISSIONER OF HEALTH FOR SUCH SERVICE PURSUANT TO REGULATIONS.

(C) NO INSURER, INCLUDING A HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW AND A CORPORATION ORGANIZED UNDER ARTICLE FORTY-THREE OF THIS CHAPTER SHALL DENY PAYMENT OF A CLAIM SUBMITTED FOR A SERVICE COVERED UNDER THE INSURER'S POLICY OR CONTRACT AND PROVIDED UNDER THE EARLY INTERVENTION PROGRAM BASED UPON THE FOLLOWING:

(I) THE LOCATION WHERE SERVICES ARE PROVIDED;

(II) THE DURATION OF THE INSURED'S CONDITION AND/OR THAT THE INSURED'S CONDITION IS NOT AMENABLE TO SIGNIFICANT IMPROVEMENT WITHIN A CERTAIN PERIOD OF TIME AS SPECIFIED IN THE POLICY;

(III) THAT THE PROVIDER OF SERVICES IS NOT A PARTICIPATING PROVIDER IN THE INSURER'S NETWORK; OR

(IV) THE ABSENCE OF A PRIMARY CARE REFERRAL.

[(c)] (D) Any right of subrogation to benefits which a municipality is entitled in accordance with paragraph (d) of subdivision three of section twenty-five hundred fifty-nine of the public health law shall be valid and enforceable to the extent benefits are available under any accident and health insurance policy. The right of subrogation does not attach to insurance benefits paid or provided under any accident and health insurance policy prior to receipt by the insurer of written

notice from the municipality. UPON THE INSURER'S RECEIPT OF WRITTEN NOTICE FROM THE MUNICIPALITY, THE INSURER SHALL PROVIDE THE MUNICIPALITY WITH INFORMATION ON THE EXTENT OF BENEFITS AVAILABLE TO AN INSURED UNDER THE POLICY OR CONTRACT.

[(d)] (E) No insurer, including a health maintenance organization issued a certificate of authority under article forty-four of the public health law and a corporation organized under article forty-three of this chapter, shall refuse to issue an accident and health insurance policy or contract or refuse to renew an accident and health insurance policy or contract solely because the applicant or insured is receiving services under the early intervention program.

S 3. The public health law is amended by adding a new section 2557-a to read as follows:

S 2557-A. PARENTAL PARTICIPATION IN PAYMENT FOR EARLY INTERVENTION SERVICES. 1. PARENTAL PARTICIPATION IN THE PAYMENT FOR EARLY INTERVENTION SERVICES SHALL BE ESTABLISHED ANNUALLY ON A PROSPECTIVE BASIS BASED ON A SLIDING SCHEDULE OF FEES AS SET FORTH IN SUBDIVISION THREE OF THIS SECTION. THE FEE SHALL BE PAID PROSPECTIVELY ON A QUARTERLY BASIS TO THE COMMISSIONER AND SHALL BE DEPOSITED INTO THE EARLY INTERVENTION PROGRAM ACCOUNT ESTABLISHED IN SECTION NINETY-NINE-T OF THE STATE FINANCE LAW. AFTER PAYING THE COSTS OF THE STATE'S ADMINISTRATION OF PARENTAL PARTICIPATION, THE COMMISSIONER SHALL PAY EACH MUNICIPALITY A PORTION OF THE PARENTAL FEES COLLECTED IN ACCORDANCE WITH THIS SECTION FROM PARENTS OF ELIGIBLE CHILDREN FOR WHICH THE MUNICIPALITY HAS FINANCIAL RESPONSIBILITY IN AN AMOUNT EQUAL TO THE MUNICIPALITY'S PROPORTIONAL SHARE OF COSTS OF EARLY INTERVENTION SERVICES. NO PARENTAL FEES 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 QUARTERLY FEE DETERMINED PURSUANT TO THE SCHEDULE OF FEES SET FORTH IN SUBDIVISION THREE OF THIS SECTION FOR EACH CHILD IN THE FAMILY RECEIVING EARLY INTERVENTION SERVICES. IF A PARENT HAS MORE THAN THREE CHILDREN RECEIVING SERVICES IN THE EARLY INTERVENTION PROGRAM, THE PARENTAL FEE SHALL BE LIMITED TO THE QUARTERLY FEE CHARGED FOR PARENTS WHO HAVE THREE CHILDREN RECEIVING SERVICES IN THE EARLY INTERVENTION PROGRAM. PARENTAL FEES SHALL APPLY WITHOUT REGARD TO WHETHER PAYMENT FOR SERVICES IS AVAILABLE THROUGH THIRD PARTY INSURANCE.

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

GROSS HOUSEHOLD INCOME	PARENTAL FEE PER CHILD /PER QUARTER
251% OF FEDERAL POVERTY LEVEL (FPL) TO 400% FPL	$45.00
401% FPL TO 600% FPL	$90.00
601% FPL TO 700% FPL	$180.00
701% FPL TO 800% FPL	$270.00
801% FPL TO 900% FPL	$360.00
901% FPL TO 1000% FPL	$450.00
1001% FPL AND ABOVE	$540.00

4. A PARENT SHALL PROVIDE DOCUMENTATION AS SPECIFIED IN PARAGRAPH (A) OF THIS SUBDIVISION, AS NECESSARY AND SUFFICIENT TO DETERMINE THE PARENTAL FEE UNDER THIS SECTION. IF A PARENT FAILS TO PROVIDE DOCUMENTATION SUFFICIENT TO DETERMINE THE 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.

THE COMMISSIONER MAY VERIFY THE ACCURACY OF SUCH INCOME INFORMATION PROVIDED BY THE PARENT BY MATCHING IT AGAINST INCOME INFORMATION CONTAINED IN DATABASES TO WHICH THE COMMISSIONER HAS ACCESS, INCLUDING THE STATE'S WAGE REPORTING SYSTEM PURSUANT TO SUBDIVISION FIVE OF SECTION ONE HUNDRED SEVENTY-ONE-A OF THE TAX LAW AND BY MEANS OF AN INCOME VERIFICATION PERFORMED PURSUANT TO A COOPERATIVE AGREEMENT WITH THE DEPARTMENT OF TAXATION AND FINANCE.

(A) INCOME DOCUMENTATION SHALL INCLUDE, BUT NOT BE LIMITED TO, ONE OR MORE OF THE FOLLOWING FOR EACH PARENT AND LEGALLY RESPONSIBLE ADULT WHO IS A MEMBER OF THE HOUSEHOLD AND WHOSE INCOME IS AVAILABLE TO THE CHILD AND FAMILY:

(I) CURRENT ANNUAL INCOME TAX RETURNS;

(II) PAYCHECK STUBS;

(III) WRITTEN DOCUMENTATION OF INCOME FROM ALL EMPLOYERS; AND

(IV) OTHER DOCUMENTATION OF INCOME (EARNED OR UNEARNED) AS DETERMINED BY THE COMMISSIONER, PROVIDED, HOWEVER, SUCH DOCUMENTATION SHALL SET FORTH THE SOURCE OF SUCH INCOME.

(B) ANY INCOME VERIFICATION RESPONSE BY THE DEPARTMENT OF TAXATION AND FINANCE PURSUANT TO THIS SUBDIVISION SHALL NOT BE A PUBLIC RECORD AND SHALL NOT BE RELEASED BY THE COMMISSIONER. INFORMATION DISCLOSED PURSUANT TO THIS SUBDIVISION SHALL BE LIMITED TO INFORMATION NECESSARY FOR VERIFICATION. INFORMATION SO DISCLOSED SHALL BE KEPT CONFIDENTIAL.

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. AT THE WRITTEN REQUEST OF THE PARENT, WHEN THE CHILD IS NO LONGER ELIGIBLE TO RECEIVE SERVICES UNDER THE EARLY INTERVENTION PROGRAM, THE DEPARTMENT SHALL RECONCILE THE PARENTAL FEE AND, IF APPLICABLE, RETURN A PRO-RATA PORTION OF THE FEE FOR THE FINAL QUARTER IN WHICH THE CHILD RECEIVED SERVICES.

6. (A) PARENT PARTICIPATION FEES SHALL BE DUE ON THE FIRST DAY OF EACH QUARTER. THE COMMISSIONER SHALL PROVIDE A BILL TO THE PARENT FOR THE PARENT PARTICIPATION FEE THIRTY DAYS PRIOR TO THE FIRST DAY OF THE QUARTER IN WHICH THE FEE IS DUE. THE BILL SHALL SET FORTH THE AMOUNT OF THE FEE AND ITS DUE DATE. PROVIDED, HOWEVER, UPON AN ELIGIBLE CHILD'S ENTRANCE INTO THE PROGRAM, THE FEE SHALL BE DUE THIRTY DAYS AFTER ISSUANCE OF THE INITIAL BILL, AND THE AMOUNT OF THE FEE SHALL BE ADJUSTED ON A PRO-RATA BASIS TO REFLECT THE DATE OF THE INITIAL INDIVIDUALIZED FAMILY SERVICE PLAN MEETING.

(B) IF PAYMENT HAS NOT BEEN RECEIVED WITHIN FIFTEEN DAYS OF ITS DUE DATE, THE COMMISSIONER SHALL PROVIDE A NOTICE TO THE PARENT REQUESTING PAYMENT BE MADE. THE NOTICE SHALL ALSO STATE THAT FAILURE TO PAY THE FEE WITHIN FIFTEEN DAYS FROM ISSUANCE OF THE NOTICE SHALL RESULT IN THE LOSS OF SERVICES AND ELIGIBILITY FOR THE PROGRAM.

(C) IF PAYMENT HAS NOT BEEN RECEIVED WITHIN THIRTY DAYS OF ITS DUE DATE OR AN AGREEMENT HAS NOT BEEN REACHED BETWEEN THE COMMISSIONER AND THE PARENT IN RELATION TO THE PARENT'S PAYMENT OF THE PAST DUE FEE, THE CHILD'S ELIGIBILITY FOR THE PROGRAM SHALL CEASE, EXCEPT FOR THOSE SERVICES SET FORTH IN SUBDIVISION ONE OF THIS SECTION FOR WHICH NO PARENTAL FEE MAY BE CHARGED. THE COMMISSIONER SHALL NOTIFY THE MUNICIPALITY THAT THE CHILD AND FAMILY ARE NO LONGER ELIGIBLE AND THAT SERVICES SHOULD CEASE WITHIN FIFTEEN DAYS OF SUCH NOTICE TO THE MUNICIPALITY. THE MUNICIPALITY SHALL NOTIFY ALL PROVIDERS CURRENTLY PROVIDING SERVICES TO THE CHILD THAT THE CHILD IS NO LONGER AUTHORIZED TO RECEIVE SERVICES.

7. THE INABILITY OF THE PARENT 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. IN SUCH A CIRCUMSTANCE:

(A) A PARENT MUST SUBMIT TO THE COMMISSIONER DOCUMENTATION OF THE PARENT'S EXTRAORDINARY EXPENSES OR OTHER CATASTROPHIC CIRCUMSTANCES. THE PARENT SHALL SUBMIT 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 LOSSES IN EXCESS OF FIFTEEN PERCENT OF GROSS INCOME.

(B) THE COMMISSIONER 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 RIGHT TO CONTEST SUCH DETERMINATION IN ACCORDANCE WITH SECTION TWENTY-FIVE HUNDRED FORTY-NINE OF THIS TITLE. IF A PARENT SUBMITS A WRITTEN REQUEST FOR A MEDIATION OR HEARING TO CONTEST THE COMMISSIONER'S DETERMINATION, EARLY INTERVENTION SERVICES SHALL NOT BE SUSPENDED FOR NONPAYMENT OF THE PARENTAL FEE PENDING RESOLUTION OF THE DUE PROCESS PROCEEDING.

S 4. The state finance law is amended by adding a new section 99-t to read as follows:

S 99-T. 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 FOR THE STATE SHARE FOR REIMBURSEMENT OF EARLY INTERVENTION SERVICES, AND FOR PAYMENT OF A MUNICIPALITY'S SHARE OF PARENTAL FEES IN ACCORDANCE WITH SUBDIVISION ONE OF SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW.

S 5. The title heading of title 1-A of article 24 of the public health law, as amended by chapter 300 of the laws of 1995, is amended to read as follows:

[BREAST] CANCER DETECTION AND EDUCATION PROGRAM[; OVARIAN CANCER INFORMATION PROGRAM]

S 6. Section 2405 of the public health law, as added by chapter 328 of the laws of 1989, subdivision 1 as amended by chapter 554 of the laws of 2002 and paragraphs (a) and (d) of subdivision 2 as amended by chapter 515 of the laws of 2003, is amended to read as follows:

S 2405. [Breast cancer] CANCER detection and education program; establishment. 1. There is hereby created within the department the [breast] cancer detection and education program, also known as the [healthy women partnership] CANCER SERVICES PROGRAM. This program is established to promote screening and detection of [breast] cancer among unserved or underserved populations, to educate the public regarding [breast] cancer and the benefits of early detection, and to provide counseling and referral services. For purposes of this section, "unserved or underserved populations" shall mean persons having inadequate access and financial resources to obtain [breast] cancer screening and detection services, including persons who lack health insurance or whose health insurance coverage is inadequate or who cannot meet their deductible

obligations for purposes of accessing coverage under their health insurance.

2. The program shall include:

(a) establishment of a statewide public education and outreach campaign to publicize [breast] EVIDENCE BASED cancer detection and education services, such campaign shall include: general community education, outreach to specific underserved populations, EVIDENCE BASED clinical [breast] cancer screening services [and follow-up care, information on the extent of coverage for such services by health insurance, the medical assistance program and other public and private programs], and an informational summary that shall include an explanation of the importance of clinical [breast] examinations[, breast-self-examinations and mammography,] AND what to expect during [a] clinical [breast examination] EXAMINATIONS and [mammography, and how to perform breast-self-examinations] CANCER SCREENING SERVICES;

(b) provision of grants to approved organizations under section twenty-four hundred six of this title;

(c) compilation of data concerning the [breast] cancer detection and education program and dissemination of the data to the public; and

(d) development of professional education programs including the benefits of early detection of [breast] cancer[,] AND clinical [breast] examinations [and breast-self-examinations], the recommended frequency of clinical [breast] examinations[, breast-self-examinations,] and [mammography] CANCER SCREENING SERVICES, and professionally recognized best practices guidelines.

S 7. Subdivisions 2 and 3 of section 2406 of the public health law are REPEALED.

S 8. Section 2409 of the public health law, as added by chapter 275 of the laws of 1995, is REPEALED.

S 9. Subdivisions 2 and 3 of section 95-a of the state finance law, as added by chapter 275 of the laws of 1995, are amended to read as follows:

2. Such fund shall consist of all monies appropriated [for the purpose of] TO such fund and any grant, gift or bequest made to the [breast cancer detection and education program advisory council] FUND.

3. Monies of the fund shall be available [to the breast cancer detection and education program advisory council] for the purposes of the [New York state innovation in breast] cancer [early] detection and [research awards] EDUCATION program, pursuant to section twenty-four hundred [nine] FIVE of the public health law.

S 9-a. Subdivision 3-a of section 2407 of the public health law is REPEALED.

S 10. Subdivisions 1, 4, 5 and 6 of section 2406 of the public health law, subdivision 1 as amended by chapter 176 of the laws of 2006, subdivision 4 as amended and subdivision 5 as renumbered by chapter 334 of the laws of 1990, subdivision 5 as added by chapter 328 of the laws of 1989, and subdivision 6 as added by chapter 323 of the laws of 1995, are amended to read as follows:

1. The commissioner[, in consultation with the breast cancer detection and education program advisory council established pursuant to section twenty-four hundred seven of this title,] shall make grants within the amounts appropriated to approved organizations[, as defined in subdivision three of this section,] for the provision of services relating to the EVIDENCE BASED screening and detection of [breast] cancer as part of this program. Such services shall include but not be limited to:

(a) promotion and provision of early detection of [breast] cancer, including [mammography,] clinical [examination, and breast self-examination] EXAMINATIONS AND CANCER SCREENING SERVICES;

(b) provision of counseling and information on treatment options and referral for appropriate medical treatment;

(c) dissemination of information to unserved and underserved populations, to the general public and to health care professionals concerning [breast] cancer, the benefits of early detection and treatment, and the availability of [breast] cancer screening services;

(d) identification of local [breast] cancer screening services within the approved organization's region;

(e) provision of information, counseling and referral services to individuals diagnosed with [breast] cancer; and

(f) provision of information regarding the availability of medical assistance, including medical assistance under paragraph (v) of subdivision four of section three hundred sixty-six of the social services law, to an individual who requires treatment for [breast, cervical, colon or prostate] cancer.

[4.] 2. The commissioner[, in consultation with the breast cancer detection and education program advisory council,] shall give notice and provide opportunity [for organizations described in subdivision three of this section] to submit applications to provide [breast] cancer detection and education programs. In order to be considered for a grant to provide [breast] cancer detection and education programs, applicants must show evidence of the following:

(a) ability to provide and to ensure consistent and quality [breast] cancer detection services;

(b) expertise in [breast] cancer detection and treatment;

(c) capacity to coordinate services with physicians, hospitals and other appropriate local institutions or agencies;

(d) ability to provide [breast] cancer detection and education services to unserved or underserved populations; and

(e) ability to implement a [breast] cancer detection and education program in accordance with the standards specified in subdivision [five] THREE of this section.

Applications shall be made on forms provided by the commissioner. [The breast cancer detection and education program advisory council shall review and evaluate applications and make recommendations to the commissioner for approval of grants to organizations to provide breast cancer detection and education programs.]

[5.] 3. The commissioner[, in consultation with the breast cancer detection and education program advisory council,] shall develop standards for the implementation of [breast] cancer detection and education programs by approved organizations which shall ensure the following:

(a) integration of the approved organization with existing health care providers;

(b) maximizing third party reimbursement;

(c) provision of services to unserved or underserved populations.

[6.] 4. Within the amounts of state or federal funds appropriated for [cervical] cancer early detection and diagnosis, approved organizations may be authorized by the department to provide such services for populations served pursuant to this title. Early detection services shall include, but not be limited to, complete [pelvic] examinations, [pap smears,] EVIDENCE BASED SCREENING, patient education, counseling, follow-up and referral.

S 11. Section 2406-a of the public health law, as added by chapter 623 of the laws of 2007, is amended to read as follows:

S 2406-a. Grants to community-based organizations. 1. The commissioner[, in consultation with the breast and cervical cancer detection and education program advisory council established pursuant to section twenty-four hundred seven of this title,] shall make grants within any such amount as may be appropriated specifically for community-based organizations for the provision of counseling, education and outreach programs for persons diagnosed with breast cancer.

2. For the purposes of this section, "community-based organizations" shall mean grass roots, free-standing organizations in which breast cancer survivors hold significant decision-making responsibility, and which offer a broad range of breast cancer education and support services free of charge.

3. The commissioner[, in consultations with the breast and cervical cancer detection and education program advisory council,] shall provide notice and opportunity for community-based organizations to submit applications to provide post-diagnosis breast cancer counseling, education and outreach programs. Such applications shall be on forms established by the commissioner. [The breast and cervical cancer detection and education program advisory council shall review and evaluate applications submitted pursuant to this subdivision and shall make recommendations thereon to the commissioner for approval of grants to community-based organizations for the provision of post-diagnosis breast cancer counseling, education and outreach programs.]

S 12. Section 1 of chapter 462 of the laws of 1996, relating to establishing a quality incentive payment program, is REPEALED.

S 13. Paragraph (bbb) 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:

(bbb) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of awarding grants to operators of adult homes, enriched housing programs and residences through the enhancing abilities and life experience (EnAbLe) program to provide for the installation, operation and maintenance of air conditioning in resident rooms, consistent with this paragraph, in an amount up to two million dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million eight hundred thousand dollars for the period April first, two thousand seven through March thirty-first, two thousand eight, up to three million eight hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, AND up to three million eight hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten[, and up to three million eight hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven]. Residents shall not be charged utility cost for the use of air conditioners supplied under the EnAbLe program. All such air conditioners must be operated in occupied resident rooms consistent with requirements applicable to common areas.

S 13-a. Subdivision 1 of section 2807-v of the public health law is amended by adding a new paragraph (iii) to read as follows:

(III) FUNDS SHALL BE RESERVED AND ACCUMULATED FROM YEAR TO YEAR AND SHALL BE AVAILABLE, INCLUDING INCOME FROM INVESTED FUNDS, FOR PURPOSES OF AWARDING GRANTS TO OPERATORS OF ADULT HOMES, ENRICHED HOUSING PROGRAMS AND RESIDENCES FOR QUALITY IMPROVEMENTS IN ADULT HOMES,

ENRICHED HOUSING PROGRAMS AND RESIDENCES, IN AN AMOUNT UP TO FOUR MILLION THREE HUNDRED ELEVEN THOUSAND SEVEN HUNDRED DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN.

S 14. Section 217 of the elder law is REPEALED.

S 14-a. Subparagraph 1 of paragraph (a) of subdivision 2 of section 214 of the elder law is amended to read as follows:

(1) a statement of goals and objectives for addressing the needs of elderly persons in the county, an assessment of the needs of elderly persons residing in the county, a description of public and private resources that currently provide community services to elderly persons within the county, a description of intended actions to consolidate and coordinate existing community services administered by county government, [a description of the intended actions to coordinate congregate services programs for the elderly operated within the county pursuant to section two hundred seventeen of this title with other community services for the elderly,] a description of the means to coordinate other community services for elderly persons in the county with those administered by county government, and a statement of the priorities for the provision of community services during the program period covered by such plan;

S 15. Section 2799-f of the public health law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

S 2799-f. Comprehensive care centers for eating disorders; established. [1.] The commissioner shall [facilitate the development, and] provide for the public identification[,] of comprehensive care centers for persons with eating disorders[. The development and identification of such centers shall be] for the purposes of:

[(a)] 1. Promoting the [development and] operation of a continuum of comprehensive, coordinated care for persons with eating disorders;

[(b)] 2. Promoting ready access to information, referral and treatment services on eating disorders for consumers, health practitioners, providers and insurers, with access in every region of the state;

[(c)] 3. Promoting community education, prevention and patient entry into care; and

[(d)] 4. Promoting and coordinating regional and statewide research efforts into effective methods of education, prevention and treatment, including research on the various models of care.

[2. In order to identify such comprehensive care centers, the commissioner shall issue a request for applications ("hereinafter referred to in this section as RFA"). The form and content of such RFA shall be prepared with input from individuals and organizations who at a minimum are representative of health care practitioners and providers with expertise in the care of persons with eating disorders as well as from persons and families with experience in the diagnosis and treatment of these disorders. Such RFA shall be issued not later than one hundred twenty days following the effective date of this article.]

S 16. Paragraph (d) of subdivision 1 of section 2799-g of the public health law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

(d) The applicant meets such additional criteria as [is specified in the RFA] ARE ESTABLISHED BY THE COMMISSIONER.

S 17. Subdivision 2 of section 2799-h of the public health law, as added by chapter 114 of the laws of 2004, is amended to read as follows:

2. The commissioner's [written notice to applicants, which shall be provided no later than ninety days following the receipt of a satisfac-

tory application, shall identify the applicant as a state-identified] IDENTIFICATION OF A comprehensive care center for eating disorders under this article[, provided however that such notice] shall be valid for not more than a two year period from the date of issuance. The commissioner may reissue such [written notices] IDENTIFICATIONS for subsequent periods of up to two years, provided that the comprehensive care center has notified the commissioner of any material changes in structure or operation based on its original [RFA submission] APPLICATION, or since its last written notice by the commissioner, and that the commissioner is satisfied that the center continues to meet the criteria required pursuant to this article.

S 18. Sections 2799-j and 2799-l of the public health law are REPEALED.

S 19. Section 95-e of the state finance law, as added by chapter 114 of the laws of 2004, is REPEALED.

S 20. Intentionally omitted.

S 21. Intentionally omitted.

S 22. Intentionally omitted.

S 23. Intentionally omitted.

S 24. Intentionally omitted.

S 25. Intentionally omitted.

S 26. Section 207 of the public health law, as added by chapter 414 of the laws of 2005, subdivision 1 as amended by chapter 471 of the laws of 2007, paragraph (f) of subdivision 1 as added by chapter 570 of the laws of 2008 and paragraph (f) of subdivision 1 as added by chapter 573 of the laws of 2008, is amended to read as follows:

S 207. Health care and wellness education and outreach program. 1. There is hereby created within the department the health care and wellness education and outreach program. The department [shall] MAY conduct education and outreach programs for consumers, patients, and health care providers relating to any health care matters the commissioner deems appropriate and:

(a) Various health conditions, diseases and health care procedures and treatment options, INCLUDING BUT NOT LIMITED TO THOSE FOR BREAST, CERVICAL, COLORECTAL, PROSTATE, TESTICULAR, SKIN, AND OVARIAN CANCER, SHAKEN BABY SYNDROME, AND REFLEX SYMPATHETIC DYSTROPHY.

(b) Recommended preventative and wellness practices and services, including EVIDENCE BASED age and gender appropriate testing and screening exams and immunization schedules.

(c) Lymphedema, an abnormal swelling of the extremities including the causes and symptoms of lymphedema, the value of early detection, possible options for treatment including their benefits and risks, and other relevant information and the recommendation that hospitals treating breast cancer patients implement a lymphedema alert program by placing a bright pink wristband on the patient's affected arm.

(d) The need and importance of organ and tissue donation, including information about being registered as an organ and tissue donor and executing documents of gift under article forty-three of this chapter.

(e) The need and importance for consumers and patients to have an advance directive, particularly a health care proxy, and the need and importance for health care providers to play a leadership role in discussing end-of-life care preferences and values with patients and to provide patients with health care proxy forms.

(f) Uterine fibroids, an abnormal growth that occurs in the uterus, including the causes and symptoms of uterine fibroids, the value of early detection, possible options for treatment including their benefits

and risks, information on the elevated risk for minority women and other relevant information.

[(f)] (G) Improving birth outcomes, including the importance of preconceptional care, early prenatal care, considerations of health risks during pregnancy, considerations of benefits and risks of labor and delivery options including, but not limited to, vaginal and cesarean section delivery, elective or repeat cesarean sections, and appropriate use of drugs during delivery.

2. Programs under this section, dealing with one or more subjects, may include but not be limited to any of the following elements:

(a) educational and informational materials in print, audio, visual, electronic or other media;

(b) public service announcements and advertisements; and

(c) establishment of toll-free telephone hotlines and electronic services to provide information.

3. The department [shall] MAY produce, make available to others for reproduction, or contract with others to develop such materials mentioned in this section as the commissioner deems appropriate. These materials shall be made available to the public free of charge as appropriate or for a fee under certain circumstances. The commissioner may require where appropriate any health care provider to make these materials available to patients.

4. In exercising any of his or her powers under this section, the commissioner [shall] MAY consult with appropriate health care professionals, providers, consumers, and patients or organizations representing them.

5. The commissioner [shall] MAY ensure that all information and materials produced pursuant to this section are maintained and updated to reflect best practice recommendations.

6. The commissioner may appoint as appropriate advisory councils relating to various matters that are or are proposed to be the subjects of programs under this section. All such councils shall include representation of health care professionals, providers, consumers, patients and other appropriate interests. The members of the councils shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in performance of their duties.

7. In addition to state funds appropriated for programs under this section, the commissioner may accept grants from public or private sources for these programs. The commissioner, in administering this section, shall seek to coordinate the department's programs with other public and private programs, and may undertake joint or cooperative programs with other public or private entities.

8. The commissioner may make rules and regulations necessary and appropriate for implementation of this section.

S 27. Paragraph (m) of subdivision 1 of section 201 of the public health law, as amended by section 3 of part A of chapter 58 of the laws of 2009, 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 [where inspections otherwise occur under the state uniform fire prevention and building code, respond to complaints relating], IN RELATION to hotels, boarding houses and temporary residences as defined in the state sanitary code [and], inspect such facilities (I) WHERE INSPECTIONS DO NOT OTHERWISE OCCUR UNDER THE STATE

UNIFORM FIRE PREVENTION AND BUILDING CODE, (II) TO RESPOND TO COMPLAINTS, OR (III) when otherwise necessary;

S 28. Article 43-C of the public health law is REPEALED.

S 29. Section 2745 of the public health law is REPEALED.

S 30. 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. 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.] HOWEVER, EXCEPT FOR DRUGS EXCLUDED FROM MEDICARE COVERAGE IN ACCORDANCE WITH SECTION 1860D-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. 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 31. Paragraphs (f), (g) and (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:

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

(i) for participants with comprehensive coverage under section two hundred forty-seven of this title, the elderly pharmaceutical insurance coverage program shall pay for the portion of the part D monthly premium that is the responsibility of the participant. Such payment shall be limited to the low-income benchmark premium amount established by the federal centers for Medicare and Medicaid services and any other amount which such agency establishes under its de minimus premium policy[, except that such payments made on behalf of participants enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program].

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

(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.]

(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 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 32. Subdivision 6 of section 250 of the elder law is REPEALED.

S 33. Subparagraph 5 of paragraph (b) of subdivision 3 of section 602 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

(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] ASSURING THE ABATEMENT OF public health nuisances BY RESPONSIBLE PARTIES.

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 34. Section 677 of the county law is amended by adding a new subdivision 9 to read as follows:

9. WHEN REQUIRED FOR OFFICIAL PURPOSES OF THE STATE DEPARTMENT OF HEALTH, THE STATE COMMISSIONER OF HEALTH OR HIS OR HER DESIGNEE MAY REQUEST COPIES OF ALL REPORTS AND RECORDS RELATED TO A DEATH, INCLUDING BUT NOT LIMITED TO AUTOPSY REPORTS AND TOXICOLOGY REPORTS. UPON RECEIPT OF THE WRITTEN REQUEST OF THE STATE COMMISSIONER OF HEALTH OR HIS OR HER DESIGNEE, A CORONER, CORONER'S PHYSICIAN OR MEDICAL EXAMINER, SHALL, WITHIN THREE BUSINESS DAYS OF THEIR COMPLETION, PROVIDE TO SUCH COMMISSIONER OR HIS OR HER DESIGNEE A COPY OF ALL REPORTS AND RECORDS, INCLUDING BUT NOT LIMITED TO AUTOPSY REPORTS AND TOXICOLOGY REPORTS, RELATED TO THE DEATH.

S 35. Article 27-I of the public health law is REPEALED.

S 36. Paragraph (a) of subdivision 5 of section 2819 of the public health law, as amended by chapter 239 of the laws of 2005, is amended to read as follows:

(a) Subject to paragraph (c) of this subdivision, on or before [May] SEPTEMBER first of each year the commissioner shall submit a report to the governor and the legislature, which shall simultaneously be published in its entirety on the department's web site, that includes, but is not limited to, hospital acquired infection rates adjusted for the potential differences in risk factors for each reporting hospital, an analysis of trends in the prevention and control of hospital acquired infection rates in hospitals across the state, regional and, if available, national comparisons for the purpose of comparing individual hospital performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs.

S 37. Section 2995-a of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-A. EACH PHYSICIAN LICENSED AND REGISTERED TO PRACTICE IN THIS STATE SHALL WITHIN ONE HUNDRED TWENTY DAYS OF THE EFFECTIVE DATE OF THIS SUBDIVISION AND UPON ENTERING OR UPDATING HIS OR HER PROFILE INFORMATION:

(A) REGISTER AND MAINTAIN AN ACCOUNT WITH THE DEPARTMENT'S HEALTH PROVIDER NETWORK AND ANY SUCCESSOR ELECTRONIC SYSTEM ESTABLISHED TO FACILITATE COMMUNICATIONS BETWEEN THE DEPARTMENT AND LICENSED HEALTH CARE PROVIDERS; OR

(B) PROVIDE AN E-MAIL ADDRESS TO THE DEPARTMENT WHICH SHALL BE USED BY THE DEPARTMENT TO COMMUNICATE WITH THE PHYSICIAN. LICENSEES SHALL PROVIDE NOTICE TO THE DEPARTMENT OF CHANGED E-MAIL ADDRESSES WITHIN THIRTY DAYS OF THE CHANGE. LICENSEE E-MAIL ADDRESSES SHALL BE CONFIDENTIAL AND SHALL NOT BE PUBLISHED AS PART OF THE LICENSEE'S PROFILE. THE E-MAIL ADDRESSES MAY BE USED FOR DEPARTMENT PURPOSES ONLY.

S 38. The public health law is amended by adding a new section 2816-a to read as follows:

S 2816-A. CARDIAC SERVICES INFORMATION. 1. DEFINITIONS. FOR THE PURPOSES OF THIS SECTION, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS:

(A) "CARDIAC SERVICES INFORMATION" SHALL MEAN THE DEMOGRAPHIC, CLINICAL, PROCEDURAL AND OUTCOME INFORMATION COLLECTED FROM HOSPITALS AND MAINTAINED BY THE DEPARTMENT REGARDING PATIENTS WHO HAVE BEEN DIAGNOSED OR TREATED FOR CARDIAC DISEASE OR CONDITIONS.

(B) "CARDIAC DATA SET" SHALL MEAN A SUBSET OF CARDIAC SERVICES INFORMATION CONSISTING OF DATA ELEMENTS RELEVANT TO A RESEARCH PROJECT.

2. NOTWITHSTANDING ARTICLES SIX AND SIX-A OF THE PUBLIC OFFICERS LAW, THE COMMISSIONER MAY COLLECT AND MAINTAIN CARDIAC SERVICES INFORMATION AND PREPARE AND RELEASE CARDIAC DATA SETS FOR USE IN RESEARCH PROJECTS AS SET FORTH IN THIS SUBDIVISION. ANY CARDIAC DATA SET RELEASED SHALL CONTAIN THE MINIMUM AMOUNT OF PERSONALLY IDENTIFIABLE INFORMATION WHICH THE COMMISSIONER DETERMINES IS NECESSARY TO CONDUCT THE RESEARCH PROJECT PROVIDED, HOWEVER, THAT NO CARDIAC DATA SET SHALL BE RELEASED THAT CONTAINS PATIENT NAMES, SOCIAL SECURITY NUMBERS, OR OTHER DATA ELEMENTS THAT DIRECTLY IDENTIFY ANY PATIENT.

3. THE COMMISSIONER MAY RELEASE CARDIAC DATA SETS FOR RESEARCH PROJECTS BASED ON THE FOLLOWING FACTORS:

(A) THE RESEARCH PROJECT'S POTENTIAL CONTRIBUTION TO IMPROVING THE QUALITY OF CARE AND OUTCOMES EXPERIENCED BY PATIENTS RECEIVING CARDIAC SERVICES, THE APPROPRIATENESS OF CARDIAC SERVICES, ACCESS TO CARDIAC SERVICES, AND/OR THE COST EFFECTIVENESS OF CARDIAC SERVICES;

(B) THE TECHNICAL FEASIBILITY OF PREPARING THE CARDIAC DATA SET REQUESTED;

(C) THE SCIENTIFIC MERIT OF THE RESEARCH PROJECT;

(D) THE EXPERIENCE AND QUALIFICATIONS OF THE RESEARCHERS;

(E) THE RESEARCH PROJECT'S FEASIBILITY;

(F) THE APPLICANT'S CAPACITY AND AGREEMENT TO PROTECT THE CONFIDENTIALITY OF THE DATA;

(G) THE RESEARCH PROJECT'S COMPLIANCE WITH APPLICABLE STATE AND FEDERAL LAWS, POLICIES AND REGULATIONS GOVERNING THE PROTECTION OF HUMAN SUBJECTS; AND

(H) SUCH OTHER CRITERIA AS THE COMMISSIONER DEVELOPS IN CONSULTATION WITH EXPERTS IN CARDIAC SERVICES.

4. ANY RESEARCHER AUTHORIZED BY THE COMMISSIONER TO ACCESS A CARDIAC DATA SET SHALL:

(A) MAINTAIN THE SECURITY AND CONFIDENTIALITY OF THE INFORMATION;

(B) NOT DISCLOSE THE CARDIAC DATA SET, OR ANY PORTION THEREOF, UNLESS SPECIFICALLY PERMITTED TO DO SO BY THE COMMISSIONER;

(C) RESTRICT THE USE OF THE DATA TO THE SPECIFIC RESEARCH PROJECT APPROVED BY THE COMMISSIONER;

(D) DESTROY, AND DOCUMENT THE DESTRUCTION OF, THE DATA WITHIN A TIME PERIOD SPECIFIED BY THE COMMISSIONER; AND

(E) EXECUTE AND COMPLY WITH A CARDIAC SERVICES DATA USE AGREEMENT, WHICH INCLUDES BUT IS NOT LIMITED TO PROVISIONS RESTRICTING THE USE AND DISCLOSURE OF THE DATA.

5. THE COMMISSIONER SHALL CHARGE A FEE FOR EACH CARDIAC DATA SET RELEASED. SUCH FEE SHALL BE PAYABLE TO THE DEPARTMENT, PRIOR TO THE RELEASE OF ANY CARDIAC DATA SET, FOR DEPOSIT INTO THE GENERAL FUND.

6. THE COMMISSIONER MAY PROMULGATE AND ENFORCE SUCH RULES AND REGULATIONS AS HE OR SHE DEEMS NECESSARY TO EFFECTUATE THE PURPOSES OF THIS SECTION.

S 39. Paragraph (iv) of subdivision 4 of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living

adjustment for designated human services programs, as amended by section 7 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

(iv) Programs eligible for the cost of living adjustments under the auspice of the department of health include: [HIV/AIDS adolescent services/ACT for youth; HIV/AIDS adolescent service/general; HIV/AIDS adolescent services/schools; HIV/AIDS clinical education; HIV/AIDS clinical guidelines development; HIV/AIDS clinical scholars; HIV/AIDS clinical trials experimental treatment; HIV/AIDS community development initiative; HIV/AIDS community HIV prevention and primary care; HIV/AIDS community services programs; HIV/AIDS criminal justice; HIV/AIDS education and training; HIV/AIDS evaluation and research; HIV/AIDS expanded syringe access program; HIV/AIDS families in transition; HIV/AIDS family centered care; HIV/AIDS harm reduction/general; HIV/AIDS harm reduction/syringe exchange; HIV/AIDS HIV health care and support services for women and kids; HIV/AIDS HIV prevention/primary care/support services for substance abusers; HIV/AIDS homeless shelters; HIV/AIDS legal services and advocacy; HIV/AIDS lesbian, gay, bisexual, transgender/adolescent; HIV/AIDS lesbian, gay, bisexual, transgender/general; HIV/AIDS lesbian, gay, bisexual, transgender/substance use; HIV/AIDS multiple service agency; HIV/AIDS nutritional services; HIV/AIDS pediatric centers of excellence; HIV/AIDS permanency planning; HIV/AIDS racial and ethnic minority; HIV/AIDS social day care; HIV/AIDS specialized care centers for youth; HIV/AIDS specialty; HIV/AIDS supportive housing; HIV/AIDS treatment adherence; HIV/AIDS women's services/general; HIV/AIDS women's services/peer; HIV/AIDS women's services/supportive services; HIV/AIDS youth access program,] REGIONAL AND TARGETED HIV, STD AND HEPATITIS C SERVICES; HIV, STD AND HEPATITIS C PREVENTION; HIV HEALTH CARE AND SUPPORTIVE SERVICES; HEPATITIS C PROGRAMS; HIV, STD AND HEPATITIS C CLINICAL AND PROVIDER EDUCATION PROGRAMS; office of minority health; center for community health program; red cross emergency preparedness; nutrition outreach and education; obesity prevention AND DIABETES RELATED PROGRAMS; women, infants, and children; hunger prevention and nutrition assistance; Indian health; asthma; prenatal care assistance program; rape crisis; [health and human services sexuality related; maternity/early childhood foundation;] comprehensive adolescent pregnancy prevention; family planning; school health; sudden infant death syndrome; childhood lead poisoning prevention; [enhanced services for kids; act for youth;] children with special health care needs; regional perinatal [data] centers; migrant health; dental services; osteoporosis prevention; [eating disorders;] cancer services PROGRAMS; [cancer registry;] healthy heart; alzheimer's disease assistance centers; alzheimer's disease - research and education; [diabetes screening, education and prevention;] tobacco control; rabies; tick-borne DISEASE; immunization; universal prenatal and postpartum home visitation public health campaign; sexually transmitted disease; and tuberculosis control.

S 40. Subdivision 18-a of section 206 of the public health law, as added by section 74 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

18-a. (A) Health information technology demonstration program. [1.] (I) The commissioner is authorized to issue grant funding to one or more organizations broadly representative of physicians licensed in this state, from funds made available for the purpose of funding research and demonstration projects under [subdivision two of this section] SUBPARAGRAPH (II) OF THIS PARAGRAPH designed to promote the development of

electronic health information exchange technologies in order to facilitate the adoption of interoperable health records.

[2.] (II) Project funding shall be disbursed to projects pursuant to a request for proposals based on criteria relating to promoting the efficient and effective delivery of quality physician services. Demonstration projects eligible for funding under this [section] PARAGRAPH shall include, but not be limited to:

[(a)] (A) efforts to incentivize electronic health record adoption;

[(b)] (B) interconnection of physicians through regional collaborations;

[(c)] (C) efforts to promote personalized health care and consumer choice;

[(d)] (D) efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring.

[3.] (III) The department shall issue a report to the governor, the temporary president of the senate and the speaker of the assembly within one year following the issuance of the grants. Such report shall contain, at a minimum, the following information: the demonstration projects implemented pursuant to this [section] PARAGRAPH, their date of implementation, their costs and the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state.

(B) THE COMMISSIONER SHALL MAKE SUCH RULES AND REGULATIONS AS MAY BE NECESSARY TO IMPLEMENT FEDERAL POLICIES AND DISBURSE FUNDS AS REQUIRED BY THE AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 AND TO PROMOTE THE DEVELOPMENT OF A STATEWIDE HEALTH INFORMATION NETWORK OF NEW YORK (SHIN-NY) TO ENABLE WIDESPREAD INTEROPERABILITY AMONG DISPARATE HEALTH INFORMATION SYSTEMS, INCLUDING ELECTRONIC HEALTH RECORDS, PERSONAL HEALTH RECORDS AND PUBLIC HEALTH INFORMATION SYSTEMS, WHILE PROTECTING PRIVACY AND SECURITY. SUCH RULES AND REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, REQUIREMENTS FOR ORGANIZATIONS COVERED BY 42 U.S.C. 17938 OR ANY OTHER ORGANIZATIONS THAT EXCHANGE HEALTH INFORMATION THROUGH THE SHIN-NY.

S 41. This act shall take effect April 1, 2010, provided however that:

(a) section three of this act shall take effect March 1, 2011;

(b) sections thirty, thirty-two and thirty-seven of this act and the amendments to paragraph (g) of subdivision 3 of section 242 of the elder law made by section thirty-one of this act shall take effect July 1, 2010;

(c) the amendments to paragraphs (f) and (h) of subdivision 3 of section 242 of the elder law made by section thirty-one of this act shall take effect January 1, 2011;

(d) section thirty-eight of this act shall take effect on the one hundred eightieth day after it shall have become a law; and

(e) the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section thirty-nine of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART B

Section 1. 1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, subdivision 2-b of section 2808 of the public health law, section 21 of chapter 1 of the laws of 1999, and any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided

on and after April 1, 2010, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities that provide extensive nursing, medical, psychological and counseling support services to children, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply zero trend factor projections attributable to the 2010 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such zero trend factor projections for such 2010 calendar year shall also be applied to rates of payment for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after April 1, 2010, trend factor projections attributable to the 2010 calendar year shall be established at zero percent.

2. The commissioner of health shall adjust rates of payment to reflect the exclusion pursuant to this section of such specified trend factor projections or adjustments.

S 2. Subparagraph (vi) of paragraph (a) of subdivision 2 of section 2807-d of the public health law, as added by section 49 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(vi) Notwithstanding any contrary provisions of this paragraph or any other provision of law or regulation, for general hospitals the assessment shall be thirty-five hundredths of one percent of each general hospital's gross receipts received from all patient care services and other operating income on a cash basis for periods on and after April first, two thousand nine, for hospital or health-related services, including, but not limited to inpatient services, outpatient services, emergency services, referred ambulatory services and ambulatory surgical services, but not including residential health care facilities services or home health care services, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, SUCH ASSESSMENT FOR SUCH SERVICES SHALL BE SEVENTY-FIVE HUNDREDTHS OF ONE PERCENT OF EACH SUCH GENERAL HOSPITAL'S GROSS RECEIPTS, PROVIDED FURTHER, HOWEVER, THAT AMOUNTS IN EXCESS OF THIRTY-FIVE HUNDREDTHS OF ONE PERCENT SHALL BE ASSESSED ONLY WITH REGARD TO GROSS RECEIPTS FOR INPATIENT CARE SERVICES AND OTHER OPERATING INCOME ON A CASH BASIS AND SHALL NOT BE ASSESSED WITH REGARD TO GROSS RECEIPTS FOR OUTPATIENT SERVICES.

S 3. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(v) Such regulations [may] SHALL incorporate quality related measures pertaining to potentially preventable complications and re-admissions; PROVIDED THAT RATE ADJUSTMENTS MADE IN ACCORDANCE WITH A METHODOLOGY SPECIFIED IN SUCH REGULATIONS SHALL RESULT IN AN AGGREGATE REDUCTION IN MEDICAID PAYMENTS OF NO LESS THAN FORTY-NINE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO

THOUSAND ELEVEN AND NO LESS THAN ONE HUNDRED EIGHT MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, NET OF ANY REINVESTMENT FOR HOSPITALS WITH IMPROVED OR CONTINUED HIGH PERFORMANCE IN RELATION TO THE ESTABLISHED READMISSION BENCHMARKS AND INITIATIVES FOR BEHAVIORAL HEALTH ADMISSION DIVERSION AND POST-DISCHARGE LINKAGE PAYMENTS;

S 4. Subparagraph (xi) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations; PROVIDED THAT FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, SUCH REGULATIONS SHALL SPECIFY A ONE PERCENTAGE POINT PER YEAR REDUCTION IN THE INDIRECT GRADUATE MEDICAL EDUCATION PAYMENT PER DISCHARGE AND THE AMOUNT OF INDIRECT GRADUATE MEDICAL EDUCATION EXCLUDED FROM THE STATEWIDE BASE PRICE CALCULATED FOR THE PERIOD DECEMBER FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN. 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.

S 5. Subdivision 35 of section 2807-c of the public health law is amended by adding a new paragraph (i) to read as follows:

(I) FOR DISCHARGES OCCURRING ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, MEDICAID RATES FOR INPATIENT SERVICES FOR GENERAL HOSPITALS WHOSE RATES ARE OTHERWISE SUBJECT TO THIS SUBDIVISION SHALL BE ADJUSTED IN ACCORDANCE WITH THE FOLLOWING IN ORDER TO PROVIDE ADDITIONAL FUNDING FOR OBSTETRICAL ACCESS AND QUALITY:

(I) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN AND EACH STATE FISCAL YEAR THEREAFTER, SUCH RATES FOR ELIGIBLE GENERAL HOSPITALS SHALL BE ADJUSTED BY AN AGGREGATE ANNUAL AMOUNT OF UP TO SEVENTY-TWO MILLION DOLLARS;

(II) SUCH ADJUSTMENTS SHALL BE MADE PROPORTIONATELY TO EACH ELIGIBLE GENERAL HOSPITAL, WITH FIFTY PERCENT OF SUCH ADJUSTMENTS BASED ON EACH SUCH HOSPITAL'S NUMBER OF REPORTED TWO THOUSAND SEVEN MEDICAID AND MEDICAID MANAGED CARE CASE-MIX ADJUSTED OBSTETRICAL AND NEO-NATAL DISCHARGES, AND FIFTY PERCENT OF SUCH ADJUSTMENTS BASED ON THE REGIONAL COST PER DISCHARGE FOR SUCH CASES BASED UPON COST DATA AS REPORTED ON LINE TWENTY-FIVE OF EXHIBIT EIGHTEEN OF THE TWO THOUSAND SIX COST REPORT FILED PRIOR TO JANUARY FIRST, TWO THOUSAND NINE;

(III) PAYMENT OF SUCH ADJUSTMENTS FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND ELEVEN SHALL BE CONTINGENT UPON AN OTHERWISE ELIGIBLE GENERAL HOSPITAL'S CERTIFICATION TO THE COMMISSIONER THAT IT HAS IMPLEMENTED OR HAS A DOCUMENTED PLAN, INCLUDING TIME-LINES, FOR IMPLEMENTING A COMPREHENSIVE AND SYSTEMATIC PERINATAL PATIENT SAFETY PROGRAM WHICH IS IN CONFORMITY WITH PUBLISHED DEPARTMENT GUIDELINES, WHICH MAY INCLUDE, BUT NOT BE LIMITED TO, SIMULATOR TRAINING, CREW RESOURCE MANAGEMENT TRAINING, ELECTRONIC FETAL MONITORING EDUCATION, PEER REVIEW, PARTICIPATION IN REGIONAL PERINATAL NETWORKS, FULL-TIME AVAILABILITY OF MATERNAL FETAL MEDICINE SPECIALISTS, FULL-TIME AVAILABILITY OF INHOUSE OBSTETRICIANS FOR LABOR AND DELIVERY, FULL PARTICIPATION IN THE DEPARTMENT'S MATERNAL MORTALITY REVIEW PROGRAM, ESTABLISHMENT OF A MATERNAL HEMORRHAGE EMERGENCY TEAM WITH PROTOCOLS AND DRILLS, A PROGRAM TO CONVERT TO ELECTRONIC MEDICAL RECORDS WITHIN TWO YEARS, CURRENT ACTIVE BOARD CERTIFICATION FOR STAFF OBSTETRICIANS ON STAFF FOR MORE THAN ONE

YEAR, AN ONGOING PROGRAM TO IMPLEMENT A FULLY INTEGRATED LONGITUDINAL COMPUTERIZED PATIENT TRACKING SYSTEM FOR OBSTETRICAL PATIENTS AT BOTH THE HOSPITAL AND AT THE PRIVATE OFFICES OF ATTENDING OBSTETRICIANS, AND A PROGRAM TO REVIEW AND IMPROVE PATIENT SAFETY STANDARDS ON AN ONGOING BASIS.

S 6. Notwithstanding any contrary provision of law, in the event the amendment to subparagraph (xi) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, reducing indirect graduate medical education payments per discharge to teaching hospitals, is not enacted into law by a chapter of the laws of 2010, then the provision of this act amending subdivision 35 of section 2807-c of the public health law by adding a new paragraph (i), and the provisions of this act amending paragraphs (d) and (e) of subdivision 5-a of section 2807-m of the public health law, shall be null and void and of no effect, provided, however, that funds made available by the provisions of the amendment to subparagraph (xi) of paragraph (b) of subdivision 35 of section 2807-c of the public health law which are not otherwise made available in connection with the implementation of amendments described herein to sections 2807-m and paragraph (i) of subdivision 35 of section 2807-c(35)(i) of the public health law, shall be made available for the statewide base price amounts computed pursuant to subdivision 35 of section 2807-c of the public health law.

S 7. Section 2807-k of the public health law is amended by adding a new subdivision 5-c to read as follows:

5-C. 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 PROVISIONS OF PARAGRAPH (D) OF SUBDIVISION FIVE-A OF THIS SECTION AND TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN, ALL FUNDS AVAILABLE FOR DISTRIBUTION PURSUANT TO THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE, AND AS HEREINAFTER DESCRIBED SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED IN ACCORDANCE WITH THE FOLLOWING:

(A) FOR THE PERIOD JANUARY FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN, PAYMENTS PURSUANT TO THIS SECTION SHALL BE MADE IN AMOUNTS REFLECTING TWENTY-FIVE PERCENT OF THE DISTRIBUTIONS OTHERWISE AUTHORIZED PURSUANT TO THE PROVISIONS OF THIS SECTION, OTHER THAN THIS SUBDIVISION, AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE.

(B) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN, PAYMENTS TOTALING SEVEN HUNDRED FORTY-SEVEN MILLION DOLLARS SHALL BE MADE AS FOLLOWS:

(I) MEDICAID DSH PAYMENTS TO MAJOR PUBLIC GENERAL HOSPITALS, INCLUDING HOSPITALS OPERATED BY PUBLIC BENEFIT CORPORATIONS, SHALL BE MADE IN AMOUNTS REFLECTING SEVENTY-FIVE PERCENT OF THE PROJECTED DISTRIBUTIONS OTHERWISE AUTHORIZED FOR SUCH FACILITIES PURSUANT TO THE PROVISIONS OF THIS SECTION, OTHER THAN THIS SUBDIVISION.

(II) EIGHTEEN MILLION SEVEN HUNDRED FIFTY THOUSAND DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO HOSPITALS ELIGIBLE FOR PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (IV) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION BASED UPON EACH FACILITY'S PROPORTION OF UNINSURED LOSSES, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION, TO SUCH LOSSES FOR ALL HOSPITALS ELIGIBLE FOR SUCH PAYMENTS.

(III) TWELVE MILLION DOLLARS SHALL BE DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SUBPARAGRAPH (III) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION.

(IV) EIGHTEEN MILLION SEVEN HUNDRED FIFTY THOUSAND DOLLARS SHALL BE DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SUBPARAGRAPH (IV) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION.

(V) THE BALANCE OF THE FUNDS IN THE POOL NOT OTHERWISE ALLOCATED PURSUANT TO SUBPARAGRAPHS (I), (II), (III), (IV) AND (VI) OF THIS PARAGRAPH SHALL BE DISTRIBUTED PROPORTIONALLY AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS, ON THE BASIS OF EACH FACILITY'S UNCOMPENSATED CARE NEED SHARE, AS DETERMINED IN ACCORDANCE WITH THE SCALE SET FORTH IN SUBPARAGRAPH (VII) OF THIS PARAGRAPH.

(VI) SEVENTY-FIVE MILLION DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS, PURSUANT TO A FORMULA SUCH THAT, TO THE EXTENT OF FUNDS AVAILABLE, NO ELIGIBLE GENERAL HOSPITAL'S REDUCTION IN PAYMENTS AS A RESULT OF THE APPLICATION OF THE PROVISIONS OF THIS SUBDIVISION EXCEEDS, ON AN ANNUALIZED BASIS, A PERCENTAGE REDUCTION, AS DETERMINED BY THE COMMISSIONER, FROM THE PROJECTED DISTRIBUTIONS SUCH HOSPITAL WOULD HAVE RECEIVED PURSUANT TO THIS SECTION, OTHER THAN THIS SUBDIVISION, AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE FOR THE TWO THOUSAND TEN CALENDAR YEAR. SUCH PAYMENTS SHALL BE DISTRIBUTED TO ELIGIBLE GENERAL HOSPITALS ON A PROPORTIONAL BASIS, BASED ON THE DEGREE OF EACH SUCH GENERAL HOSPITAL'S PROJECTED REDUCTION IN DISTRIBUTION.

(VII) THE SCALE UTILIZED FOR DEVELOPMENT OF EACH ELIGIBLE GENERAL HOSPITAL'S UNCOMPENSATED CARE NEED SHARE PAYMENT AMOUNT, AS COMPUTED IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION, SHALL BE AS FOLLOWS, PROVIDED, HOWEVER, THAT THE REDUCTION DESCRIBED IN SUBPARAGRAPH (III) OF PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION SHALL BE COMPUTED AS TEN PERCENT:

UNCOMPENSATED NEED PERCENTAGE	PERCENTAGE OF REIMBURSEMENT ATTRIBUTABLE TO THAT PORTION OF UNCOMPENSATED NEED
0 - 4%	70%
4 - 6%	80%
6+%	90%

(C) FOR THE TWO THOUSAND ELEVEN CALENDAR YEAR AND EACH CALENDAR YEAR THEREAFTER, PAYMENTS TOTALING NINE HUNDRED NINETY-SIX MILLION DOLLARS SHALL BE MADE AS FOLLOWS:

(I) MEDICAID DSH PAYMENTS TO MAJOR PUBLIC GENERAL HOSPITALS, INCLUDING HOSPITALS OPERATED BY PUBLIC BENEFIT CORPORATIONS, SHALL BE MADE IN AMOUNTS EQUAL TO THE PROJECTED DISTRIBUTIONS THAT WOULD HAVE BEEN MADE TO SUCH FACILITIES PURSUANT TO THE PROVISIONS OF THIS SECTION, OTHER THAN THIS SUBDIVISION, FOR THE TWO THOUSAND TEN CALENDAR YEAR.

(II) TWENTY-FIVE MILLION DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO HOSPITALS ELIGIBLE FOR PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (IV) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION BASED UPON EACH FACILITY'S PROPORTION OF UNINSURED LOSSES, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION, TO SUCH LOSSES FOR ALL HOSPITALS ELIGIBLE FOR SUCH PAYMENTS.

(III) SIXTEEN MILLION DOLLARS SHALL BE DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SUBPARAGRAPH (III) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION.

(IV) TWENTY-FIVE MILLION DOLLARS SHALL BE DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SUBPARAGRAPH (IV) OF PARAGRAPH (A) OF SUBDIVISION FIVE-B OF THIS SECTION.

(V) THE BALANCE OF THE FUNDS NOT OTHERWISE ALLOCATED BY SUBPARAGRAPHS (I), (II), (III), (IV) AND (VI) OF THIS PARAGRAPH, SHALL BE DISTRIBUTED

PROPORTIONALLY AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS, ON THE BASIS OF EACH FACILITY'S UNCOMPENSATED CARE NEED SHARE, AS DETERMINED IN ACCORDANCE WITH THE SCALE SET FORTH IN SUBPARAGRAPH (VII) OF PARAGRAPH (B) OF THIS SUBDIVISION.

(VI) FIFTY MILLION DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS, IN ACCORDANCE WITH THE METHODOLOGY SET FORTH IN SUBPARAGRAPH (VI) OF PARAGRAPH (B) OF THIS SUBDIVISION, PROVIDED, HOWEVER, THAT FOR THE TWO THOUSAND TWELVE CALENDAR YEAR SUCH PAYMENTS SHALL BE TWENTY-FIVE MILLION DOLLARS, AND PROVIDED FURTHER, HOWEVER, THAT FOR THE TWO THOUSAND THIRTEEN CALENDAR YEAR AND EACH CALENDAR YEAR THEREAFTER SUCH PAYMENTS SHALL BE ZERO.

S 8. Intentionally omitted.

S 9. 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 12 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, 2011, 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 recon-

ciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 AND 2008, RESPECTIVELY, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, FOR STATE FISCAL YEARS BEGINNING ON AND AFTER APRIL 1, 2010, BASED INITIALLY ON REPORTED RECONCILED DATA FROM THE BASE YEAR TWO YEARS PRIOR TO THE PAYMENT YEAR, ADJUSTED FOR AUTHORIZED MEDICAID RATE CHANGES APPLICABLE TO THE STATE FISCAL YEAR, AND FURTHER RECONCILED TO ACTUAL REPORTED DATA FROM SUCH PAYMENT YEAR, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 10. 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 13 of part B of chapter 58 of the laws of 2009, 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 up to four hundred twenty million dollars [annually for the state fiscal year beginning April 1, 2009 through March 31, 2010, and] FOR THE STATE FISCAL YEAR BEGINNING APRIL 1, 2009 THROUGH MARCH 31, 2010, AND FOUR HUNDRED TWENTY MILLION DOLLARS, AS FURTHER INCREASED BY UP TO THE MAXIMUM PAYMENT AMOUNTS PERMITTED UNDER SECTIONS 1923(F) AND 1923(G) OF THE FEDERAL SOCIAL SECURITY ACT, AS DETERMINED BY THE COMMISSIONER OF HEALTH AFTER APPLICATION OF ALL OTHER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AUTHORIZED BY STATE LAW, for the state fiscal year beginning April 1, 2010 through March 31, 2011 and up to one hundred twenty million dollars, AS FURTHER INCREASED BY UP TO THE MAXIMUM PAYMENT AMOUNTS PERMITTED UNDER SECTIONS 1923(F) AND 1923(G) OF THE FEDERAL SOCIAL SECURITY ACT, AS DETERMINED BY THE COMMISSIONER OF HEALTH AFTER APPLICATION OF ALL OTHER DISPROPORTIONATE SHARE HOSPITAL PAYMENTS AUTHORIZED BY STATE LAW, annually for the state fiscal year beginning April 1, 2011, and annually 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 ACTUAL REPORTED 2008 OR 2009 DATA, RESPECTIVELY, for payments made during the state fiscal year ending on and after March 31, 2010, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported 2009 OR 2010 data, FOR PAYMENTS MADE DURING THE STATE FISCAL YEAR ENDING ON MARCH 31, 2011, BASED INITIALLY ON REPORTED RECONCILED DATA FROM THE BASE YEAR TWO YEARS PRIOR TO THE PAYMENT YEAR, ADJUSTED FOR AUTHORIZED MEDICAID RATE CHANGES APPLICABLE TO THE STATE FISCAL YEAR, AND AS FURTHER RECONCILED TO ACTUAL REPORTED DATA FROM SUCH PAYMENT YEAR, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 11. Subdivision 8 of section 272 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:

8. The commissioner shall provide notice of any recommendations developed by the committee regarding the preferred drug program, at least [thirty] FIVE days before any final determination by the commissioner, by making such information available on the department's website. Such public notice shall include: a summary of the deliberations of the committee; a summary of the positions of those making public comments at meetings of the committee; the response of the committee to those comments, if any; and the findings and recommendations of the committee.

S 12. 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 13. 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 14. Paragraph (f) of subdivision 9 of section 367-a of the social services law is REPEALED.

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

(V) ADMINISTRATION OF VACCINATIONS IN A PHARMACY BY A CERTIFIED PHARMACIST WITHIN HIS OR HER SCOPE OF PRACTICE.

S 16. 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 OCTOBER FIRST, TWO THOUSAND TEN, 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 OF NEW YORK 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 SUBMIT-

TED 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 17. Subparagraphs (vii) and (viii) of paragraph (uu) of subdivision 1 of section 2807-v of the public health law, as amended by section 120 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(vii) [seven] ONE million [five] EIGHT hundred SEVENTY-FIVE thousand dollars for the period January first, two thousand ten through [December] MARCH thirty-first, two thousand ten shall be available for disease management demonstration programs[; and

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

S 18. Intentionally omitted.

S 19. Intentionally omitted.

S 20. Intentionally omitted.

S 21. Paragraph (jj) 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:

(jj) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purposes of a grant program to improve access to infertility services, treatments and procedures, from the tobacco control and insurance initiatives pool established for the period January first, two thousand two through December thirty-first, two thousand two in the amount of nine million one hundred seventy-five thousand dollars, for the period April first, two thousand six through March thirty-first, two thousand seven in the amount of five million dollars, for the period April first, two thousand seven through March thirty-first, two thousand eight in the amount of five million dollars, for the period April first, two thousand eight through March thirty-first, two thousand nine in the amount of five million dollars, AND for the period April first, two thousand nine through March thirty-first, two thousand ten in the amount of five million dollars, and for the period April first, two thousand ten through March thirty-first, two thousand eleven in the amount of [five] TWO million TWO HUNDRED THOUSAND dollars.

S 22. Subparagraphs (vii) and (viii) of paragraph (qq) 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:

(vii) up to [five million] FOUR HUNDRED EIGHTY-EIGHT THOUSAND dollars for the period January first, two thousand ten through [December] MARCH thirty-first, two thousand ten; of such funds [one million nine] FOUR hundred [fifty] EIGHTY-EIGHT thousand dollars shall be made available to the department for the purpose of developing, implementing and adminis-

tering the long-term care insurance education and outreach program [and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long-term care insurance resource centers with the necessary resources to carry out their operations; and

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

S 23. Subparagraphs (xi) and (xii) of 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, are amended to read as follows:

(xi) up to [ninety-four] EIGHTY-THREE million [one] TWO hundred [fifty] SEVENTY-FIVE thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(xii) up to [twenty-three] NINETEEN million [five] NINE hundred [thirty-seven] TWELVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

S 24. Subparagraph (iv) of paragraph (c) 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:

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

S 25. Clause (B) of subparagraph (i) of paragraph (b) of subdivision 2 of section 369 of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(B) from the estate of [an individual] A DECEDENT who was fifty-five years of age or older when he or she received such assistance, OR FROM THE RECIPIENT OF THE PROPERTY OF SUCH DECEDENT BY DISTRIBUTION OR BY SURVIVAL.

S 25-a. Subdivision 6 of section 369 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

6. For purposes of this section, the term "estate" means all OF AN INDIVIDUAL'S real and personal property and other assets [included within the individual's estate and] passing under the terms of a valid will or by intestacy, AND ANY OTHER PROPERTY IN WHICH THE INDIVIDUAL HAD ANY LEGAL TITLE OR INTEREST AT THE TIME OF DEATH, INCLUDING JOINTLY HELD PROPERTY, RETAINED LIFE ESTATES, AND INTERESTS IN TRUSTS, TO THE EXTENT OF SUCH INTERESTS.

S 26. Paragraph (d) of subdivision 1 of section 453 of the general business law, as amended by chapter 557 of the laws of 2001, is amended to read as follows:

(d) Moneys paid for such an agreement for an applicant or recipient of supplemental security income benefits under section two hundred nine of the social services law or of medical assistance under section three hundred sixty-six of such law, OR MONEYS PAID BY SUCH AN APPLICANT OR RECIPIENT FOR SUCH AN AGREEMENT FOR HIS OR HER FAMILY MEMBER, shall be placed into a trust which shall be irrevocable but under which such applicant/recipient reserves the right to select any funeral firm, funeral director, undertaker, cemetery or any other person, firm or corporation to whom such payment is made and to change such selection any time to any type of funeral or any funeral firm, funeral director, cemetery or any other person, firm or corporation to whom such payment is made, located in the state of New York or any other state. Any such change must be carried out within ten business days following receipt of a request by the purchaser to the funeral firm, funeral director, cemetery or any other person, firm or corporation to whom such payment is made, with which such trust was established. This requirement is subject to any limits set forth in federal law or regulation pertaining to disregarded resources or income.

S 27. Paragraph (f) of subdivision 3 of section 453 of the general business law, as added by chapter 660 of the laws of 1996, is amended to read as follows:

(f) With respect to an agreement for an irrevocable trust fund pursuant to section two hundred nine of the social services law OR PARAGRAPH (D) OF SUBDIVISION ONE OF THIS SECTION, include the following statement in the agreement in conspicuous print of at least twelve point type:

DISCLOSURE

NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR [RECEIPT] AND RECIPIENTS OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. WHETHER THE AGREEMENT IS FOR YOUR FUNERAL AND BURIAL EXPENSES OR FOR THOSE OF A FAMILY MEMBER, IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME. IF THIS AGREEMENT IS FOR THE FUNERAL AND BURIAL EXPENSES OF A FAMILY MEMBER, AFTER YOUR DEATH SUCH FAMILY MEMBER MAY CHANGE THE CHOICE OF FUNERAL HOME AT ANY TIME.

S 28. Subdivision 6 of section 209 of the social services law, as amended by chapter 660 of the laws of 1996, paragraphs (a) and (b) as amended by chapter 317 of the laws of 2002, is amended to read as follows:

6. (a) As applicable federal law, rules and regulations so provide, a recipient of supplemental security income benefits or medical assistance

in the state of New York or any other state may establish an irrevocable trust fund for the exclusive purpose of their OR A FAMILY MEMBER'S funeral and burial. Such trust fund and any accumulated interest not withdrawn by the recipient shall remain the responsibility of the funeral firm, funeral director, undertaker, cemetery or any other person, firm or corporation to whom such payment is made to administer for funeral and burial expenses of the recipient. Those persons who establish such a trust fund shall be given the opportunity to select the funeral firm, funeral director, undertaker, cemetery or any other person, firm or corporation to whom such payment is made of their choice to provide for their OR A FAMILY MEMBER'S burial arrangements and to change such selection at any time to any funeral firm, funeral director, undertaker, cemetery or any other person, firm or corporation to whom such payment is made, located either in the state of New York or any other state. Any such change of funeral firm, funeral director, undertaker, cemetery, or any other person, firm or corporation to whom such payment is made, must be carried out within ten business days following receipt of a request by the purchaser to the funeral firm, funeral director, undertaker, cemetery, or any other person, firm or corporation to whom such payment is made with which the current trust fund was established. Funds in such trust fund shall be placed in an interest bearing account pursuant to section four hundred fifty-three of the general business law. Accumulated interest from such account shall not be reported as "countable income" pursuant to section two hundred eight of this title.

(b) An applicant for or a recipient of medical assistance in the state of New York or any other state who enters into an agreement pursuant to section four hundred fifty-three of the general business law FOR THEIR OWN BENEFIT OR FOR THE BENEFIT OF A FAMILY MEMBER shall establish a single irrevocable trust fund FOR EACH SUCH BENEFICIARY pursuant to paragraph (a) of this subdivision.

(c) A funeral firm, funeral director, undertaker, cemetery, or any other person, firm or corporation which makes an agreement for and accepts payment for such an irrevocable trust fund, shall comply with the provisions of section four hundred fifty-three of the general business law, and shall include the following statement in any such agreement in conspicuous print of at least twelve point type:

DISCLOSURE

NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR [RECEIPT] AND RECIPIENTS OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. WHETHER THIS AGREEMENT IS FOR YOUR FUNERAL AND BURIAL EXPENSES OR FOR THOSE OF A FAMILY MEMBER, IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME. IF THIS AGREEMENT IS FOR THE FUNERAL AND BURIAL EXPENSES OF A FAMILY MEMBER, AFTER YOUR DEATH SUCH FAMILY MEMBER MAY CHANGE THE CHOICE OF FUNERAL HOME AT ANY TIME.

(d) Any promotional literature prepared after January first, nineteen hundred ninety-seven by a funeral firm, funeral director, undertaker, cemetery, or any other person, firm or corporation for prearranged funeral and burial services must contain language disclosing the irrevocable nature of burial trusts established BY OR for an applicant or

recipient of supplemental security income benefits or medical assistance.

S 29. Paragraph (g) of subdivision 3 of section 453 of the general business law, as added by chapter 660 of the laws of 1996, is amended to read as follows:

(g) Any promotional literature prepared after January first, nineteen hundred ninety-seven by a funeral firm, funeral director, undertaker, cemetery, or any other person, firm or corporation for prearranged funeral and burial services must contain language disclosing the irrevocable nature of burial trusts established BY OR for an applicant or recipient of supplemental security income benefits or medical assistance.

S 30. Subdivision 6 of section 141 of the social services law, as added by chapter 660 of the laws of 1996, is amended to read as follows:

6. If an applicant for or a recipient of public assistance or care or of medical assistance under section two hundred nine or three hundred sixty-six of this chapter [dies having established] ESTABLISHES an irrevocable trust for the payment of his or her funeral expenses, OR THOSE OF A FAMILY MEMBER, under section four hundred fifty-three of the general business law, any funds remaining in such trust after the payment of all funeral expenses must be paid over to the social services official responsible for arranging for burials under this section in the local government subdivision where the decedent resided.

S 31. 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 NEW YORK 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; MANAGEMENT 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 IS AUTHORIZED TO ENTER INTO A CONTRACT UNDER THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS.

S 32. Subdivision 7 of section 2510 of the public health law, as amended by chapter 645 of the laws of 2005, is amended to read as follows:

7. "Covered health care services" means: the services of physicians, optometrists, nurses, nurse practitioners, midwives and other related professional personnel which are provided on an outpatient basis, including routine well-child visits; diagnosis and treatment of illness and injury; inpatient health care services; laboratory tests; diagnostic x-rays; prescription and non-prescription drugs and durable medical equipment; radiation therapy; chemotherapy; hemodialysis; emergency room services; hospice services; emergency, preventive and routine dental care, [except orthodontia and] INCLUDING MEDICALLY NECESSARY ORTHODONTIA BUT EXCLUDING cosmetic surgery; emergency, preventive and routine vision care, including eyeglasses; speech and hearing services; and, inpatient and outpatient mental health, alcohol and substance abuse services as defined by the commissioner in consultation with the superintendent. "Covered health care services" shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that any denial of coverage of such drugs, procedures or supplies shall provide the patient with the means of obtaining additional information concerning both the denial and the means of challenging such denial.

S 33. Section 2511 of the public health law is amended by adding a new subdivision 2-b to read as follows:

2-B. (A) EFFECTIVE JULY FIRST, TWO THOUSAND TEN, FOR PURPOSES OF CLAIMING FEDERAL FINANCIAL PARTICIPATION UNDER PARAGRAPH NINE OF SUBSECTION (C) OF SECTION TWENTY-ONE HUNDRED FIVE OF THE FEDERAL SOCIAL SECURITY ACT, FOR INDIVIDUALS DECLARING TO BE CITIZENS AT INITIAL APPLICATION, A HOUSEHOLD SHALL PROVIDE:

(I) THE SOCIAL SECURITY NUMBER FOR THE APPLICANT TO BE VERIFIED BY THE COMMISSIONER IN ACCORDANCE WITH A PROCESS ESTABLISHED BY THE SOCIAL SECURITY ADMINISTRATION PURSUANT TO FEDERAL LAW, OR

(II) DOCUMENTATION OF CITIZENSHIP AND IDENTITY OF THE APPLICANT CONSISTENT WITH REQUIREMENTS UNDER THE MEDICAL ASSISTANCE PROGRAM, AS SPECIFIED BY THE COMMISSIONER ON THE INITIAL APPLICATION.

(B) PENDING RECEIPT OF THE INFORMATION REQUIRED BY SUBPARAGRAPH (I) OF PARAGRAPH (A) OF THIS SUBDIVISION, AN INITIAL APPLICATION SHALL CONTINUE TO BE PROCESSED BY AN APPROVED ORGANIZATION OR ENROLLMENT FACILITATOR

AND A CHILD SHALL BE PRESUMPTIVELY ENROLLED IN THE PROGRAM IN ACCORDANCE WITH PROCEDURES AND TIMEFRAMES CURRENTLY SPECIFIED IN CONTRACTS.

(C) THE COMMISSIONER IS AUTHORIZED TO IMPOSE THE SAME INFORMATION AND DOCUMENTATION REQUIREMENTS AT ANNUAL RECERTIFICATION OF ENROLLEES ONLY IF CLAIMING FEDERAL FINANCIAL PARTICIPATION FOR SUCH ENROLLEES BECOMES CONTINGENT ON MEETING SUCH REQUIREMENTS.

S 34. Subparagraphs (i) and (ii) of paragraph (f) of subdivision 2 of section 2511 of the public health law, subparagraph (i) as amended by section 4 and subparagraph (ii) as amended by section 5 of part OO of chapter 57 of the laws of 2008, are amended to read as follows:

(i) In order to establish income eligibility under this subdivision at initial application, a household shall provide such documentation specified in subparagraph (iii) of this paragraph, as necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title. The commissioner may verify the accuracy of such income information provided by the household by matching it against income information contained in databases to which the commissioner has access, including the state's wage reporting system pursuant to subdivision five of section one hundred seventy-one-a of the tax law and by means of an income verification performed [by] PURSUANT TO A COOPERATIVE AGREEMENT WITH the department of taxation and finance [pursuant to subdivision four of section one hundred seventy-one-b of the tax law].

(ii) In order to establish income eligibility under this subdivision at recertification, a household shall attest to all information regarding the household's income that is necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title and shall provide the social security numbers for each parent and legally responsible adult who is a member of the household and whose income is available to the child, subject to subparagraph (v) of this paragraph. The commissioner may verify the accuracy of such income information provided by the household by matching it against income information contained in databases to which the commissioner has access, including the state's wage reporting system and by means of an income verification performed [by] PURSUANT TO A COOPERATIVE AGREEMENT WITH the department of taxation and finance [pursuant to subdivision four of section one hundred seventy-one-b of the tax law]. In the event that there is an inconsistency between the income information attested to by the household and any information obtained by the commissioner from other sources pursuant to this subparagraph, and such inconsistency is material to the household's eligibility for a subsidy payment under this title, the commissioner shall require the approved organization to obtain income documentation from the household as specified in subparagraph (iii) of this paragraph.

S 34-a. Paragraph (a) of subdivision 8 of section 366-a of the social services law, as amended by section 45-c of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(a) Notwithstanding subdivisions two and five of this section, information concerning income and resources of applicants for and recipients of medical assistance may be verified by matching client information with information contained in the wage reporting system established by section one hundred seventy-one-a of the tax law and in similar systems operating in other geographically contiguous states, by means of an income verification performed [by] PURSUANT TO A MEMORANDUM OF UNDERSTANDING WITH the department of taxation and finance [pursuant to subdivision four of section one hundred seventy-one-b of the tax law,] and, to the extent required by federal law, with information contained in the

non-wage income file maintained by the United States internal revenue service, in the beneficiary data exchange maintained by the United States department of health and human services, and in the unemployment insurance benefits file. Such matching shall provide for procedures which document significant inconsistent results of matching activities. Nothing in this section shall be construed to prohibit activities the department reasonably believes necessary to conform with federal requirements under section one thousand one hundred thirty-seven of the social security act.

S 34-b. Subdivision 4 of section 171-b of the tax law, as amended by section 45-e of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(4) The commissioner is authorized and directed to enter into an agreement with the commissioner of health which shall set forth the procedures by which the commissioner shall (a) [verify] FACILITATE THE VERIFICATION OF income eligibility for subsidized health insurance coverage under the child health insurance plan pursuant to subparagraphs (i) and (ii) of paragraph (f) of subdivision two of section two thousand five hundred eleven of the public health law, and for the medical assistance and family health plus programs pursuant to subdivision eight of section three hundred sixty-six-a and paragraphs (b) and (d) of subdivision two of section three hundred sixty-nine-ee of the social services law, AND FOR IMPOSING PARENTAL FEES IN THE EARLY INTERVENTION PROGRAM PURSUANT TO SUBDIVISION FOUR OF SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND TEN, as specified by the commissioner of health and agreed to by the commissioner, and (b) shall provide the information required by subdivision two-a of section two thousand five hundred elev-en of the public health law.

S 34-c. Subdivision 5 of section 171-a of the tax law, as amended by section 2 of part A of chapter 58 of the laws of 2005, is amended to read as follows:

5. Notwithstanding any provision of law to the contrary, the commis-sioner shall enter into a cooperative agreement with the department of health, which agreement shall provide for the utilization of information obtained pursuant to subdivision one of this section, for the purpose of verifying eligibility for child health insurance plan subsidy payments and required premium payments under sections two thousand five hundred ten and two thousand five hundred eleven of the public health law, [and] for the purpose of verifying eligibility for the program for elderly pharmaceutical insurance coverage under title three of article two of the elder law, AND FOR THE PURPOSE OF IMPOSING PARENTAL FEES UNDER THE EARLY INTERVENTION PROGRAM PURSUANT TO SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND TEN, when requested by the department of health.

S 34-d. Paragraph 3 of subsection (e) of section 697 of the tax law, as amended by section 4 of part V of chapter 57 of the laws of 2009, is amended to read as follows:

(3) Nothing herein shall be construed to prohibit the department, its officers or employees from furnishing information to the office of temporary and disability assistance relating to the payment of the cred-it for certain household and dependent care services necessary for gain-ful employment under subsection (c) of section six hundred six of this article and the earned income credit under subsection (d) of section six hundred six of this article, or pursuant to a local law enacted by a city having a population of one million or more pursuant to subsection

(f) of section thirteen hundred ten of this chapter, only to the extent necessary to calculate qualified state expenditures under paragraph seven of subdivision (a) of section four hundred nine of the federal social security act or to document the proper expenditure of federal temporary assistance for needy families funds under section four hundred three of such act. The office of temporary and disability assistance may redisclose such information to the United States department of health and human services only to the extent necessary to calculate such qualified state expenditures or to document the proper expenditure of such federal temporary assistance for needy families funds. Nothing herein shall be construed to prohibit the delivery by the commissioner to a commissioner of jurors, appointed pursuant to section five hundred four of the judiciary law, or, in counties within cities having a population of one million or more, to the county clerk of such county, of a mailing list of individuals to whom income tax forms are mailed by the commissioner for the sole purpose of compiling a list of prospective jurors as provided in article sixteen of the judiciary law. Provided, however, such delivery shall only be made pursuant to an order of the chief administrator of the courts, appointed pursuant to section two hundred ten of the judiciary law. No such order may be issued unless such chief administrator is satisfied that such mailing list is needed to compile a proper list of prospective jurors for the county for which such order is sought and that, in view of the responsibilities imposed by the various laws of the state on the department, it is reasonable to require the commissioner to furnish such list. Such order shall provide that such list shall be used for the sole purpose of compiling a list of prospective jurors and that such commissioner of jurors, or such county clerk, shall take all necessary steps to insure that the list is kept confidential and that there is no unauthorized use or disclosure of such list. Furthermore, nothing herein shall be construed to prohibit the delivery to a taxpayer or his or her duly authorized representative of a certified copy of any return or report filed in connection with his or her tax or to prohibit the publication of statistics so classified as to prevent the identification of particular reports or returns and the items thereof, or the inspection by the attorney general or other legal representatives of the state of the report or return of any taxpayer or of any employer filed under section one hundred seventy-one-h of this chapter, where such taxpayer or employer shall bring action to set aside or review the tax based thereon, or against whom an action or proceeding under this chapter or under this chapter and article eighteen of the labor law has been recommended by the commissioner, the commissioner of labor with respect to unemployment insurance matters, or the attorney general or has been instituted, or the inspection of the reports or returns required under this article by the comptroller or duly designated officer or employee of the state department of audit and control, for purposes of the audit of a refund of any tax paid by a taxpayer under this article, or the furnishing to the state department of labor of unemployment insurance information obtained or derived from quarterly combined withholding, wage reporting and unemployment insurance returns required to be filed by employers pursuant to paragraph four of subsection (a) of section six hundred seventy-four of this article, for purposes of administration of such department's unemployment insurance program, employment services program, federal and state employment and training programs, employment statistics and labor market information programs, worker protection programs, federal programs for which the department has administrative responsibility or for other purposes

deemed appropriate by the commissioner of labor consistent with the provisions of the labor law, and redisclosure of such information in accordance with the provisions of sections five hundred thirty-six and five hundred thirty-seven of the labor law or any other applicable law, or the furnishing to the state office of temporary and disability assistance of information obtained or derived from New York state personal income tax returns as described in paragraph (b) of subdivision two of section one hundred seventy-one-g of this chapter for the purpose of reviewing support orders enforced pursuant to title six-A of article three of the social services law to aid in the determination of whether such orders should be adjusted, or the furnishing of information obtained from the reports required to be submitted by employers regarding newly hired or re-hired employees pursuant to section one hundred seventy-one-h of this chapter to the state office of temporary and disability assistance, the state department of health, the state department of labor and the workers' compensation board for purposes of administration of the child support enforcement program, verification of individuals' eligibility for one or more of the programs specified in subsection (b) of section eleven hundred thirty-seven of the federal social security act and for other public assistance programs authorized by state law, and administration of the state's employment security and workers' compensation programs, and to the national directory of new hires established pursuant to section four hundred fifty-three-A of the federal social security act for the purposes specified in such section, or the furnishing to the state office of temporary and disability assistance of the amount of an overpayment of income tax and interest thereon certified to the comptroller to be credited against past-due support pursuant to section one hundred seventy-one-c of this chapter and of the name and social security number of the taxpayer who made such overpayment, or the disclosing to the commissioner of finance of the city of New York, pursuant to section one hundred seventy-one-l of this chapter, of the amount of an overpayment and interest thereon certified to the comptroller to be credited against a city of New York tax warrant judgment debt and of the name and social security number of the taxpayer who made such overpayment, or the furnishing to the New York state higher education services corporation of the amount of an overpayment of income tax and interest thereon certified to the comptroller to be credited against the amount of a default in repayment of any education loan debt, including judgments, owed to the federal or New York state government that is being collected by the New York state higher education services corporation, and of the name and social security number of the taxpayer who made such overpayment, or the furnishing to the state department of health of the information required by paragraph (f) of subdivision two and subdivision two-a of section two thousand five hundred eleven of the public health law and by subdivision eight of section three hundred sixty-six-a and paragraphs (b) and (d) of subdivision two of section three hundred sixty-nine-ee of the social services law, AND BY SUBDIVISION FOUR OF SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND TEN, or the furnishing to the state university of New York or the city university of New York respectively or the attorney general on behalf of such state or city university the amount of an overpayment of income tax and interest thereon certified to the comptroller to be credited against the amount of a default in repayment of a state university loan pursuant to section one hundred seventy-one-e of this chapter and of the name and social security number of the taxpayer who made such

overpayment, or the disclosing to a state agency, pursuant to section one hundred seventy-one-f of this chapter, of the amount of an overpayment and interest thereon certified to the comptroller to be credited against a past-due legally enforceable debt owed to such agency and of the name and social security number of the taxpayer who made such overpayment, or the furnishing of employee and employer information obtained through the wage reporting system, pursuant to section one hundred seventy-one-a of this chapter, as added by chapter five hundred forty-five of the laws of nineteen hundred seventy-eight, to the state office of temporary and disability assistance, the department of health or to the state office of the medicaid inspector general for the purpose of verifying eligibility for and entitlement to amounts of benefits under the social services law or similar law of another jurisdiction, locating absent parents or other persons legally responsible for the support of applicants for or recipients of public assistance and care under the social services law and persons legally responsible for the support of a recipient of services under section one hundred eleven-g of the social services law and, in appropriate cases, establishing support obligations pursuant to the social services law and the family court act or similar provision of law of another jurisdiction for the purpose of evaluating the effect on earnings of participation in employment, training or other programs designed to promote self-sufficiency authorized pursuant to the social services law by current recipients of public assistance and care and by former applicants and recipients of public assistance and care, (except that with regard to former recipients, information which relates to a particular former recipient shall be provided with client identifying data deleted), to the state office of temporary and disability assistance for the purpose of determining the eligibility of any child in the custody, care and custody or custody and guardianship of a local social services district or of the office of children and family services for federal payments for foster care and adoption assistance pursuant to the provisions of title IV-E of the federal social security act by providing information with respect to the parents, the stepparents, the child and the siblings of the child who were living in the same household as such child during the month that the court proceedings leading to the child's removal from the household were initiated, or the written instrument transferring care and custody of the child pursuant to the provisions of section three hundred fifty-eight-a or three hundred eighty-four-a of the social services law was signed, provided however that the office of temporary and disability assistance shall only use the information obtained pursuant to this subdivision for the purpose of determining the eligibility of such child for federal payments for foster care and adoption assistance pursuant to the provisions of title IV-E of the federal social security act, and to the state department of labor, or other individuals designated by the commissioner of labor, for the purpose of the administration of such department's unemployment insurance program, employment services program, federal and state employment and training programs, employment statistics and labor market information programs, worker protection programs, federal programs for which the department has administrative responsibility or for other purposes deemed appropriate by the commissioner of labor consistent with the provisions of the labor law, and redisclosure of such information in accordance with the provisions of sections five hundred thirty-six and five hundred thirty-seven of the labor law, or the furnishing of information, which is obtained from the wage reporting system operated pursuant to section one hundred seventy-

one-a of this chapter, as added by chapter five hundred forty-five of the laws of nineteen hundred seventy-eight, to the state office of temporary and disability assistance so that it may furnish such information to public agencies of other jurisdictions with which the state office of temporary and disability assistance has an agreement pursuant to paragraph (h) or (i) of subdivision three of section twenty of the social services law, and to the state office of temporary and disability assistance for the purpose of fulfilling obligations and responsibilities otherwise incumbent upon the state department of labor, under section one hundred twenty-four of the federal family support act of nineteen hundred eighty-eight, by giving the federal parent locator service, maintained by the federal department of health and human services, prompt access to such information as required by such act, or to the state department of health to verify eligibility under the child health insurance plan pursuant to subdivisions two and two-a of section two thousand five hundred eleven of the public health law, to verify eligibility under the medical assistance and family health plus programs pursuant to subdivision eight of section three hundred sixty-six-a and paragraphs (b) and (d) of subdivision two of section three hundred sixty-nine-ee of the social services law, and to verify eligibility for the program for elderly pharmaceutical insurance coverage under title three of article two of the elder law, AND FOR PURPOSES OF IMPOSING PARENTAL FEES UNDER THE EARLY INTERVENTION PROGRAM PURSUANT TO SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND TEN, or to the office of vocational and educational services for individuals with disabilities of the education department, the commission for the blind and visually handicapped and any other state vocational rehabilitation agency, for purposes of obtaining reimbursement from the federal social security administration for expenditures made by such office, commission or agency on behalf of disabled individuals who have achieved economic self-sufficiency or to the higher education services corporation for the purpose of assisting the corporation in default prevention and default collection of education loan debt, including judgments, owed to the federal or New York state government; provided, however, that such information shall be limited to the names, social security numbers, home and/or business addresses, and employer names of defaulted or delinquent student loan borrowers.

Provided, however, that with respect to employee information the office of temporary and disability assistance shall only be furnished with the names, social security account numbers and gross wages of those employees who are (A) applicants for or recipients of benefits under the social services law, or similar provision of law of another jurisdiction (pursuant to an agreement under subdivision three of section twenty of the social services law) or, (B) absent parents or other persons legally responsible for the support of applicants for or recipients of public assistance and care under the social services law or similar provision of law of another jurisdiction (pursuant to an agreement under subdivision three of section twenty of the social services law), or (C) persons legally responsible for the support of a recipient of services under section one hundred eleven-g of the social services law or similar provision of law of another jurisdiction (pursuant to an agreement under subdivision three of section twenty of the social services law), or (D) employees about whom wage reporting system information is being furnished to public agencies of other jurisdictions, with which the state office of temporary and disability assistance has an agreement

pursuant to paragraph (h) or (i) of subdivision three of section twenty of the social services law, or (E) employees about whom wage reporting system information is being furnished to the federal parent locator service, maintained by the federal department of health and human services, for the purpose of enabling the state office of temporary and disability assistance to fulfill obligations and responsibilities otherwise incumbent upon the state department of labor, under section one hundred twenty-four of the federal family support act of nineteen hundred eighty-eight, and, only if, the office of temporary and disability assistance certifies to the commissioner that such persons are such applicants, recipients, absent parents or persons legally responsible for support or persons about whom information has been requested by a public agency of another jurisdiction or by the federal parent locator service and further certifies that in the case of information requested under agreements with other jurisdictions entered into pursuant to subdivision three of section twenty of the social services law, that such request is in compliance with any applicable federal law. Provided, further, that where the office of temporary and disability assistance requests employee information for the purpose of evaluating the effects on earnings of participation in employment, training or other programs designed to promote self-sufficiency authorized pursuant to the social services law, the office of temporary and disability assistance shall only be furnished with the quarterly gross wages (excluding any reference to the name, social security number or any other information which could be used to identify any employee or the name or identification number of any employer) paid to employees who are former applicants for or recipients of public assistance and care and who are so certified to the commissioner by the commissioner of the office of temporary and disability assistance. Provided, further, that with respect to employee information, the department of health shall only be furnished with the information required pursuant to the provisions of paragraph (f) of subdivision two and subdivision two-a of section two thousand five hundred eleven of the public health law and subdivision eight of section three hundred sixty-six-a and paragraphs (b) and (d) of subdivision two of section three hundred sixty-nine-ee of the social services law, with respect to those individuals whose eligibility under the child health insurance plan, medical assistance program, and family health plus program is to be determined pursuant to such provisions and with respect to those members of any such individual's household whose income affects such individual's eligibility and who are so certified to the commissioner or by the department of health, AND THE INFORMATION REQUIRED PURSUANT TO THE PROVISIONS OF SUBDIVISION FOUR OF SECTION TWENTY-FIVE HUNDRED FIFTY-SEVEN-A OF THE PUBLIC HEALTH LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND TEN, WITH RESPECT TO THOSE INDIVIDUALS FOR WHICH A PARENTAL FEE IS REQUIRED UNDER THE EARLY INTERVENTION PROGRAM AND WITH RESPECT TO THOSE MEMBERS OF ANY SUCH INDIVIDUAL'S HOUSEHOLD WHOSE INCOME IS USED TO DETERMINE THE PARENTAL FEE OBLIGATION. Provided, further, that wage reporting information shall be furnished to the office of vocational and educational services for individuals with disabilities of the education department, the commission for the blind and visually handicapped and any other state vocational rehabilitation agency only if such office, commission or agency, as applicable, certifies to the commissioner that such information is necessary to obtain reimbursement from the federal social security administration for expenditures made on behalf of disabled individuals who have achieved

self-sufficiency. Reports and returns shall be preserved for three years and thereafter until the commissioner orders them to be destroyed.

S 35. Section 2511 of the public health law is amended by adding a new subdivision 2-c to read as follows:

2-C. EXPRESS LANE ELIGIBILITY. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, RULE OR REGULATION, THE COMMISSIONER IS AUTHORIZED TO (I) ESTABLISH STANDARDS AND PROCEDURES FOR EXPRESS LANE ELIGIBILITY AND ENROLLMENT IMPLEMENTED IN ACCORDANCE WITH SECTION 2107(E)(1)(B) OF THE FEDERAL SOCIAL SECURITY ACT, INCLUDING BUT NOT LIMITED TO RELIANCE ON A FINDING MADE BY AN EXPRESS LANE AGENCY, AS DEFINED IN SECTION 1902(E)(13)(F) OF THE FEDERAL SOCIAL SECURITY ACT, TO DETERMINE WHETHER A CHILD MEETS ONE OR MORE OF THE ELIGIBILITY CRITERIA SET FORTH IN SUBDIVISION TWO OF THIS SECTION; (II) SPECIFY SUCH STANDARDS AND PROCEDURES IN THE STATE CHILD HEALTH PLAN ESTABLISHED UNDER TITLE XXI OF THE FEDERAL SOCIAL SECURITY ACT AND APPLICABLE CONTRACTS WITH APPROVED ORGANIZATIONS AND ENROLLMENT FACILITATORS; AND (III) WAIVE ANY INFORMATION AND DOCUMENTATION REQUIREMENTS SET FORTH IN THIS SECTION NECESSARY TO IMPLEMENT EXPRESS LANE ELIGIBILITY PURSUANT TO STANDARDS AND PROCEDURES ESTABLISHED UNDER SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH; PROVIDED, HOWEVER, THAT INFORMATION AND DOCUMENTATION REQUIRED PURSUANT TO SUBDIVISION TWO-B OF THIS SECTION MAY NOT BE WAIVED.

(B) SUBJECT TO FEDERAL APPROVAL, SUCH STANDARDS AND PROCEDURES SHALL SPECIFY THAT INFORMATION AND DOCUMENTATION REGARDING CITIZENSHIP AND IMMIGRATION STATUS COLLECTED BY AN EXPRESS LANE AGENCY AND PROVIDED TO THE COMMISSIONER FOR THE PURPOSE OF EXPRESS LANE ELIGIBILITY MAY BE USED TO SATISFY THE REQUIREMENTS OF SUBDIVISION TWO-B OF THIS SECTION.

(C) SUCH STANDARDS AND PROCEDURES SHALL ALSO INCLUDE A PROCESS FOR DETERMINING ENROLLMENT ERROR RATES AND IMPLEMENTING CORRECTIVE ACTIONS AS REQUIRED BY SECTION 1902(E)(13)(E) OF THE FEDERAL SOCIAL SECURITY ACT.

S 36. Section 366-a of the social services law is amended by adding a new subdivision 11 to read as follows:

11. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, RULE OR REGULATION, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO (I) ESTABLISH STANDARDS AND PROCEDURES FOR EXPRESS LANE ELIGIBILITY AND ENROLLMENT IMPLEMENTED IN ACCORDANCE WITH SECTION 2107(E)(1)(B) OF THE FEDERAL SOCIAL SECURITY ACT, INCLUDING BUT NOT LIMITED TO RELIANCE ON A FINDING MADE BY AN EXPRESS LANE AGENCY, AS DEFINED IN SECTION 1902(E)(13)(F) OF THE FEDERAL SOCIAL SECURITY ACT, TO DETERMINE WHETHER A CHILD MEETS ONE OR MORE OF THE ELIGIBILITY CRITERIA FOR MEDICAL ASSISTANCE; (II) SPECIFY SUCH STANDARDS AND PROCEDURES IN THE MEDICAL ASSISTANCE STATE PLAN ESTABLISHED UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT; AND (III) WAIVE ANY INFORMATION AND DOCUMENTATION REQUIREMENTS SET FORTH IN THIS SECTION NECESSARY TO IMPLEMENT EXPRESS LANE ELIGIBILITY; PROVIDED, HOWEVER, INFORMATION AND DOCUMENTATION REQUIRED PURSUANT TO SECTION ONE HUNDRED TWENTY-TWO OF THIS CHAPTER MAY NOT BE WAIVED.

(B) SUBJECT TO FEDERAL APPROVAL, SUCH STANDARDS AND PROCEDURES SHALL SPECIFY THAT INFORMATION AND DOCUMENTATION REGARDING CITIZENSHIP AND IMMIGRATION STATUS COLLECTED BY AN EXPRESS LANE AGENCY AND PROVIDED TO THE COMMISSIONER FOR THE PURPOSE OF EXPRESS LANE ELIGIBILITY MAY BE USED TO SATISFY THE REQUIREMENTS OF SECTION ONE HUNDRED TWENTY-TWO OF THIS CHAPTER.

(C) SUCH STANDARDS AND PROCEDURES SHALL ALSO INCLUDE A PROCESS FOR DETERMINING ENROLLMENT ERROR RATES AND IMPLEMENTING CORRECTIVE ACTIONS AS REQUIRED BY SECTION 1902(E)(13)(E) OF THE FEDERAL SOCIAL SECURITY ACT.

(D) FOR PURPOSES OF A MEDICAL ASSISTANCE ELIGIBILITY DETERMINATION MADE IN ACCORDANCE WITH THIS SUBDIVISION, A CHILD SHALL BE DEEMED TO SATISFY THE INCOME ELIGIBILITY CRITERIA FOR MEDICAL ASSISTANCE IF AN EXPRESS LANE AGENCY, AS DEFINED IN SECTION 1902(E)(13)(F) OF THE FEDERAL SOCIAL SECURITY ACT AND SPECIFIED IN THE STANDARDS AND PROCEDURES ESTABLISHED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, HAS DETERMINED THAT: THE CHILD'S FAMILY HAS INCOME THAT DOES NOT EXCEED A SCREENING THRESHOLD AMOUNT, AS DETERMINED BY THE COMMISSIONER OF HEALTH, EQUAL TO A PERCENTAGE OF THE FEDERAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) THAT EXCEEDS BY THIRTY PERCENTAGE POINTS THE HIGHEST INCOME ELIGIBILITY LEVEL APPLICABLE TO A FAMILY OF THE SAME SIZE UNDER THE MEDICAL ASSISTANCE PROGRAM.

S 37. Section 369-ff of the social services law is amended by adding a new subdivision 3-a to read as follows:

3-A. (A) INDIVIDUALS ENROLLED IN FAMILY HEALTH PLUS PLANS UNDER THIS SECTION WHO ARE NOT OTHERWISE ELIGIBLE FOR FAMILY HEALTH PLUS UNDER SECTION THREE HUNDRED SIXTY-NINE-EE OF THIS TITLE SHALL BE RESPONSIBLE TO MAKE CO-PAYMENTS IN ACCORDANCE WITH THE TERMS OF PARAGRAPH (B) OF THIS SUBDIVISION.

(B) CO-PAYMENTS SHALL BE CHARGED IN THE FOLLOWING AMOUNTS:

(I) THE CO-PAYMENT CHARGED FOR EACH DISCHARGE FOR INPATIENT CARE SHALL BE ONE HUNDRED DOLLARS;

(II) THE CO-PAYMENT CHARGED FOR EACH EMERGENCY ROOM VISIT AND FOR EACH OUTPATIENT SURGERY SHALL BE FIFTY DOLLARS;

(III) THE CO-PAYMENT CHARGED FOR EACH PRIMARY CARE PHYSICIAN OFFICE VISIT, FOR EACH DENTAL SERVICE VISIT, FOR EACH LABORATORY SERVICE, FOR EACH RADIOLOGY SERVICE, FOR EACH OUTPATIENT MENTAL HEALTH SERVICE, AND FOR EACH OUTPATIENT SUBSTANCE ABUSE SERVICE SHALL BE TEN DOLLARS;

(IV) THE CO-PAYMENT CHARGED FOR EACH PHYSICIAN SPECIALIST SERVICE OFFICE VISIT, FOR EACH PHYSICAL THERAPY SERVICE, FOR EACH OCCUPATIONAL THERAPY SERVICE, FOR EACH SPEECH THERAPY SERVICE, FOR EACH HEARING SERVICE, FOR EACH VISION SERVICE, AND FOR EACH PODIATRIC SERVICE SHALL BE THIRTY-FIVE DOLLARS;

(V) THE CO-PAYMENT CHARGED FOR EACH GENERIC PRESCRIPTION DRUG DISPENSED SHALL BE FIVE DOLLARS AND FOR EACH BRAND NAME PRESCRIPTION DRUG DISPENSED SHALL BE FIFTEEN DOLLARS.

(C) EFFECTIVE JANUARY FIRST, TWO THOUSAND TWELVE, AND NOTWITHSTANDING THE CO-PAYMENT AMOUNTS SET FORTH IN PARAGRAPH (B) OF THIS SECTION, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO AMEND SUCH CO-PAYMENT AMOUNTS PURSUANT TO REGULATION.

S 38. The public health law is amended by adding a new section 279 to read as follows:

S 279. INTERACTIONS BETWEEN PHARMACEUTICAL COMPANIES AND HEALTH CARE PROFESSIONALS. 1. THIS SECTION SETS FORTH A CODE OF CONDUCT FOR ALL PHARMACEUTICAL COMPANIES THAT SELL OR MARKET PRESCRIPTION DRUGS, BIOLOGICS OR MEDICAL DEVICES IN THE STATE AND FOR ALL HEALTH CARE PROFESSIONALS PRACTICING IN THIS STATE TO WHOM SUCH DRUGS, BIOLOGICS OR DEVICES ARE SOLD OR MARKETED. THESE PROVISIONS ARE INTENDED TO BENEFIT PATIENTS, ENHANCE THE PRACTICE OF MEDICINE, AND ENSURE THAT THE RELATIONSHIP BETWEEN PHARMACEUTICAL COMPANIES AND HEALTH CARE PROFESSIONALS DOES NOT INTERFERE WITH THE INDEPENDENT JUDGMENT OF SUCH PROFESSIONALS IN MAKING PRESCRIBING DECISIONS.

2. AS USED IN THIS SECTION:

(A) "BIOLOGIC" MEANS A VIRUS, THERAPEUTIC SERUM, TOXIN, ANTITOXIN, VACCINE, BLOOD, BLOOD COMPONENT OR DERIVATIVE, ALLERGENIC PRODUCT, IMMU-

NOGLOBULIN PRODUCT, OR ANALOGOUS PRODUCT, AS DEFINED BY THE PUBLIC HEALTH SERVICE ACT, APPLICABLE TO THE PREVENTION, TREATMENT, OR CURE OF A DISEASE OR CONDITION OF HUMAN BEINGS AND REGULATED AS A DRUG UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(B) "BONA FIDE CONSULTING SERVICES" MEANS AN ARRANGEMENT WITH ONE OR MORE HEALTH CARE PROFESSIONALS FOR THE PROVISION OF CONSULTING SERVICES BY SUCH PROFESSIONAL OR PROFESSIONALS, WHERE THE ARRANGEMENT IS CHARACTERIZED BY THE FOLLOWING FACTORS:

(I) A WRITTEN CONTRACT SPECIFIES THE NATURE OF THE CONSULTING SERVICES TO BE PROVIDED AND THE BASIS FOR PAYMENT OF THOSE SERVICES;

(II) A LEGITIMATE NEED FOR THE SERVICES HAS BEEN CLEARLY IDENTIFIED IN ADVANCE OF REQUESTING THE SERVICES AND ENTERING INTO THE PROSPECTIVE CONSULTING ARRANGEMENT;

(III) THE CRITERIA FOR SELECTING CONSULTANTS ARE DIRECTLY RELATED TO THE IDENTIFIED PURPOSE AND THE PERSONS RESPONSIBLE FOR SELECTING THE CONSULTANTS HAVE THE EXPERTISE NECESSARY TO EVALUATE WHETHER THE PARTICULAR HEALTH CARE PROFESSIONALS MEET THOSE CRITERIA;

(IV) THE NUMBER OF HEALTH CARE PROFESSIONALS RETAINED IS NOT GREATER THAN THE NUMBER REASONABLY NECESSARY TO ACHIEVE THE IDENTIFIED PURPOSE;

(V) THE RETAINING COMPANY MAINTAINS RECORDS CONCERNING AND MAKES APPROPRIATE USE OF THE SERVICES PROVIDED BY CONSULTANTS; AND

(VI) THE VENUE AND CIRCUMSTANCES OF ANY MEETING WITH CONSULTANTS ARE CONDUCIVE TO THE CONSULTING SERVICES AND ACTIVITIES RELATED TO THE SERVICES ARE THE PRIMARY FOCUS OF THE MEETING.

(C) "CONFERENCE OR MEETING" MEANS ANY GATHERING:

(I) WHERE RESPONSIBILITY FOR AND CONTROL OVER THE SELECTION OF CONTENT, FACULTY, EDUCATIONAL METHODS, MATERIALS, AND VENUE BELONGS TO THE EVENT'S ORGANIZERS;

(II) WHICH IS HELD IN A VENUE THAT IS APPROPRIATE AND CONDUCIVE TO INFORMATIONAL COMMUNICATION AND TRAINING ABOUT MEDICAL INFORMATION;

(III) WHICH IS PRIMARILY DEDICATED, IN BOTH TIME AND EFFORT, TO PROMOTING OBJECTIVE SCIENTIFIC AND EDUCATIONAL ACTIVITIES AND DISCOURSE;

(IV) WHICH INCLUDES ONE OR MORE EDUCATIONAL PRESENTATIONS; AND

(V) WHICH HAS AS THE MAIN INCENTIVE FOR BRINGING ATTENDEES TOGETHER TO FURTHER THEIR KNOWLEDGE ON THE TOPIC OR TOPICS BEING PRESENTED.

(D) "CONTINUING MEDICAL EDUCATION" MEANS COURSE WORK OR TRAINING PROVIDED IN THE STATE TO HEALTH CARE PROFESSIONALS LICENSED HEALTH CARE PROVIDERS AUTHORIZED BY LAW TO PRESCRIBE DRUGS, BIOLOGICS OR DEVICES, WHICH PERTAINS TO THE PRACTICE OF THEIR PROFESSION AND FOR WHICH CONTINUING MEDICAL EDUCATION OR CONTINUING PROFESSIONAL EDUCATION CREDITS MAY BE AWARDED.

(E) "DRUGS" 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, NOT INCLUDING MEDICAL DEVICES OR THEIR COMPONENTS, PARTS OR ACCESSORIES.

(F) "FINANCIAL SUPPORT" MEANS ANYTHING WITH AN ECONOMIC VALUE, INCLUDING BUT NOT LIMITED TO MONEY, GOODS AND SERVICES, OR A PROMISE OR AGREEMENT TO PROVIDE SUCH FINANCIAL SUPPORT IN THE FUTURE, REGARDLESS OF THE FORM OF SUCH FINANCIAL SUPPORT, WHICH MAY INCLUDE BUT IS NOT LIMITED TO

PAYMENT, COMPENSATION, REIMBURSEMENT, REBATE, DISCOUNT, FEE REDUCTION, GRANT, SCHOLARSHIP OR GIFT.

(G) "HEALTH CARE PROFESSIONAL" MEANS A PHYSICIAN, DENTIST, PHYSICIAN ASSISTANT, SPECIALIST'S ASSISTANT, NURSE PRACTITIONER, MIDWIFE, OPTOMETRIST OR OTHER PERSON WHO IS LICENSED, REGISTERED OR CERTIFIED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW AND IS AUTHORIZED UNDER SUCH TITLE TO PRESCRIBE DRUGS OR MEDICAL DEVICES.

(H) "HOSPITAL SETTING" MEANS:

(I) A HOSPITAL, AS THAT TERM IS USED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER;

(II) ACADEMIC MEDICAL CENTER; OR

(III) PHARMACEUTICAL OR MEDICAL DEVICE SPECIALIZED TRAINING FACILITY, WHERE THE FACILITY, AS CERTIFIED TO THE DEPARTMENT BY THE PHARMACEUTICAL OR MEDICAL DEVICE MANUFACTURING COMPANY, IS SPECIFICALLY DESIGNED TO APPROXIMATE THE CONDITIONS OF A SURGICAL SUITE, OR THE CONDITIONS OF A WORKING CLINICAL LABORATORY OR TO PROVIDE MEDICAL TRAINING ON LARGE AND TECHNICAL MEDICAL DEVICES, SUCH AS SURGICAL EQUIPMENT, IMPLANTS, AND IMAGING AND CLINICAL LABORATORY EQUIPMENT.

(I) "MEDICAL DEVICE" MEANS INSTRUMENTS, APPARATUS, AND CONTRIVANCES, INCLUDING THEIR COMPONENTS, PARTS AND ACCESSORIES, WHICH ARE:

(I) RECOGNIZED IN THE OFFICIAL NATIONAL FORMULARY OR THE UNITED STATES PHARMACOPEIA OR ANY SUPPLEMENT THERETO;

(II) INTENDED FOR USE IN THE DIAGNOSIS OF DISEASE OR OTHER CONDITIONS OR IN THE CURE, MITIGATION, TREATMENT OR PREVENTION OF DISEASE, IN PERSONS OR ANIMALS; OR

(III) INTENDED TO AFFECT THE STRUCTURE OR FUNCTION OF THE BODY OF A PERSON OR ANIMAL, AND WHICH DOES NOT ACHIEVE ITS PRIMARY INTENDED PURPOSES THROUGH CHEMICAL ACTION WITHIN OR ON SUCH BODY AND WHICH IS NOT DEPENDENT UPON BEING METABOLIZED FOR THE ACHIEVEMENT OF ITS PRIMARY INTENDED PURPOSES.

(J) "PHARMACEUTICAL COMPANY" MEANS:

(I) AN ENTITY THAT IS ENGAGED IN THE PRODUCTION, PREPARATION, PROPAGATION, COMPOUNDING, CONVERSION, OR PROCESSING OF PRESCRIPTION DRUGS, BIOLOGICS, OR MEDICAL DEVICES, EITHER DIRECTLY OR INDIRECTLY, BY EXTRACTION FROM SUBSTANCES OF NATURAL ORIGIN OR INDEPENDENTLY BY MEANS OF CHEMICAL SYNTHESIS OR BY A COMBINATION OF EXTRACTION AND CHEMICAL SYNTHESIS;

(II) AN ENTITY ENGAGED IN THE PACKAGING, REPACKAGING, LABELING, RELABELING, OR DISTRIBUTION OF DRUGS; OR

(III) A PERSON WHO ENGAGES IN PHARMACEUTICAL DETAILING, PROMOTIONAL ACTIVITIES, OR OTHER MARKETING OF PRESCRIPTION DRUGS, BIOLOGICS OR MEDICAL DEVICES TO HEALTH CARE PROFESSIONALS IN THIS STATE ON BEHALF OF AN ENTITY DESCRIBED IN SUBPARAGRAPHS (I) OR (II) OF THIS PARAGRAPH, INCLUDING BUT NOT LIMITED TO FIELD SALES REPRESENTATIVES.

"PHARMACEUTICAL COMPANY" DOES NOT INCLUDE A LICENSED PHARMACIST TO THE EXTENT HE OR SHE DISPENSES OR PREPARES FOR DISPENSING A PRESCRIPTION DRUG, BIOLOGIC OR MEDICAL DEVICE.

(K) "PRESENTER" MEANS A HEALTH CARE PROFESSIONAL WHO CONDUCTS, TEACHES OR PARTICIPATES, OTHER THAN SOLELY AS AN ATTENDEE, IN ANY ASPECT OF A CONTINUING MEDICAL EDUCATION PROGRAM.

(L) "PROVIDER" MEANS A PERSON OR ENTITY THAT REPRESENTS TO ATTENDEES OR POTENTIAL ATTENDEES THAT IT IS THE ORGANIZER, OR AN ORGANIZER, OF A CONTINUING MEDICAL EDUCATION EVENT.

(M) "SPEAKER" MEANS ANY HEALTH CARE PROFESSIONAL ENGAGED BY A PHARMACEUTICAL COMPANY TO PARTICIPATE IN EXTERNAL PROMOTIONAL PROGRAMS THAT

PROVIDE MEDICAL OR SCIENTIFIC INFORMATION TO OTHER HEALTH CARE PROFESSIONALS ON BEHALF OF THE COMPANY.

(N) "SPONSOR" MEANS A PHARMACEUTICAL COMPANY, OR A PERSON OR ENTITY ACTING ON BEHALF OF A PHARMACEUTICAL COMPANY, THAT PROVIDES FINANCIAL SUPPORT TO A PROVIDER IN CONNECTION WITH ONE OR MORE CONTINUING MEDICAL EDUCATION PROGRAMS.

(O) "SUBSTANTIAL VALUE" MEANS THE VALUE OF AN ITEM OR SERVICE WHICH REASONABLY APPEARS TO AN OBJECTIVE PERSON TO BE ONE HUNDRED DOLLARS OR MORE.

3. (A) NO PHARMACEUTICAL COMPANY SHALL OFFER OR PROVIDE TO A HEALTH CARE PROFESSIONAL, AND NO HEALTH CARE PROFESSIONAL SHALL ACCEPT:

(I) ANY FINANCIAL SUPPORT, INCLUDING BUT NOT LIMITED TO ANY GRANT, SCHOLARSHIP, SUBSIDY, SUPPORT, CONSULTING CONTRACT, SPEAKER CONTRACT OR EDUCATIONAL OR PRACTICE-RELATED ITEMS TO REWARD THE PROFESSIONAL FOR HAVING PRESCRIBED PARTICULAR DRUGS, BIOLOGICS OR MEDICAL DEVICES IN THE PAST, OR TO INDUCE THE PROFESSIONAL TO PRESCRIBE OR CONTINUE PRESCRIBING PARTICULAR DRUGS, BIOLOGICS OR MEDICAL DEVICES IN THE FUTURE;

(II) ANY TANGIBLE OR INTANGIBLE GOOD OR SERVICE IN A MANNER OR ON CONDITIONS THAT WOULD INTERFERE WITH THE INDEPENDENCE OF THE HEALTH CARE PROFESSIONAL'S PRESCRIBING PRACTICES; OR

(III) ANY PAYMENT IN CASH OR CASH EQUIVALENTS, EITHER DIRECTLY OR INDIRECTLY, EXCEPT AS COMPENSATION FOR BONA FIDE CONSULTING SERVICES OR SPEAKER SERVICES PURSUANT TO SUBDIVISION NINE OR TEN OF THIS SECTION.

(B) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT:

(I) THE PROVISION OF PRICE CONCESSIONS BY A PHARMACEUTICAL COMPANY TO A HEALTH CARE PROFESSIONAL, SUCH AS REBATES OR DISCOUNTS, OF THE TYPE THAT ARE COMMONLY OFFERED IN THE NORMAL COURSE OF BUSINESS, FOR LEGITIMATE BUSINESS REASONS AND TO THE EXTENT SUCH CONCESSIONS COMPLY WITH APPLICABLE LAWS AND REGULATIONS;

(II) THE PROVISION OF PRESCRIPTION DRUGS BY A PHARMACEUTICAL COMPANY TO A HEALTH CARE PROFESSIONAL WITHOUT CHARGE SOLELY AND EXCLUSIVELY FOR THE PURPOSE OF PERMITTING THE PROFESSIONAL TO DISTRIBUTE SUCH DRUGS TO HIS OR HER PATIENTS WITHOUT CHARGE, TO THE EXTENT SUCH PROVISION AND DISTRIBUTION COMPLY WITH APPLICABLE LAWS AND REGULATIONS INCLUDING THE PRESCRIPTION DRUG MARKETING ACT; OR

(III) THE INVESTMENT OF A PHARMACEUTICAL COMPANY IN A BUSINESS VENTURE IN THE PHARMACEUTICAL OR BIOTECHNOLOGY FIELD IN WHICH A HEALTH CARE PROFESSIONAL IS A PRINCIPAL, OR OTHER JOINT ARRANGEMENT BETWEEN A PHARMACEUTICAL COMPANY OR HEALTH CARE PROFESSIONAL IN SUCH A VENTURE, PROVIDED THAT THE RELATIONSHIP BETWEEN THE COMPANY AND THE PROFESSIONAL CHIEFLY RELATES TO SUCH VENTURE AND IS NOT INTENDED TO INFLUENCE THE PROFESSIONAL'S PRESCRIBING DECISIONS.

4. NO PHARMACEUTICAL COMPANY SHALL PROVIDE ANY PROMOTIONAL MATERIALS TO A HEALTH CARE PROFESSIONAL UNLESS SUCH MATERIALS:

(A) ARE ACCURATE AND NOT MISLEADING;

(B) MAKE CLAIMS ABOUT A PRODUCT ONLY WHEN PROPERLY SUBSTANTIATED;

(C) ACCURATELY REFLECT THE BALANCE BETWEEN RISKS AND BENEFITS;

(D) ARE CONSISTENT WITH ALL OTHER REQUIREMENTS OF THE UNITED STATES FOOD AND DRUG ADMINISTRATION GOVERNING SUCH COMMUNICATIONS; AND

(E) DO NOT VIOLATE THE PROVISIONS OF ARTICLE TWENTY-TWO-A OF THE GENERAL BUSINESS LAW.

NOTHING IN THIS SECTION SHALL BE CONSTRUED TO LIMIT THE APPLICATION OF ANY PROVISION OF ARTICLE TWENTY-TWO-A OF THE GENERAL BUSINESS LAW OR OF SUBDIVISION TWELVE OF SECTION SIXTY-THREE OF THE EXECUTIVE LAW, OR ANY OTHER APPLICABLE FEDERAL OR STATE LAW OR REGULATION.

5. (A) NO PHARMACEUTICAL COMPANY MAY OFFER OR PROVIDE MEALS TO HEALTH CARE PROFESSIONALS, AND NO HEALTH CARE PROFESSIONAL MAY ACCEPT OR PERMIT HIS OR HER STAFF MEMBERS TO ACCEPT SUCH MEALS FROM A PHARMACEUTICAL COMPANY, UNLESS SUCH MEALS:

(I) ARE PROVIDED IN CONNECTION WITH STRUCTURED, ORAL INFORMATIONAL PRESENTATIONS THAT PROVIDE SCIENTIFIC OR EDUCATIONAL VALUE AND MEET THE CRITERIA SET FORTH IN SUBDIVISION FOUR OF THIS SECTION;

(II) ARE SERVED ONLY FOR CONSUMPTION DURING SUCH PRESENTATION AND ARE NOT OFFERED OR SERVED FOR CONSUMPTION AT ANOTHER TIME OR PLACE OR OUTSIDE THE PRESENCE OF THE PHARMACEUTICAL COMPANY;

(III) ARE, IF OFFERED OR PROVIDED BY A FIELD SALES REPRESENTATIVE OR THEIR IMMEDIATE MANAGERS, PROVIDED ONLY IN THE PROFESSIONAL'S OFFICE OR IN A HOSPITAL SETTING;

(IV) ARE OFFERED OR PROVIDED ONLY TO HEALTH CARE PROFESSIONALS AND MEMBERS OF THEIR STAFF ATTENDING PRESENTATIONS, AND ARE NOT OFFERED OR PROVIDED TO SPOUSES OR OTHER GUESTS OF A HEALTH CARE PROFESSIONAL;

(V) ARE MODEST AS JUDGED BY LOCAL STANDARDS;

(VI) ARE NOT PROVIDED AS PART OF AN ENTERTAINMENT OR RECREATIONAL EVENT;

(VII) ARE PROVIDED IN A MANNER AND LOCATION CONDUCIVE TO INFORMATIONAL COMMUNICATION; AND

(VIII) ARE PROVIDED TO A PARTICULAR HEALTH CARE PROFESSIONAL OR MEMBERS OF SUCH PROFESSIONAL'S STAFF ON NO MORE THAN AN OCCASIONAL BASIS.

(B) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION, MEALS MAY BE PROVIDED TO AND ACCEPTED BY HEALTH CARE PROFESSIONALS WHO INTERACT WITH PERSONNEL EMPLOYED BY A PHARMACEUTICAL COMPANY, OTHER THAN FIELD SALES REPRESENTATIVES OR THEIR IMMEDIATE MANAGERS, OR WHO ARE ENGAGED IN BONA FIDE CONSULTING SERVICES OR SPEAKER SERVICES PURSUANT TO SUBDIVISION NINE OR TEN OF THIS SECTION, OUTSIDE OF THE PROFESSIONAL'S OFFICE OR A HOSPITAL SETTING, PROVIDED THAT SUCH MEALS:

(I) ARE INCIDENTAL TO A SUBSTANTIVE INTERACTION WITH THE HEALTH CARE PROFESSIONAL;

(II) ARE NOT PROVIDED AS PART OF AN ENTERTAINMENT OR RECREATIONAL EVENT;

(III) ARE HELD IN VENUES THAT ARE APPROPRIATE AND CONDUCIVE TO INFORMATIONAL COMMUNICATION AND TRAINING ABOUT MEDICAL INFORMATION;

(IV) ARE MODEST AS JUDGED BY LOCAL STANDARDS; AND

(V) ARE PROVIDED ON NO MORE THAN AN OCCASIONAL BASIS.

6. (A) NO PHARMACEUTICAL COMPANY SHALL OFFER OR PROVIDE TO ANY HEALTH CARE PROFESSIONAL, AND NO HEALTH CARE PROFESSIONAL SHALL ACCEPT FROM A PHARMACEUTICAL COMPANY, ANY ENTERTAINMENT OR RECREATIONAL ITEMS OR BENEFITS, INCLUDING BUT NOT LIMITED TO TICKETS TO THE THEATER OR SPORTING EVENTS, SPORTING EQUIPMENT, OR LEISURE OR VACATION TRIPS, REGARDLESS OF:

(I) THE VALUE OF THE ITEMS OR BENEFITS;

(II) WHETHER THE COMPANY ENGAGES THE HEALTH CARE PROFESSIONAL AS A SPEAKER OR CONSULTANT; OR

(III) WHETHER THE ENTERTAINMENT OR RECREATION IS SECONDARY TO AN EDUCATIONAL PURPOSE.

(B) NOTHING CONTAINED IN PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE CONSTRUED TO PROHIBIT A PHARMACEUTICAL COMPANY FROM PROVIDING TO A HEALTH CARE PROFESSIONAL, OR TO PROHIBIT A HEALTH CARE PROFESSIONAL FROM ACCEPTING, ENTERTAINMENT OR RECREATIONAL BENEFITS IF THE HEALTH CARE PROFESSIONAL IS EMPLOYED BY THE PHARMACEUTICAL COMPANY ON A FULL-TIME, SALARIED BASIS.

7. (A) NO PHARMACEUTICAL COMPANY SHALL BE A PROVIDER OF ANY CONTINUING MEDICAL EDUCATION PROGRAM WITHIN THE STATE.

(B) NO PHARMACEUTICAL COMPANY SHALL BE A SPONSOR OF ANY CONTINUING MEDICAL EDUCATION PROGRAM WITHIN THE STATE UNLESS THE COMPANY HAS ADOPTED AND IS IN COMPLIANCE WITH POLICIES BY WHICH THE COMPANY:

(I) HAS SEPARATED ITS CONTINUING MEDICAL EDUCATION GRANT-MAKING FUNCTIONS FROM ITS SALES AND MARKETING DEPARTMENTS AND DOES NOT PERMIT ITS SALES AND MARKETING DEPARTMENTS TO HAVE ANY INVOLVEMENT IN ITS CONTINUING MEDICAL EDUCATION GRANT-MAKING ACTIVITIES;

(II) HAS DEVELOPED AND UTILIZES OBJECTIVE CRITERIA FOR MAKING CONTINUING MEDICAL EDUCATION GRANT DECISIONS TO ENSURE THAT THE PROGRAM FUNDED BY THE COMPANY IS A BONA FIDE EDUCATIONAL PROGRAM AND THAT THE FINANCIAL SUPPORT IS NOT AN INDUCEMENT TO PRESCRIBE OR RECOMMEND A PARTICULAR MEDICINE OR COURSE OF TREATMENT; AND

(III) AGREES TO RESPECT THE INDEPENDENT JUDGMENT OF THE CONTINUING MEDICAL EDUCATION PROVIDER AND TO FOLLOW STANDARDS FOR COMMERCIAL SUPPORT ESTABLISHED BY THE ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION OR AN EQUIVALENT NATIONAL ENTITY THAT ACCREDITS CONTINUING MEDICAL EDUCATION AND IS INDEPENDENT OF ANY SPONSOR OR ORGANIZATION OF SPONSORS.

(C) NO PHARMACEUTICAL COMPANY SHALL, IN CONNECTION WITH ANY CONTINUING MEDICAL EDUCATION PROGRAM WITHIN THE STATE:

(I) PROVIDE ANY ADVICE OR GUIDANCE TO THE CONTINUING MEDICAL EDUCATION PROVIDER, EVEN IF ASKED BY THE PROVIDER, REGARDING THE CONTENT OR FACULTY FOR A PARTICULAR CONTINUING MEDICAL EDUCATION PROGRAM FUNDED BY THE COMPANY; OR

(II) PROVIDE ANY VERBAL OR WRITTEN INFORMATION TO A HEALTH CARE PROFESSIONAL WHO IS EXPECTED TO SERVE AS A PRESENTER AT SUCH CONTINUING MEDICAL EDUCATION PROGRAM REGARDING ANY DRUG, BIOLOGIC OR DEVICE MANUFACTURED, DISTRIBUTED OR MARKETED BY OR ON BEHALF OF THE COMPANY UNLESS SUCH INFORMATION IS CONSISTENT WITH THE CRITERIA SET FORTH IN SUBDIVISION FOUR OF THIS SECTION.

(D) NO PHARMACEUTICAL COMPANY MAY DIRECTLY OR INDIRECTLY OFFER OR PROVIDE, AND NO HEALTH CARE PROFESSIONAL SHALL ACCEPT, ANY FINANCIAL SUPPORT IN CONNECTION WITH THE PROFESSIONAL'S ATTENDANCE OR PRESENTATION AT A CONTINUING MEDICAL EDUCATION PROGRAM, INCLUDING BUT NOT LIMITED TO FINANCIAL SUPPORT INTENDED TO COMPENSATE THE PROFESSIONAL FOR HIS OR HER TIME SPENT ATTENDING OR PRESENTING AT THE CONTINUING MEDICAL EDUCATION PROGRAM OR TO REIMBURSE THE PROFESSIONAL FOR THE COSTS OF TRAVEL, LODGING, OR OTHER PERSONAL EXPENSES INCURRED FOR ATTENDANCE OR PRESENTATION AT THE CONTINUING MEDICAL EDUCATION PROGRAM.

(E) THE PROVIDER OF A CONTINUING MEDICAL EDUCATION PROGRAM AT ITS OWN DISCRETION MAY APPLY FINANCIAL SUPPORT RECEIVED FROM A PHARMACEUTICAL COMPANY FOR SUCH PROGRAM TO REDUCE THE OVERALL CONTINUING MEDICAL EDUCATION REGISTRATION FEE FOR ALL ATTENDEES. IN SUCH CASE, NOTWITHSTANDING PARAGRAPH (D) OF THIS SUBDIVISION, HEALTH CARE PROFESSIONALS MAY ACCEPT THE BENEFIT OF THE REDUCED FEE.

(F) A PHARMACEUTICAL COMPANY SHALL NOT PROVIDE MEALS DIRECTLY AT CONTINUING MEDICAL EDUCATION PROGRAMS, EXCEPT THAT A CONTINUING MEDICAL EDUCATION PROVIDER AT ITS OWN DISCRETION MAY APPLY THE FINANCIAL SUPPORT PROVIDED BY A COMPANY FOR A CONTINUING MEDICAL EDUCATION PROGRAM TO PROVIDE MODEST MEALS FOR ALL PARTICIPANTS. IN SUCH CASE, NOTWITHSTANDING PARAGRAPH (D) OF THIS SUBDIVISION, HEALTH CARE PROFESSIONALS MAY ACCEPT SUCH MEALS.

(G) NOTWITHSTANDING PARAGRAPH (D) OF THIS SUBDIVISION, A PHARMACEUTICAL COMPANY MAY PROVIDE FINANCIAL SUPPORT FOR THE COSTS OF TRAVEL,

LODGING, OR OTHER PERSONAL EXPENSES TO A HEALTH CARE PROFESSIONAL ATTENDING OR PRESENTING AT A CONTINUING MEDICAL EDUCATION PROGRAM WHO IS A FULL-TIME SALARIED EMPLOYEE OF THE PHARMACEUTICAL COMPANY, OR WHO IS ENGAGED BY THE COMPANY AS A SPEAKER OR CONSULTANT PURSUANT TO A BONA FIDE AGREEMENT AND SUCH FINANCIAL SUPPORT IS PROVIDED PURSUANT TO SUCH AGREEMENT.

(H) NO HEALTH CARE PROFESSIONAL PRACTICING IN THE STATE SHALL ATTEND OR PRESENT AT ANY CONTINUING MEDICAL EDUCATION PROGRAM SPONSORED BY ANY PHARMACEUTICAL COMPANY UNLESS ADVISED BY THE PROGRAM PROVIDER THAT SUCH PHARMACEUTICAL COMPANY HAS PROVIDED ASSURANCE THAT IT HAS ADOPTED THE POLICIES ARTICULATED IN PARAGRAPH (B) OF THIS SUBDIVISION AND IS IN COMPLIANCE WITH SUCH POLICIES AND WITH THE REQUIREMENTS OF PARAGRAPH (C) OF THIS SUBDIVISION.

(I) NO HEALTH CARE PROFESSIONAL WHO PRACTICES IN THE STATE AND SERVES AS A PRESENTER AT A CONTINUING MEDICAL EDUCATION PROGRAM SHALL:

(I) PRESENT OR MAKE AVAILABLE ANY MATERIALS AT SUCH CONTINUING MEDICAL EDUCATION PROGRAM UNLESS SUCH MATERIALS ARE, TO THE BEST OF THE PROFESSIONAL'S KNOWLEDGE BASED ON REASONABLE INQUIRY, CONSISTENT WITH THE CRITERIA SET FORTH IN SUBDIVISION FOUR OF THIS SECTION;

(II) REPRESENT TO ATTENDEES OF SUCH CONTINUING MEDICAL EDUCATION PROGRAM THAT HE OR SHE AUTHORED ANY MATERIALS DISCUSSED, DISTRIBUTED OR OTHERWISE PRESENTED DURING HIS OR HER PRESENTATION AT SUCH CONTINUING MEDICAL EDUCATION PROGRAM UNLESS HE OR SHE MADE SUBSTANTIAL CONTRIBUTIONS TO THE INTELLECTUAL CONTENT OF SUCH MATERIALS; OR

(III) FAIL TO DISCLOSE DURING HIS OR HER PRESENTATION THE EXISTENCE AND NATURE OF ANY FINANCIAL SUPPORT HE OR SHE HAS RECEIVED FROM OR EXPECTS TO RECEIVE FROM A SPONSOR OF SUCH CONTINUING MEDICAL EDUCATION PROGRAM OR FROM A PHARMACEUTICAL COMPANY THAT MANUFACTURERS, DISTRIBUTES OR MARKETS ANY DRUG, BIOLOGIC OR MEDICAL DEVICE DISCUSSED IN SUCH PRESENTATION OR COMMONLY PRESCRIBED FOR A DISEASE, INJURY OR CONDITION DISCUSSED IN SUCH PRESENTATION, EXCEPT THAT DISCLOSURE NEED NOT BE MADE OF ANY FEE REDUCTION PURSUANT TO PARAGRAPH (G) OF THIS SUBDIVISION OR THE ACCEPTANCE OF A MEAL PURSUANT TO PARAGRAPH (F) OF THIS SUBDIVISION.

8. (A) NO PHARMACEUTICAL COMPANY SHALL DIRECTLY OR INDIRECTLY OFFER OR PROVIDE ANY FINANCIAL SUPPORT TO A HEALTH CARE PROFESSIONAL IN CONNECTION WITH THE PROFESSIONAL'S ATTENDANCE AT OR PARTICIPATION IN A CONFERENCE OR MEETING, INCLUDING BUT NOT LIMITED TO COMPENSATION FOR THE PROFESSIONAL'S TIME SPENT ATTENDING OR PARTICIPATING IN THE CONFERENCE OR MEETING OR REIMBURSEMENT OF THE COSTS INCURRED BY THE PROFESSIONAL FOR TRAVEL, LODGING, OR OTHER PERSONAL EXPENSES IN CONNECTION WITH THE ATTENDANCE AT OR PARTICIPATION IN THE CONFERENCE OR MEETING.

(B) NO PHARMACEUTICAL COMPANY SHALL PROVIDE FINANCIAL SUPPORT FOR A CONFERENCE OR MEETING IF IT HAS ANY RESPONSIBILITY FOR AND CONTROL OVER THE SELECTION OF CONTENT, FACULTY, EDUCATIONAL METHODS, MATERIALS, OR VENUE OF THE CONFERENCE OR GUIDELINES, EXCEPT FOR CONFERENCES OR MEETINGS SPONSORED BY THE COMPANY.

(C) NOTWITHSTANDING PARAGRAPH (A) OR (B) OF THIS SUBDIVISION, A PHARMACEUTICAL COMPANY MAY PROVIDE FINANCIAL SUPPORT TO THE SPONSOR OF A CONFERENCE OR MEETING, WHICH MAY BE USED BY THE SPONSOR TO REDUCE THE OVERALL CONFERENCE REGISTRATION FEE FOR ALL ATTENDEES.

(D) A PHARMACEUTICAL COMPANY MAY PROVIDE MODEST MEALS OR RECEPTIONS DURING COMPANY-SPONSORED MEETINGS TO HEALTH CARE PROFESSIONALS WITH WHOM THEY HAVE BONA FIDE CONSULTING OR SPEAKER ARRANGEMENTS, BUT MAY NOT PROVIDE RECREATIONAL OR ENTERTAINMENT EVENTS IN CONJUNCTION WITH SUCH MEETINGS.

9. NO PHARMACEUTICAL COMPANY SHALL PROVIDE FINANCIAL SUPPORT TO A HEALTH CARE PROFESSIONAL PURSUANT TO A CONSULTING AGREEMENT, AND NO HEALTH CARE PROFESSIONAL SHALL ACCEPT SUCH FINANCIAL SUPPORT, UNLESS:

(A) THE CONSULTING ARRANGEMENT IS A BONA FIDE CONSULTING AGREEMENT; AND

(B) SUCH FINANCIAL SUPPORT CONSTITUTES REASONABLE COMPENSATION FOR THE PROFESSIONAL'S CONSULTING SERVICES AND REASONABLE REIMBURSEMENT FOR REASONABLE TRAVEL, LODGING, AND MEAL EXPENSES INCURRED AS PART OF PROVIDING SUCH SERVICES, AND IS BASED ON FAIR MARKET VALUE.

10. (A) NO PHARMACEUTICAL COMPANY SHALL PROVIDE FINANCIAL SUPPORT TO A HEALTH CARE PROFESSIONAL AS A SPEAKER PURSUANT TO A SPEAKER AGREEMENT, AND NO HEALTH CARE PROFESSIONAL SHALL ACCEPT SUCH FINANCIAL SUPPORT, UNLESS:

(I) THE SPEAKER ARRANGEMENT MEETS THE CRITERIA OF A BONA FIDE CONSULTING AGREEMENT;

(II) SUCH FINANCIAL SUPPORT CONSTITUTES REASONABLE COMPENSATION FOR THE PROFESSIONAL'S SPEAKER SERVICES AND REASONABLE REIMBURSEMENTS FOR REASONABLE TRAVEL, LODGING AND MEAL EXPENSES INCURRED AS PART OF PROVIDING SUCH SERVICES, AND IS BASED ON FAIR MARKET VALUE; AND

(III) THE PROFESSIONAL POSSESSES THE GENERAL MEDICAL EXPERTISE AND REPUTATION, KNOWLEDGE AND EXPERIENCE REGARDING A PARTICULAR THERAPEUTIC AREA, AND COMMUNICATIONS SKILLS SUCH AS WOULD REASONABLY BE EXPECTED OF A SPEAKER IN THE RELEVANT FIELD.

(B) NO PHARMACEUTICAL COMPANY SHALL RETAIN A HEALTH CARE PROFESSIONAL AS A SPEAKER UNLESS THE COMPANY:

(I) CAPS THE TOTAL AMOUNT OF ANNUAL COMPENSATION IT WILL PAY TO AN INDIVIDUAL HEALTH CARE PROFESSIONAL IN CONNECTION WITH ALL SPEAKING ARRANGEMENTS AT A REASONABLE AMOUNT;

(II) PROVIDES FOR PERIODIC MONITORING OF SPEAKER PROGRAMS FOR COMPLIANCE WITH UNITED STATES FOOD AND DRUG ADMINISTRATION REGULATORY REQUIREMENTS FOR COMMUNICATIONS ON BEHALF OF THE COMPANY ABOUT ITS MEDICINES;

(III) ENSURES THAT EACH PROFESSIONAL RECEIVES EXTENSIVE TRAINING ON THE COMPANY'S DRUG PRODUCTS OR OTHER SPECIFIC TOPIC TO BE PRESENTED AND ON COMPLIANCE WITH UNITED STATES FOOD AND DRUG ADMINISTRATION REGULATORY REQUIREMENTS FOR COMMUNICATIONS;

(IV) REASONABLY BELIEVES THAT THE TRAINING WILL RESULT IN THE PARTICIPANTS PROVIDING A VALUABLE SERVICE TO THE COMPANY; AND

(V) SPEAKER TRAINING SESSIONS ARE HELD IN VENUES THAT ARE APPROPRIATE AND CONDUCIVE TO INFORMATIONAL COMMUNICATION AND TRAINING ABOUT MEDICAL INFORMATION.

(C) A PHARMACEUTICAL COMPANY SHALL NOT PROVIDE MEALS TO HEALTH CARE PROFESSIONALS AT SPEAKER PROGRAMS UNLESS SUCH MEALS ARE MODEST, OFFERED TO ALL ATTENDEES AND OCCUR IN A VENUE AND MANNER CONDUCIVE TO INFORMATIONAL COMMUNICATION.

(D) A PHARMACEUTICAL COMPANY SHALL ENSURE THAT EACH SPEAKER AND HIS OR HER MATERIALS CLEARLY IDENTIFY THE COMPANY THAT IS SPONSORING THE PRESENTATION, THE FACT THAT THE SPEAKER IS PRESENTING ON BEHALF OF THE COMPANY, AND THAT THE SPEAKER IS PRESENTING INFORMATION THAT IS CONSISTENT WITH UNITED STATES FOOD AND DRUG ADMINISTRATION GUIDELINES.

11. (A) NO PHARMACEUTICAL COMPANY SHALL RETAIN AS A SPEAKER OR CONSULTANT ANY HEALTH CARE PROFESSIONAL WHO IS A MEMBER OF A COMMITTEE THAT SETS FORMULARIES OR DEVELOPS CLINICAL GUIDELINES UNLESS THE COMPANY REQUIRES THAT THE PROFESSIONAL DISCLOSE TO SUCH COMMITTEE THE EXISTENCE AND NATURE OF HIS OR HER RELATIONSHIP WITH THE COMPANY, FOR AS LONG AS SUCH RELATIONSHIP LASTS AND FOR AT LEAST TWO YEARS AFTER SUCH RELATIONSHIP IS TERMINATED.

(B) NO HEALTH CARE PROFESSIONAL SHALL SERVE BOTH AS A SPEAKER OR CONSULTANT FOR A PHARMACEUTICAL COMPANY AND AS A MEMBER OF A COMMITTEE THAT SETS FORMULARIES OR DEVELOPS CLINICAL GUIDELINES UNLESS HE OR SHE:

(I) DISCLOSES TO SUCH COMMITTEE THE EXISTENCE AND NATURE OF HIS OR HER RELATIONSHIP WITH THE COMPANY, WHICH DISCLOSURE REQUIREMENT SHALL EXTEND FOR A MINIMUM OF TWO YEARS BEYOND THE TERMINATION OF ANY SPEAKER OR CONSULTANT ARRANGEMENT; AND

(II) FOLLOWS THE RELEVANT PROCEDURES SET FORTH BY THE COMMITTEE OF WHICH THEY ARE A MEMBER, WHICH MAY INCLUDE RECUSING THEMSELVES FROM DECISIONS RELATING TO THE PRESCRIPTION DRUG, DEVICE OR BIOLOGIC FOR WHICH THEY HAVE PROVIDED SPEAKING OR CONSULTING SERVICES.

12. NO PHARMACEUTICAL COMPANY SHALL OFFER OR PROVIDE FINANCIAL ASSISTANCE FOR SCHOLARSHIPS OR OTHER EDUCATIONAL FUNDS TO PERMIT MEDICAL STUDENTS, RESIDENTS, FELLOWS, AND OTHER HEALTH CARE PROFESSIONALS IN TRAINING TO ATTEND EDUCATIONAL CONFERENCES UNLESS:

(A) SUCH CONFERENCES ARE SPONSORED BY THE MAJOR EDUCATIONAL, SCIENTIFIC, OR POLICY-MAKING MEETINGS OF NATIONAL, REGIONAL, OR SPECIALTY MEDICAL ASSOCIATIONS; AND

(B) THE SELECTION OF INDIVIDUALS WHO WILL RECEIVE THE ASSISTANCE IS MADE BY THE ACADEMIC OR TRAINING INSTITUTION.

13. A PHARMACEUTICAL COMPANY THAT OBTAINS PRESCRIBER DATA FROM HEALTH CARE PROFESSIONALS SHALL:

(A) MAINTAIN THE CONFIDENTIAL NATURE OF PRESCRIBER DATA AND COMPLY WITH ALL APPLICABLE LAWS AND REGULATIONS THAT PROTECT THE CONFIDENTIALITY OF PATIENT INFORMATION;

(B) DEVELOP WRITTEN POLICIES REGARDING THE USE OF THE DATA;

(C) EDUCATE ITS EMPLOYEES AND AGENTS ABOUT SUCH POLICIES;

(D) DESIGNATE AN INTERNAL CONTACT PERSON TO HANDLE INQUIRIES REGARDING THE USE OF THE DATA;

(E) IDENTIFY APPROPRIATE DISCIPLINARY ACTIONS FOR MISUSE OF PRESCRIBER DATA; AND

(F) ABIDE BY THE WISHES OF ANY HEALTH CARE PROFESSIONAL WHO REQUESTS THAT HIS OR HER PRESCRIBER DATA NOT BE MADE AVAILABLE FOR ANY SALES OR MARKETING PURPOSE.

14. NO PHARMACEUTICAL COMPANY SHALL OFFER OR PROVIDE TO HEALTH CARE PROFESSIONALS OR MEMBERS OF THEIR STAFF:

(A) ANY ITEM OR SERVICE INTENDED FOR THE PERSONAL BENEFIT OF THE PROFESSIONAL OR STAFF MEMBERS, SUCH AS FLORAL ARRANGEMENTS, ARTWORK, COMPACT DISCS OR TICKETS TO A SPORTING EVENT;

(B) ANY TANGIBLE ITEM, EVEN IF THEY ARE PRACTICE-RELATED ITEMS OF MINIMAL VALUE SUCH AS PENS, NOTE PADS, OR MUGS, OR ARE ACCOMPANIED BY PATIENT OR PHYSICIAN EDUCATIONAL MATERIALS, EXCEPT FOR EDUCATIONAL ITEMS DESCRIBED IN THIS SUBDIVISION; OR

(C) ANY CASH OR CASH EQUIVALENTS, SUCH AS GIFT CERTIFICATES, EITHER DIRECTLY OR INDIRECTLY, EXCEPT AS COMPENSATION FOR BONA FIDE SERVICES EXPRESSLY PERMITTED UNDER THIS SECTION.

15. A PHARMACEUTICAL COMPANY MAY OFFER OR PROVIDE TO HEALTH CARE PROFESSIONALS ITEMS DESIGNED PRIMARILY FOR THE EDUCATION OF PATIENTS OR HEALTH CARE PROFESSIONALS ONLY IF THE ITEMS:

(A) ARE NOT OF SUBSTANTIAL VALUE AND DO NOT HAVE VALUE TO THE HEALTH CARE PROFESSIONAL OUTSIDE OF HIS OR HER PROFESSIONAL RESPONSIBILITIES, SUCH AS AN ANATOMICAL MODEL FOR USE IN AN EXAMINATION ROOM; AND

(B) ARE NOT OFFERED TO A PARTICULAR HEALTH CARE PROFESSIONAL ON MORE THAN AN OCCASIONAL BASIS, EVEN IF EACH INDIVIDUAL ITEM IS APPROPRIATE.

16. (A) NO PHARMACEUTICAL COMPANY SHALL SELL OR MARKET PRESCRIPTION DRUGS, BIOLOGICS OR MEDICAL DEVICES TO HEALTH CARE PROFESSIONALS PRAC-

TICING IN THIS STATE UNLESS THE REPRESENTATIVES WHO ARE EMPLOYED BY OR ACT ON BEHALF OF THE COMPANY AND WHO VISIT HEALTH CARE PROFESSIONALS PRACTICING IN THIS STATE ARE:

(I) TRAINED IN THE APPLICABLE LAWS AND REGULATIONS THAT GOVERN THE REPRESENTATIVES' INTERACTIONS WITH HEALTH CARE PROFESSIONALS, WHICH TRAINING SHALL BE UPDATED AS NECESSARY;

(II) TRAINED IN OR OTHERWISE KNOWLEDGEABLE ABOUT GENERAL SCIENCE AND PRODUCT-SPECIFIC INFORMATION SUFFICIENT TO ALLOW THE REPRESENTATIVES TO PROVIDE ACCURATE, UP-TO-DATE INFORMATION, CONSISTENT WITH UNITED STATES FOOD AND DRUG ADMINISTRATION REQUIREMENTS AND OTHER CRITERIA SET FORTH IN SUBDIVISION FOUR OF THIS SECTION;

(III) PERIODICALLY ASSESSED TO ENSURE THAT THEY COMPLY WITH APPLICABLE LAWS, REGULATIONS AND RELEVANT COMPANY POLICIES AND STANDARDS OF CONDUCT; AND

(IV) SUBJECT TO APPROPRIATE ACTION WHEN THEY FAIL TO COMPLY WITH LAWS, REGULATIONS AND RELEVANT COMPANY POLICIES AND STANDARDS OF CONDUCT.

17. THE COMMISSIONER MAY ASSESS A CIVIL PENALTY:

(A) AGAINST A PHARMACEUTICAL COMPANY THAT VIOLATES ANY PROVISION OF THIS SECTION IN AN AMOUNT THAT IS NOT LESS THAN FIFTEEN THOUSAND DOLLARS AND NOT MORE THAN TWO HUNDRED FIFTY THOUSAND DOLLARS PER VIOLATION; AND

(B) AGAINST A HEALTH CARE PROFESSIONAL THAT VIOLATES ANY PROVISION OF THIS SECTION IN AN AMOUNT THAT IS NOT LESS THAN FIVE THOUSAND DOLLARS AND NOT MORE THAN TEN THOUSAND DOLLARS PER VIOLATION.

S 38-a. 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 38-b. 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 39. The opening paragraphs of paragraphs (d) and (e) of subdivision 5-a of section 2807-m of the public health law, as amended by section 98 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, [one] TWO million [nine] SEVEN hundred [sixty] FIFTEEN thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, and [four] SEVEN hundred [ninety] FORTY-ONE 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:

Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars [annually] for the period January first, two thousand nine through December thirty-first,

two thousand [ten] NINE, SIX MILLION SEVEN HUNDRED THOUSAND DOLLARS FOR THE PERIOD JANUARY FIRST, TWO THOUSAND TEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN, and one million [two] SIX hundred [twenty-five] NINETY-SEVEN 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:

S 39-a. Paragraphs (a) and (c) of subdivision 10 of section 2807-m of the public health law, as added by section 75-e of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(a) Beginning January first, two thousand eight, the commissioner is authorized, within amounts available pursuant to subdivision five-a of this section, to make loan repayment awards to primary care physicians or other physician specialties determined by the commissioner to be in short supply, licensed to practice medicine in New York state, who agree to practice for at least five years in an underserved area, as determined by the commissioner. Such physician shall be eligible for a loan repayment award of up to one hundred fifty thousand dollars over a five year period distributed as follows: fifteen percent of total loan debt not to exceed twenty thousand dollars for the first year; fifteen percent of total loan debt not to exceed twenty-five thousand dollars for the second year; twenty percent of total loan debt not to exceed thirty-five thousand dollars for the third year; and twenty-five percent of total loan debt not to exceed thirty-five thousand dollars per year for the fourth [and] YEAR; AND ANY UNPAID BALANCE OF THE TOTAL LOAN DEBT NOT TO EXCEED THE MAXIMUM AWARD AMOUNT FOR THE fifth [years] YEAR of practice in such area.

(c) In the event that a five-year commitment pursuant to the agreement referenced in paragraph (a) of this subdivision is not fulfilled, the recipient shall be responsible for repayment[, plus interest at a rate 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, based upon the following schedule: service of less than two years requires repayment of one hundred percent of total funds received; service of less than three years requires repayment of fifty percent of total funds received; service of less than four years requires repayment of twenty-five percent of total funds received, and service of more than four years but less than five years requires repayment of ten percent of total funds received] IN AMOUNTS WHICH SHALL BE CALCULATED IN ACCORDANCE WITH THE FORMULA SET FORTH IN SUBDIVISION (B) OF SECTION TWO HUNDRED FIFTY-FOUR-O OF TITLE FORTY-TWO OF THE UNITED STATES CODE, AS AMENDED.

S 40. Subdivision 1 of section 2802-a of the public health law, as added by section 87 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

1. Notwithstanding any other provision of law to the contrary, the commissioner is authorized to approve up to [five] TEN general hospitals within the state to operate transitional care units by and within such general hospitals. For purposes of this section, "transitional care" shall mean sub acute care services provided to patients of a general

hospital who no longer require acute care general hospital inpatient services, but continue to need specialized medical, nursing and other hospital ancillary services and are not yet appropriate for discharge.

S 41. Subdivision 2 of section 105 of part B of chapter 58 of the laws of 2005, amending the public health law and other laws relating to implementing the state fiscal plan for the 2005-2006 state fiscal year, is amended to read as follows:

2. Section eighty-seven of this act shall expire and be deemed repealed [five] TEN years from the date on which it shall have become a law;

S 42. Subdivision 2 of section 12 of the public health law, as amended by chapter 856 of the laws of 1974, is amended and a new subdivision 1-a is added to read as follows:

1-A. (A) ANY PERSON WHO, WITH THE INTENT TO DEFRAUD, KNOWINGLY AND WILLFULLY VIOLATES, DISOBEYS OR DISREGARDS ANY MATERIAL TERM OR PROVISION OF THE MEDICAL ASSISTANCE PROGRAM ESTABLISHED UNDER SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW OR OF ANY LAWFUL NOTICE, ORDER OR REGULATION PURSUANT THEREOF SHALL BE LIABLE TO THE PEOPLE OF THE STATE FOR A CIVIL PENALTY OF TEN THOUSAND DOLLARS FOR EVERY SUCH VIOLATION.

(B) THE PENALTY PROVIDED FOR IN PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE INCREASED TO TWENTY-FIVE THOUSAND DOLLARS FOR A SUBSEQUENT VIOLATION COMMITTED WITHIN FIVE YEARS OF THE INITIAL VIOLATION FOR WHICH A PENALTY WAS ASSESSED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION.

(C) THE PENALTY PROVIDED FOR IN PARAGRAPH (B) OF THIS SUBDIVISION SHALL BE INCREASED TO FIFTY THOUSAND DOLLARS FOR A SUBSEQUENT VIOLATION COMMITTED WITHIN FIVE YEARS OF THE INITIAL VIOLATION FOR WHICH A PENALTY WAS ASSESSED PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION.

2. The [penalty] PENALTIES provided for in [subdivision] SUBDIVISIONS one AND ONE-A of this section may be recovered by an action brought by the commissioner in any court of competent jurisdiction.

S 43. Subdivision 4 of section 6 of part C of chapter 58 of the laws of 2005, amending the public health law and other laws relating to authorizing reimbursements for expenditures made by social services districts for medical assistance, is amended to read as follows:

4. If the commissioner of health finds that a district has either substantially failed to demonstrate due diligence, including due diligence with respect to the identification and reporting of fraud and abuse, according to the prescribed requirements and guidelines or continues to fail to comply with such requirements then such commissioner may impose such sanctions and penalties as are permitted under the public health law and the social services law. IN ADDITION, IF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, OR A SUCCESSOR AGENCY, DISALLOWS CLAIMS FOR FEDERAL FINANCIAL PARTICIPATION SUBMITTED TO IT BY THE DEPARTMENT OF HEALTH, OR IF ANY FEDERAL AGENCY DETERMINES TO RECOVER FEDERAL MEDICAID FUNDS PREVIOUSLY PAID TO THE DEPARTMENT OF HEALTH, THE DEPARTMENT MAY RECOVER FROM A DISTRICT THE AMOUNT OF SUCH DISALLOWANCE OR RECOVERY THAT THE COMMISSIONER DETERMINES WAS CAUSED BY A DISTRICT'S FAILURE TO PROPERLY ADMINISTER, SUPERVISE OR OPERATE THE MEDICAID PROGRAM. ANY SUCH RECOVERY FROM A DISTRICT SHALL BE MADE NOTWITHSTANDING, AND IN ADDITION TO, ANY DISTRICT MEDICAID SHARE AMOUNTS CALCULATED PURSUANT TO SECTION ONE OF THIS PART.

S 43-a. Paragraph (f) of section 1 of part C of chapter 58 of the laws of 2005, amending the public health law and other laws relating to authorizing reimbursements for expenditures made by social services

districts for medical assistance, as amended by section 62 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(f) Subject to paragraph (g) of this section, the state fiscal year social services district expenditure cap amount calculated for each social services district pursuant to paragraph (d) of this section shall be allotted to each district during that fiscal year and paid to the department in equal weekly amounts in a manner to be determined by the commissioner and communicated to such districts and, SUBJECT TO THE PROVISIONS OF SUBDIVISION FOUR OF SECTION SIX OF THIS PART, shall represent each district's maximum responsibility for medical assistance expenditures governed by this section.

S 43-b. Paragraph (b) of section 1 of part C of chapter 58 of the laws of 2005, amending the public health law and other laws relating to authorizing reimbursements for expenditures made by social services districts for medical assistance, is amended to read as follows:

(b) Commencing with the period April 1, 2005 though March 31, 2006, a social services district's yearly net share of medical assistance expenditures shall be calculated in relation to a reimbursement base year which, for purposes of this section, is defined as January 1, 2005 through December 31, 2005. The final base year expenditure calculation for each social services district shall be made by the commissioner of health, and approved by the director of the division of the budget, no later than June 30, 2006. Such calculations shall be based on actual expenditures made by or on behalf of social services districts, and revenues received by social services districts, during the base year and shall be made without regard to expenditures made, and revenues received, outside the base year that are related to services provided during, or prior to, the base year. Such base year calculations shall be based on the social services district medical assistance shares provisions in effect on January 1, 2005. SUBJECT TO THE PROVISIONS OF SUBDIVISION FOUR OF SECTION SIX OF THIS PART, THE STATE/LOCAL SOCIAL SERVICES DISTRICT RELATIVE PERCENTAGES OF THE NON-FEDERAL SHARE OF MEDICAL ASSISTANCE EXPENDITURES INCURRED PRIOR TO JANUARY 1, 2006 SHALL NOT BE SUBJECT TO ADJUSTMENT ON AND AFTER JULY 1, 2006.

S 44. Notwithstanding any contrary provision of law, surcharges and assessments due and owing pursuant to sections 2807-j, 2807-s and 2807-t of the public health law for any period prior to January 1, 2010, which are paid and accompanied by all required reports and which were received on or before December 31, 2010 shall not be subject to penalties as otherwise provided in such sections, provided, however, that such reports may be based on estimates by payors and designated providers of services of the amounts owed, subject to subsequent audit by the commissioner of health or such commissioner's designee, however, with regard to all principal, interest and penalty amounts collected by the commissioner of health prior to the effective date of this act, the interest and penalty provisions of sections 2807-j, 2807-s and 2807-t of the public health law shall remain in full force and effect and such amounts collected shall not be subject to further adjustment pursuant to this section. Furthermore, the provisions of this section shall not apply to any surcharge or assessment payments made in response to a final audit finding issued by such commissioner of health or such commissioner's designee.

S 45. Paragraph (f) of subdivision 8-a of section 2807-j of the public health law, as added by section 39 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(f) The commissioner may enter into agreements with designated providers of services, and with third-party payors, in regard to which audit findings have been made pursuant to this section or section twenty-eight hundred seven-s of this article, extending and applying such audit findings or a portion thereof in settlement and satisfaction of potential audit liabilities for subsequent un-audited periods through the two thousand [five] NINE calendar year. The commissioner may waive payment of interest and penalties otherwise applicable to such subsequent unaudited periods when such amounts due as a result of such agreement, other than waived penalties and interest, are paid in full to the commissioner or the commissioner's designee within sixty days of execution of such agreement by all parties to the agreement.

S 46. Section 2872 of the public health law is amended by adding a new subdivision 3-b to read as follows:

3-B. "ELIGIBLE SECURED HOSPITAL BORROWER". A NOT-FOR-PROFIT HOSPITAL CORPORATION ORGANIZED UNDER THE LAWS OF THIS STATE, WHICH HAS FINANCED OR REFINANCED A PROJECT OR PROJECTS PURSUANT TO THE FORMER SECTION SEVEN-A OF SECTION ONE OF CHAPTER THREE HUNDRED NINETY-TWO OF THE LAWS OF NINETEEN HUNDRED SEVENTY-THREE AND FOR WHICH SPECIAL HOSPITAL PROJECT BONDS (AS DEFINED IN FORMER PARAGRAPH (D) OF SUBDIVISION THREE OF SECTION THREE OF SECTION ONE OF CHAPTER THREE HUNDRED NINETY-TWO OF THE LAWS OF NINETEEN HUNDRED SEVENTY-THREE) REMAIN OUTSTANDING.

S 46-a. The public health law is amended by adding a new section 2874-b to read as follows:

S 2874-B. REFINANCING MORTGAGE LOANS TO ELIGIBLE SECURED HOSPITAL BORROWERS. ELIGIBLE SECURED HOSPITAL BORROWERS, AS DEFINED IN SUBDIVISION THREE-B OF SECTION TWENTY-EIGHT HUNDRED SEVENTY-TWO OF THIS ARTICLE, SHALL BE AUTHORIZED TO REFINANCE ANY MORTGAGE LOAN FINANCED WITH THE PROCEEDS OF SPECIAL HOSPITAL PROJECT BONDS, WHICH LOANS ARE OUTSTANDING AS OF THE EFFECTIVE DATE OF THIS SECTION. A MORTGAGE LOAN TO AN ELIGIBLE SECURED HOSPITAL BORROWER, AS DEFINED IN SUBDIVISION THREE-B OF SECTION TWENTY-EIGHT HUNDRED SEVENTY-TWO OF THIS ARTICLE, MADE BY THE MEDICAL CARE FACILITIES FINANCE AGENCY, AND ANY SUCCESSOR THERETO, MAY BE REFINANCED FOR A TERM NOT LONGER THAN THE TERM SUFFICIENT TO ASSURE THAT THE INTEREST ON BONDS ISSUED TO REFINANCE THE MORTGAGE LOAN WILL BE EXCLUDABLE FROM GROSS INCOME OF THE HOLDERS THEREOF FOR FEDERAL TAX PURPOSES, PROVIDED THAT IN NO EVENT SHALL THE TERM OF SUCH REFINANCING LOAN EXCEED THIRTY YEARS FROM THE DATE OF THE ISSUANCE OF THE REFUNDING BONDS AND SHALL INCLUDE ALL COSTS ASSOCIATED WITH THE REFINANCING OF INDEBTEDNESS. ALL REFINANCING APPLICATIONS BY ELIGIBLE SECURED HOSPITAL BORROWERS SHALL BE APPROVED BY THE ELIGIBLE SECURED HOSPITAL BORROWER'S BOARD AND THE COMMISSIONER. SUCH REFINANCING APPLICATIONS SHALL INCLUDE ANALYTICAL EVIDENCE SUFFICIENT TO DEMONSTRATE THAT THE PROPOSED REFINANCING IS BEING UNDERTAKEN FOR SOUND BUSINESS PURPOSES AND IN FURTHERANCE OF MAINTAINING OR IMPROVING THE FINANCIAL CONDITION OF THE HOSPITAL. SUCH EVIDENCE MAY INCLUDE BUT IS NOT LIMITED TO: PRESENT VALUE ANALYSIS OF DEBT SERVICE PAYMENTS, INCLUDING WHERE APPLICABLE, PRESENT VALUE ANALYSIS THAT SEGREGATES DEBT SERVICE PAYMENTS BETWEEN PRINCIPAL AND INTEREST COMPONENTS; FINANCIAL PRO FORMAS THAT PROJECT THE BORROWER'S REVENUES, EXPENSES AND FINANCIAL POSITION FOR A PERIOD DETERMINED BY THE COMMISSIONER; OR ANY OTHER ANALYSIS OR INFORMATION THE COMMISSIONER DEEMS NECESSARY TO EVALUATE THE APPLICATION (INCLUDING BUT NOT LIMITED TO ANALYSIS AND RECOMMENDATIONS OF CONSULTANTS). AS A CONDITION OF SUCH PRIOR APPROVAL, THE COMMISSIONER SHALL APPROVE THE PRINCIPAL AMOUNT OF THE REFINANCING, AND REQUIRE THE ELIGIBLE SECURED HOSPITAL BORROWER TO GIVE THE DEPARTMENT A WRITTEN UNDERTAKING, ACCEPTABLE TO THE

COMMISSIONER, THAT IT WILL NOT CLAIM ADDITIONAL REIMBURSEMENT UNDER THE MEDICAL ASSISTANCE PROGRAM AS ESTABLISHED UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW DUE TO INTEREST PAYMENTS ON REFINANCING INDEBTEDNESS. ANY SUCH ADDITIONAL INTEREST PAYMENTS ON REFINANCED INDEBTEDNESS COVERED BY SUCH WRITTEN UNDERTAKING SHALL NOT BE CONSIDERED AS ALLOWABLE COSTS UNDER THE MEDICAL ASSISTANCE PROGRAM AND SHALL NOT BE INCLUDED IN REIMBURSEMENT RATES OF PAYMENT UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER.

S 46-b. Subdivision 3 of section 3 of section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, is amended by adding a new paragraph (d-1) to read as follows:

(D-1) "SPECIAL HOSPITAL PROJECT BONDS" SHALL MEAN BONDS ISSUED PURSUANT TO SECTION SEVEN-C OF THIS ACT FOR THE PURPOSE OF REFINANCING OUTSTANDING MORTGAGE LOANS OF ELIGIBLE SECURED HOSPITAL BORROWERS, AS DEFINED IN SUBDIVISION SIX-C OF THIS SECTION, PURSUANT TO THIS ACT.

S 46-c. Section 3 of section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, is amended by adding a new subdivision 6-c to read as follows:

6-C. "ELIGIBLE SECURED HOSPITAL BORROWER" SHALL MEAN A NOT-FOR-PROFIT HOSPITAL CORPORATION ORGANIZED UNDER THE LAWS OF THIS STATE, WHICH HAS FINANCED OR REFINANCED A PROJECT OR PROJECTS PURSUANT TO FORMER SECTION SEVEN-A OF THIS ACT, AND FOR WHICH SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN FORMER PARAGRAPH D OF SUBDIVISION THREE OF THIS SECTION, REMAIN OUTSTANDING.

S 46-d. Subdivision 10 of section 3 of section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, as amended by chapter 803 of the laws of 1984, is amended to read as follows:

10. "Hospital project" shall mean a specific work or improvement or the refinancing of existing indebtedness which constitutes a lien or encumbrance upon the real property or assets of the eligible borrower OR THE REFINANCING OF EXISTING INDEBTEDNESS OF AN ELIGIBLE SECURED HOSPITAL BORROWER, AS DEFINED IN SUBDIVISION SIX-C OF THIS SECTION, FOR WHICH SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN FORMER PARAGRAPH (D) OF SUBDIVISION THREE OF THIS SECTION, REMAIN OUTSTANDING whether or not such refinancing is related to the construction, acquisition or rehabilitation of a specified work or improvement undertaken by a non-profit hospital corporation or a non-profit medical corporation, constituting an eligible borrower in accordance with the provisions of article [twenty-eight-B] 28-B of the public health law.

S 46-e. Subdivision 11 of section 3 of section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, is amended to read as follows:

11. "Hospital project cost" shall mean the sum total of all costs incurred by a non-profit hospital corporation or a non-profit medical corporation, constituting an eligible borrower undertaking a project as approved by the commissioner in accordance with the provisions of article [twenty-eight-B] 28-B of the public health law, OR, IN CASE OF AN ELIGIBLE SECURED HOSPITAL BORROWER, ALL COSTS INCURRED IN CONNECTION WITH THE REFINANCING OF EXISTING INDEBTEDNESS APPROVED BY THE COMMISSIONER PURSUANT TO SECTION 2874-B OF THE PUBLIC HEALTH LAW.

S 46-f. Subdivision 12 of section 3 of section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, as amended by chapter 156 of the laws of 1974, is amended to read as follows:

12. "Mortgage loan" shall mean a loan made by the agency to an eligible borrower in an amount not to exceed the total hospital project cost and secured by a first mortgage lien on the real property of which the hospital project consists and the personal property attached to or used in connection with the construction, acquisition, reconstruction, rehabilitation, improvement or operation of the hospital project. Such loan may be further secured by such a lien upon other real property owned by the eligible borrower. Notwithstanding the foregoing provisions of this subdivision or any other provisions of this act to the contrary, any personal property may be excluded from the lien of the mortgage provided (a) the commissioner [of health] finds that such property is not essential for the rendition of required hospital services as such term is defined in article [twenty-eight] 28 of the public health law, and (b) the agency consents to such exclusion.

The term "mortgage loan" shall also mean and include a loan made by the agency to a limited-profit nursing home company in an amount not to exceed ninety-five [percentum] PER CENTUM of the nursing home project cost, or to a non-profit nursing home company in an amount not to exceed the total nursing home project cost, and secured by a first mortgage lien on the real property of which the nursing home project consists and the personal property attached to or used in connection with the construction, acquisition, reconstruction, rehabilitation, improvement or operation of the nursing home project. Notwithstanding the foregoing provisions of this subdivision or any other provision of this article to the contrary, any personal property may be excluded from the lien of the mortgage provided (a) the commissioner finds that such property is not essential for the nursing home project as such term is defined in article [twenty-eight-A] 28-A of the public health law, and (b) the agency consents to such exclusion.

THE TERM "MORTGAGE LOAN" SHALL ALSO MEAN AND INCLUDE A LOAN MADE TO AN ELIGIBLE SECURED HOSPITAL BORROWER, AS DEFINED IN SUBDIVISION SIX-C OF THIS SECTION, TO REFINANCE OUTSTANDING INDEBTEDNESS PURSUANT TO THIS ACT.

S 46-g. Subdivision 10 of section 5 of section 1 of chapter 392 of the laws of 1973 constituting the New York state medical care facilities finance agency act, as amended by chapter 387 of the laws of 2006, is amended to read as follows:

10. Subject to the approval of the commissioner of health pursuant to the provisions of article 28-B of the public health law, to make mortgage loans and project loans to non-profit hospital corporations and non-profit medical corporations constituting eligible borrowers AND ELIGIBLE SECURED HOSPITAL BORROWERS AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT and to undertake commitments to make any such mortgage loans and project loans;

S 46-h. Section 1 of chapter 392 of the laws of 1973, constituting the New York state medical care facilities finance agency act, is amended by adding a new section 7-c to read as follows:

S 7-C. SECURED HOSPITAL PROJECTS RESERVE FUNDS AND APPROPRIATIONS. 1. SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT, ISSUED TO REFINANCE THE PROJECTS OF ELIGIBLE SECURED HOSPITAL BORROWERS, AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT, SHALL BE SECURED BY (A) A MORTGAGE LIEN, (B) FUNDS AND ACCOUNTS ESTABLISHED UNDER THE BOND RESOLUTION, (C) THE SECURED HOSPITAL SPECIAL DEBT SERVICE RESERVE FUND OR FUNDS, (D) THE SECURED HOSPITAL CAPITAL RESERVE FUND OR FUNDS, AND (E) SUCH SERVICE

CONTRACT OR CONTRACTS ENTERED INTO IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION FOUR OF THIS SECTION.

2. (A) THE AGENCY SHALL ESTABLISH A SECURED HOSPITAL SPECIAL DEBT SERVICE RESERVE FUND OR FUNDS AND PAY INTO SUCH FUND OR FUNDS MONEYS FROM THE SECURED HOSPITAL FUND UP TO AN AMOUNT NOT TO EXCEED AN AMOUNT NECESSARY TO ENSURE THE REPAYMENT OF PRINCIPAL AND INTEREST DUE ON ANY OUTSTANDING INDEBTEDNESS ON SPECIAL HOSPITAL PROJECTS BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT.

FUNDS DEPOSITED IN SUCH SECURED HOSPITAL SPECIAL DEBT SERVICE RESERVE FUND OR FUNDS SHALL BE USED IN THE EVENT THAT AN ELIGIBLE SECURED HOSPITAL BORROWER, AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT, FAILS TO MAKE PAYMENTS IN AN AMOUNT SUFFICIENT TO PAY THE REQUIRED DEBT SERVICE PAYMENTS ON SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT.

(B) THE AGENCY SHALL, FOR THE PURPOSES OF PARAGRAPH (A) OF THIS SUBDIVISION AND FOR THE SUPPORT OF ELIGIBLE SECURED HOSPITAL BORROWERS, PAY INTO THE SECURED HOSPITAL FUND CURRENTLY ESTABLISHED AND MAINTAINED BY THE AGENCY: (I) ALL FUNDS REQUIRED TO BE PAID IN ACCORDANCE WITH THE PROVISIONS OF ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW AND REGULATIONS PROMULGATED IN SUCH ARTICLE; (II) ANY MORTGAGE INSURANCE PREMIUM ASSESSED IN AN AMOUNT FIXED AT THE DISCRETION OF THE AGENCY, UPON THE ISSUANCE OF SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT; (III) ANY INCOME OR INTEREST EARNED ON OTHER RESERVE FUNDS WHICH THE AGENCY ELECTS TO TRANSFER TO THE SECURED HOSPITAL FUND; AND (IV) ANY OTHER MONEYS WHICH MAY BE MADE AVAILABLE TO THE AGENCY FROM ANY OTHER SOURCE OR SOURCES. MONEYS PAID INTO THE SECURED HOSPITAL FUND SHALL, IN THE DISCRETION OF THE AGENCY, BUT SUBJECT TO AGREEMENTS WITH BONDHOLDERS, BE USED TO FUND THE SPECIAL DEBT SERVICE RESERVE FUND OR FUNDS AT A LEVEL OR LEVELS WHICH MINIMIZE THE NEED FOR USE OF THE CAPITAL RESERVE FUND OR FUNDS IN THE EVENT OF THE FAILURE OF AN ELIGIBLE SECURED HOSPITAL BORROWER, AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT, TO MAKE THE REQUIRED DEBT SERVICE PAYMENTS ON SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT.

(C) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPHS (A) AND (B) OF THIS SUBDIVISION, THE STATE HEREBY EXPRESSLY RESERVES THE RIGHT TO MODIFY OR REPEAL THE PROVISIONS OF ARTICLE 28 OF THE PUBLIC HEALTH LAW.

3. THE AGENCY SHALL ESTABLISH A SECURED HOSPITAL CAPITAL RESERVE FUND OR FUNDS WHICH SHALL BE FUNDED AT AN AMOUNT OR AMOUNTS EQUAL TO THE LESSER OF EITHER: (A) THE MAXIMUM AMOUNT OF PRINCIPAL, SINKING FUND PAYMENTS AND INTEREST DUE IN ANY SUCCEEDING YEAR ON OUTSTANDING SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT, OR (B) FOR TAX EXEMPT BONDS, THE MAXIMUM AMOUNT TO ENSURE THAT SUCH BONDS WILL NOT BE CONSIDERED ARBITRAGE BONDS UNDER THE INTERNAL REVENUE CODE OF 1986, AS AMENDED. THE CAPITAL RESERVE FUND SHALL BE FUNDED BY THE SALE OF SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT, OR FROM SUCH OTHER FUNDS AS MAY BE LEGALLY AVAILABLE FOR SUCH PURPOSE, AS PROVIDED FOR IN THE BOND RESOLUTION OR RESOLUTIONS AUTHORIZING THE ISSUANCE OF SUCH BONDS.

4. (A) NOTWITHSTANDING THE PROVISIONS OF ANY GENERAL OR SPECIAL LAW TO THE CONTRARY, AND SUBJECT TO THE MAKING OF ANNUAL APPROPRIATIONS THEREFOR BY THE LEGISLATURE IN ORDER TO REFINANCE MORTGAGE LOANS TO ELIGIBLE SECURED HOSPITAL BORROWERS, AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT, THE DIRECTOR OF THE BUDGET IS AUTHORIZED IN ANY STATE

FISCAL YEAR TO ENTER INTO ONE OR MORE SERVICE CONTRACTS, WHICH SERVICE CONTRACTS SHALL NOT EXCEED THE TERM OF THE SPECIAL HOSPITAL PROJECT BONDS, ISSUED FOR THE BENEFIT OF THE ELIGIBLE SECURED HOSPITAL BORROWER, UPON SUCH TERMS AS THE DIRECTOR OF THE BUDGET AND THE AGENCY AGREE, SO AS TO PROVIDE ANNUALLY TO THE AGENCY IN THE AGGREGATE SUCH SUM, IF ANY, AS NECESSARY TO MEET THE DEBT SERVICE PAYMENTS DUE ON OUTSTANDING SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT, IN ANY YEAR IF THE FUNDS PROVIDED FOR IN THIS SECTION ARE INADEQUATE.

(B) ANY SERVICE CONTRACT ENTERED INTO PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL PROVIDE (I) THAT THE OBLIGATION OF THE DIRECTOR OF THE BUDGET OR OF THE STATE TO FUND OR TO PAY THE AMOUNTS THEREIN PROVIDED FOR SHALL NOT CONSTITUTE A DEBT OF THE STATE WITHIN THE MEANING OF ANY CONSTITUTIONAL OR STATUTORY PROVISION AND SHALL BE DEEMED EXECUTORY ONLY TO THE EXTENT OF MONEYS AVAILABLE AND THAT NO LIABILITY SHALL BE INCURRED BY THE STATE BEYOND THE MONEYS AVAILABLE FOR SUCH PURPOSE, AND THAT SUCH OBLIGATION IS SUBJECT TO ANNUAL APPROPRIATION BY THE LEGISLATURE; AND (II) THAT THE AMOUNTS PAID TO THE AGENCY PURSUANT TO ANY SUCH CONTRACT MAY BE USED BY IT SOLELY TO PAY OR TO ASSIST IN FINANCING COSTS OF MORTGAGE LOANS TO ELIGIBLE SECURED HOSPITAL BORROWERS, AS DEFINED IN SUBDIVISION SIX-C OF SECTION THREE OF THIS ACT.

5. THE AGENCY SHALL NOT ISSUE SPECIAL HOSPITAL PROJECT BONDS, AS DEFINED IN PARAGRAPH (D-1) OF SUBDIVISION THREE OF SECTION THREE OF THIS ACT, EXCEPT TO REFINANCE MORTGAGE LOANS FOR ELIGIBLE SECURED HOSPITAL BORROWERS AS PROVIDED IN SECTION THREE OF THIS ACT.

S 46-i. Notwithstanding any other provision of this act: (i) reimbursement for interest on any indebtedness hereunder to be paid by the medical assistance program established under title 11 of article 5 of the social services law shall be subject to the availability of federal financial participation; and (ii) the refinancing of a mortgage loan pursuant to this act shall not alter, affect or change the component of medical assistance reimbursement applicable to the depreciation of any asset or assets.

S 47. Subdivision 2 of section 366-a of the social services law is amended by adding a new paragraph (d) to read as follows:

(D) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION, AN APPLICANT OR RECIPIENT WHOSE ELIGIBILITY UNDER THIS TITLE IS DETERMINED WITHOUT REGARD TO THE AMOUNT OF HIS OR HER ACCUMULATED RESOURCES MAY ATTEST TO THE AMOUNT OF INTEREST INCOME GENERATED BY SUCH RESOURCES IF THE AMOUNT OF SUCH INTEREST INCOME IS EXPECTED TO BE IMMATERIAL TO MEDICAL ASSISTANCE ELIGIBILITY, AS DETERMINED BY THE COMMISSIONER OF HEALTH. IN THE EVENT THERE IS AN INCONSISTENCY BETWEEN THE INFORMATION REPORTED BY THE APPLICANT OR RECIPIENT AND ANY INFORMATION OBTAINED BY THE COMMISSIONER OF HEALTH FROM OTHER SOURCES AND SUCH INCONSISTENCY IS MATERIAL TO MEDICAL ASSISTANCE ELIGIBILITY, THE COMMISSIONER OF HEALTH SHALL REQUEST THAT THE APPLICANT OR RECIPIENT PROVIDE ADEQUATE DOCUMENTATION TO VERIFY HIS OR HER INTEREST INCOME.

S 47-a. Subdivision 2 of section 369-ee of the social services law is amended by adding a new paragraph (b-1) to read as follows:

(B-1) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (B) OF THIS SUBDIVISION, AN INDIVIDUAL MAY ATTEST TO THE AMOUNT OF INTEREST INCOME GENERATED BY HIS OR HER ACCUMULATED RESOURCES IF THE AMOUNT OF SUCH INTEREST INCOME IS EXPECTED TO BE IMMATERIAL TO ELIGIBILITY UNDER THIS SECTION, AS DETERMINED BY THE COMMISSIONER OF HEALTH. IN THE EVENT THERE IS AN INCONSISTENCY BETWEEN THE INFORMATION REPORTED BY THE INDIVIDUAL AND ANY INFORMATION OBTAINED BY THE COMMISSIONER OF HEALTH FROM OTHER SOURCES

AND SUCH INCONSISTENCY IS MATERIAL TO ELIGIBILITY UNDER THIS SECTION, THE COMMISSIONER OF HEALTH SHALL REQUEST THAT THE INDIVIDUAL PROVIDE ADEQUATE DOCUMENTATION TO VERIFY HIS OR HER INTEREST INCOME.

S 48. Paragraph (d) of subdivision 5 of section 366-a of the social services law, as amended by section 1 of part R of chapter 58 of the laws of 2009, is amended to read as follows:

(d) In order to establish place of residence and income eligibility under this title at recertification, a recipient of assistance under this title shall attest to place of residence and to all information regarding the household's income that is necessary and sufficient to determine such eligibility; provided, however, that this paragraph shall not apply to persons described in subparagraph two of paragraph (a) of subdivision one of section three hundred sixty-six of this title, or to persons receiving long term care services, as defined in paragraph (b) of subdivision two of this section; and provided, further, that a non-applying legally responsible relative recertifying on behalf of a recipient of assistance who is under the age of twenty-one years shall be permitted to attest to household income under this paragraph only if the social security numbers of all legally responsible relatives are provided to the district. Provided, however, for purposes of recertification OF ELIGIBILITY for assistance under this title [for a recipient of], PERSONS RECEIVING medicaid COMMUNITY COVERAGE WITH COMMUNITY-BASED LONG TERM CARE, INCLUDING BUT NOT LIMITED TO waiver services provided or authorized by the office of mental retardation and developmental disabilities, beginning on or after January first, two thousand ten, [such recipient] may be permitted, as determined by the commissioner of health, to attest to place of residence and to all information regarding the household's income and/or resources that are necessary to [determine] RECERTIFY such eligibility.

S 49. Paragraph (a) of subdivision 4 of section 366 of the social services law, as amended by chapter 453 of the laws of 1990, subparagraph (i) as amended by section 59 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

(a) [(i)] Notwithstanding any other provision of law, each family which was eligible for medical assistance pursuant to subparagraph eight or nine of paragraph (a) of subdivision one of this section in at least [three] ONE of the six months immediately preceding the month in which such family became ineligible for such assistance because of hours of, or income from, employment of the caretaker relative, or because of loss of entitlement to the earnings disregard under subparagraph (iii) of paragraph (a) of subdivision eight of section one hundred thirty-one-a of this [chapter] ARTICLE shall, while such family includes a dependent child, remain eligible for medical assistance for [six] TWELVE calendar months immediately following the month in which such family would otherwise be determined to be ineligible for medical assistance pursuant to the provisions of this title and the regulations of the department governing income and resource limitations relating to eligibility determinations for families described in subparagraph eight of paragraph (a) of subdivision one of this section.

[(ii) Each family which received medical assistance for the entire six month period under subparagraph (i) of this paragraph and complied with the department's reporting requirements for such initial six month period shall be offered the option of extending such eligibility for an additional six calendar months if and for so long as such family includes a dependent child and meets the income requirements in subparagraph (ii) of paragraph (b) of this subdivision.]

S 50. Paragraph (b) of subdivision 4 of section 366 of the social services law, as added by chapter 453 of the laws of 1990, subparagraph (i) as amended by section 60 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

(b) (i) Upon giving notice of termination of medical assistance provided pursuant to subparagraph eight or nine of paragraph (a) of subdivision one of this section, the department shall notify each such family of its rights to extended benefits under paragraph (a) of this subdivision and describe [any reporting requirements and] the conditions under which such extension may be terminated. [The department shall also provide subsequent notices of the option to extend coverage pursuant to paragraph (a) of this subdivision in the third and sixth months of the initial six month extended coverage period and notices of the reporting requirements under such paragraph in each of the third and sixth months of the initial six month extended coverage period and in the third month of the additional extended coverage period.]

(ii) The department shall promulgate regulations implementing the requirements of this paragraph and paragraph (a) of this subdivision relating to the conditions under which [initial] extended coverage [and additional extended coverage] hereunder may be terminated, the scope of coverage, [the reporting requirements] and the conditions under which coverage may be extended pending a redetermination of eligibility. Such regulations shall, at a minimum, provide for: (A) termination of such coverage at the close of the first month in which the family ceases to include a dependent child [and at the close of the first or fourth month of the additional extended coverage period if the family fails to report, as required by the regulations, or the caretaker relative had no earnings in one or more of the previous three months unless such lack of earnings was for good cause, or the family's average gross monthly earnings, less necessary work related child care costs of the caretaker relative, during the preceding three months was greater than one hundred eighty-five percent of the federal income official poverty line applicable to the family's size]; (B) notice of termination prior to the effective date of any terminations; (C) [quarterly reporting of income and child care costs during the initial and additional extended coverage periods; (D)] coverage under employee health plans and health maintenance organizations; and [(E)] (D) disqualification of persons for extended coverage benefits under this paragraph for fraud.

S 51. Notwithstanding any inconsistent provision of section 112 or 163 of the state finance law or any other contrary provision of the state finance law or any other contrary provision of law, the commissioner of health may, without a competitive bid or request for proposal process, enter into contracts with one or more certified public accounting firms for the purpose of conducting audits of disproportionate share hospital payments made by the state of New York to general hospitals and for the purpose of conducting audits of hospital cost reports as submitted to the state of New York in accordance with article 28 of the public health law.

S 52. Section 17 of part C of chapter 58 of the laws of 2005 amending the public health law and other laws relating to implementing the state fiscal plan for the 2005-2006 state fiscal year, as added by section 21 of part E of chapter 63 of the laws of 2005, is amended to read as follows:

S 17. 1. Notwithstanding any inconsistent provision of law, rule or regulation, for payments made by a state governmental agency to a general hospital for specialty inpatient AND OUTPATIENT hospital services

provided to patients eligible for payments pursuant to title 11 of article 5 of the social services law discharged on or after April 1, 2005 through March 31, [2010] 2015, the commissioner of health, subject to the approval of the director of the budget, may:

(a) after a hospital has agreed to participate in a program selected pursuant to subdivision two of this section, establish rates of payment or special payment rate methodologies for specialty [inpatient] hospital services selected in accordance with subdivision two of this section provided to patients eligible for payments pursuant to title 11 of article 5 of the social services law through negotiations with hospitals in any area of the state. Such negotiated rates, if any, shall be negotiated with each individual selected hospital. Such negotiation shall include a process for the commissioner of health and each selected hospital to mutually identify services for which such negotiated rates shall apply. Such rates shall be reasonable and adequate to reimburse the costs of an economically and efficiently operated provider of services. The commissioner of health may establish adjusted rates of payment pursuant to an administrative rate appeal process to hospitals that participate in such negotiations and agree to receive the negotiated payment rates established under this paragraph for the patients described in this paragraph in lieu of rates of payment otherwise applicable pursuant to section 2807-c of the public health law without a competitive bid or request for proposal process; and/or

(b) select among hospitals in any area of the state those eligible for reimbursement for specialty [inpatient] hospital services selected in accordance with subdivision two of this section and establish payments for such services based on a competitive bidding process.

2. The commissioner of health shall select [a maximum of five geographically defined inpatient] hospital sites for which reimbursement may be negotiated for a maximum of [five] TEN specialty inpatient AND OUTPATIENT services that are selected based on the following criteria:

(a) such services may be provided more efficiently and economically; and

(b) there is a correlation between the volume of such services or procedures performed by [an inpatient] A hospital and improved patient outcomes that is accepted by medical experts in the field as evidenced by inclusion in peer reviewed scientific literature published and/or recognized by national organizations; and

(c) identification of such services and the implementation of this section with respect to such services is consistent with other initiatives to enhance the quality and patient outcomes of [inpatient] HOSPITAL services and procedures that are or are being planned to be undertaken by the department of health, including but not limited to projects that identify centers of excellence for particular services; and

(d) identification of such services for purposes of implementing this section will not diminish access, including geographic access, which for purposes of this section shall mean that a patient shall not be prevented from accessing services in a timely fashion due to distance or travel time; [and]

(e) [such services have low utilization or are provided in units with low occupancy; and

(f)] any other criteria determined by the commissioner of health to promote the cost effective delivery of specialty [inpatient] hospital services; AND

(F) CRITERIA UTILIZED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES WITH REGARD TO PAYMENT METHODOLOGIES UTILIZED WITH REGARD TO

CENTERS OF EXCELLENCE PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT (MEDICARE).

3. Selection of hospitals by the commissioner of health pursuant to subdivision two of this section shall be made based on the following criteria:

(a) Consultation with hospitals, hospital associations or other provider organizations, and consumers; and

(b) Assurances of patient access, including geographic access, to the selected specialty services; and

(c) Historical volume of services provided by the hospital; and

(d) Consistency with other quality and outcomes improvement initiatives being or planned to be pursued by the department of health, including but not limited to, projects that identify centers of excellence; and

(e) The order and timeline under which services identified pursuant to this section shall be provided; and

(f) Such other criteria that the commissioner of health may deem appropriate.

4. [Inpatient hospital] HOSPITAL services not selected by the commissioner of health pursuant to this section and not subject to negotiation under paragraph (a) of subdivision one of this section provided to patients eligible for payments pursuant to title 11 of article 5 of the social services law shall be reimbursed pursuant to [section] SECTIONS 2807 OR 2807-c of the public health law, AS APPLICABLE.

5. Notwithstanding any inconsistent provisions of law, rule or regulation, for purposes of this program, no payments within a geographically defined site shall be made for specialty [inpatient] hospital services selected by the commissioner of health in accordance with subdivision two of this section for which there is an adjusted rate of payment with a hospital pursuant to paragraph (a) or (b) of subdivision one of this section when such services are provided to patients eligible for payments pursuant to title 11 of article 5 of the social services law by a hospital which has not received adjusted rates of payment pursuant to paragraph (a) or (b) of subdivision one of this section; provided, however, payments may be made to such hospital in accordance with section 2807-c of the public health law if the provision of such services has been prior approved by the commissioner of health, or if the inpatient admission is a result of an emergency admission.

6. Payment of rates established pursuant to this section for purposes of this program shall be contingent upon federal approval of a waiver application submitted by the commissioner of health in order to receive federal financial participation for services provided under this section; provided, however, the commissioner of health shall provide a copy of such waiver application to the legislature prior to submission for federal approval. The commissioner of health may take any steps necessary to implement this section prior to receiving federal approval of such waiver application.

7. The commissioner of health shall report to the governor and the legislature concerning the implementation of this section, including available data regarding the cost effective delivery of specialty inpatient services selected in accordance with this section, within eighteen months from the date of issuance of adjusted rates of payment entered into pursuant to paragraphs (a) and (b) of subdivision one of this section.

S 53. Paragraph (q) of subdivision 2 of section 365-a of the social services law, as added by section 32 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(q) diabetes self-management training services for persons diagnosed with diabetes when such services are ordered by a physician, registered [physician's] PHYSICIAN assistant, registered nurse practitioner, or licensed midwife and provided by a licensed, registered, or certified health care professional, as determined by the commissioner of health, who is certified as a diabetes educator by the National Certification Board for Diabetes Educators, or a successor national certification board, OR PROVIDED BY SUCH A PROFESSIONAL WHO IS AFFILIATED WITH A PROGRAM CERTIFIED BY THE AMERICAN DIABETES ASSOCIATION, THE AMERICAN ASSOCIATION OF DIABETES EDUCATORS, THE INDIAN HEALTH SERVICES, OR ANY OTHER NATIONAL ACCREDITATION ORGANIZATION APPROVED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES; provided, however, that 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 health care services provided pursuant to this paragraph. Nothing in this paragraph shall be construed to modify any licensure, certification or scope of practice provision under title eight of the education law.

S 54. The opening paragraph of paragraph (i) of subdivision 1 of section 2807-c of the public health law, as amended by section 19 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state fiscal year thereafter through March thirty-first, two thousand [eleven,] NINE, AND FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE, PROVIDED, HOWEVER, THAT FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE THE AGGREGATE RATE ADJUSTMENTS CALCULATED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH SHALL NOT EXCEED FOUR MILLION DOLLARS, AND contingent upon the availability of federal financial participation:

S 55. The opening paragraph of paragraph (j) of subdivision 1 of section 2807-c of the public health law, as amended by section 19-a of part B of chapter 58 of the laws of 2008, is amended to read as follows:

For the rate period July first, two thousand seven through March thirty-first, two thousand eight and for rates applicable to the state fiscal year commencing April first, two thousand eight, and each state fiscal year thereafter through March thirty-first, two thousand [eleven,] NINE AND FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE, PROVIDED, HOWEVER, THAT FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE THE AGGREGATE RATE ADJUSTMENTS CALCULATED PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH SHALL NOT EXCEED TWENTY-EIGHT MILLION DOLLARS, AND contingent upon the availability of federal financial participation:

S 56. The opening paragraph of paragraph (1) of subdivision 1 of section 2807-c of the public health law, as added by section 65-f of part A of chapter 58 of the laws of 2007, is amended to read as follows:

Effective for periods on and after July first, two thousand seven THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE:

S 57. Paragraph (a) of subdivision 32 of section 2807-c of the public health law, as amended by section 1 of part U of chapter 57 of the laws of 2007, is amended to read as follows:

(a) The commissioner shall adjust inpatient medical assistance rates of payment established pursuant to this section for rural hospitals as defined in paragraph (c) of subdivision one of section twenty-eight hundred seven-w of this article in accordance with paragraph (b) of this subdivision for purposes of supporting critically needed health care services in rural areas in the following aggregate amounts for the following periods:

seven million dollars for the period May first, two thousand five through December thirty-first, two thousand five, seven million dollars for the period January first, two thousand six through December thirty-first, two thousand six, seven million dollars for the period April first, two thousand seven through December thirty-first, two thousand seven, [and] seven million dollars for [each] calendar year [thereafter] TWO THOUSAND EIGHT, AND SIX MILLION FOUR HUNDRED SEVENTEEN THOUSAND DOLLARS FOR THE PERIOD JANUARY FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE.

S 58. Subparagraph (ii) of paragraph (k) of subdivision 1 of section 2807-c of the public health law, as amended by section 30-a of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(ii) for the period April first, two thousand eight through March thirty-first, two thousand nine, and each state fiscal year thereafter through [March thirty-first, two thousand eleven] NOVEMBER THIRTIETH, TWO THOUSAND NINE, thirty-eight million dollars shall be allocated ON AN ANNUALIZED BASIS for such purpose to such hospitals in accordance with [regulations promulgated by the commissioner and which shall provide] THE METHODOLOGY SET FORTH IN SUBPARAGRAPH (I) OF THIS PARAGRAPH, PROVIDED, HOWEVER, that [up to] thirty percent of such funds shall be allocated proportionally, based on the number of foreign languages utilized by one or more percent of the residents in each hospital total service area population, PROVIDED, HOWEVER, THAT FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH NOVEMBER THIRTIETH, TWO THOUSAND NINE, SUCH ALLOCATION SHALL BE REDUCED TO TWENTY-FIVE MILLION THREE HUNDRED THIRTY-THREE THOUSAND DOLLARS.

S 59. The opening paragraph and subparagraphs (i) and (ii) of paragraph (e-1) of subdivision 4 of section 2807-c of the public health law, as added by section 12 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

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] ASSOCIATED WITH ADMISSIONS occurring on and after [December first, two thousand nine,] APRIL FIRST, TWO THOUSAND TEN, be in accordance with the following:

(i) For rate periods on and after [December first, two thousand nine] APRIL 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] JULY FIRST, TWO THOUSAND NINE 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.

(ii) Rates of payment established pursuant to subparagraph [(ii)] (I) of this paragraph shall reflect an aggregate net statewide increase in reimbursement for such services of up to twenty-five million dollars on an annual basis.

S 60. Paragraph (u) of subdivision 2 of section 365-a of the social services law, as added by section 27 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(u) screening, brief intervention, and referral to treatment in hospital OUTPATIENT AND emergency departments AND FREE-STANDING DIAGNOSTIC AND TREATMENT CENTERS of individuals at risk for substance abuse including referral to the appropriate level of intervention and treatment in a community setting; provided, however, that the provisions of this paragraph relating to screening, brief intervention, and referral to treatment services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in such costs.

S 61. Subparagraph (ii) of paragraph (f) of subdivision 2-a of section 2807 of the public health law, as amended by section 16-a of part C of chapter 58 of the laws of 2009, 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] TWENTY-ONE 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;

(F) WHEELCHAIR EVALUATION SERVICES AND EYEGLASS DISPENSING SERVICES; AND

(G) IMMUNIZATION SERVICES, EFFECTIVE FOR SERVICES RENDERED ON AND AFTER JUNE TENTH, TWO THOUSAND NINE.

S 62. Clauses (A) and (B) of subparagraph (iii) of paragraph (g) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(A) for the period December first, two thousand nine through March thirty-first, two thousand ten, up to [seventy-five] THIRTY-THREE million FIVE HUNDRED THOUSAND dollars;

(B) for the period April first, two thousand ten through March thirty-first, two thousand eleven, up to [thirty-three] SEVENTY-FIVE million [five hundred thousand] dollars, PROVIDED, HOWEVER, THAT, NOTWITHSTANDING SUBPARAGRAPH (II) OF THIS PARAGRAPH, NO FACILITY SHALL RECEIVE AN AMOUNT PURSUANT TO THIS CLAUSE THAT IS LESS THAN SUCH FACILITY RECEIVED PURSUANT TO CLAUSE (A) OF THIS SUBPARAGRAPH;

S 63. Intentionally omitted.

S 64. Subparagraphs (i) and (ii) of paragraph (b) of subdivision 2-a of section 2807 of the public health law, as amended by section 14 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(i) for the period [March] SEPTEMBER first, two thousand nine through [December first] NOVEMBER 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] DECEMBER first, two thousand [ten] NINE through December thirty-first, 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;

S 65. Paragraph (s) of subdivision 2 of section 365-a of the social services law, as added by section 27 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(s) smoking cessation counseling services for pregnant women on any day of pregnancy through the end of the month in which the one hundred eightieth day following the end of the pregnancy occurs, and children

and adolescents ten to [nineteen] TWENTY years of age, during a medical visit when provided by a general hospital outpatient department or a free-standing clinic, or by a physician, registered physician's assistant, registered nurse practitioner or licensed midwife in office-based settings; provided, however, that the provisions of this paragraph relating to smoking cessation counseling services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

S 66. Subdivision 2-a of section 2807 of the public health law is amended by adding a new paragraph (f-1) to read as follows:

(F-1) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER MAY WITH THE APPROVAL OF THE DIRECTOR OF THE BUDGET, FOR PERIODS PRIOR TO TWO THOUSAND TWELVE, ESTABLISH RATES OF PAYMENTS FOR SELECTED PATIENT SERVICE CATEGORIES THAT ARE BASED ENTIRELY UPON THE AMBULATORY PATIENT GROUPS METHODOLOGY AS AUTHORIZED PURSUANT TO PARAGRAPH (E) OF THIS SUBDIVISION.

S 67. Subdivision 7-a of section 101 of part A of chapter 57 of the laws of 2006, amending the social services law relating to medically fragile children, as amended by section 65 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

7-a. Sections fifty-eight, fifty-eight-a and fifty-eight-b shall take effect January 1, 2007 [and shall expire and be deemed repealed January 1, 2011].

S 67-a. Paragraph (d) of subdivision 3 of section 367-a of the social services law, as added by chapter 33 of the laws of 1998, subparagraphs 1 and 2 as amended by section 2 of part G of chapter 23 of the laws of 2002, is amended to read as follows:

(d) (1) Beginning April first, two thousand two and to the extent that federal financial participation is available at a one hundred percent federal Medical assistance percentage and subject to sections 1933 and 1902(a)(10)(E)(iv) of the federal social security act, medical assistance shall be available for full payment of medicare part B premiums for individuals (referred to as qualified individuals 1) who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income exceeds the income level established by the state and is at least one hundred twenty percent, but less than one hundred thirty-five percent, of the federal poverty level, for a family of the size involved and who are not otherwise eligible for medical assistance under the state plan;

(2) [Beginning April first, two thousand two and to the extent that federal financial participation is available at a one hundred percent federal Medical assistance percentage and subject to sections 1933 and 1902(a)(10)(E)(iv) of the federal social security act, medical assistance shall be available for payment of that portion of the medicare part B premium increase that is attributable to the operation of the amendments made by section 4611(e)(3) of the balanced budget act of 1997, for individuals (referred to as qualified individuals 2) who are entitled to hospital insurance benefits under part A of title XVIII of the federal social security act and whose income exceeds the income level established by the state and is at least one hundred thirty-five percent, but less than one hundred seventy-five percent, of the federal poverty level, for a family of the size involved and who are not otherwise eligible for medical assistance under the state plan;

(3)] Premium payments for the individuals described in [subparagraphs] SUBPARAGRAPH one [and two] of this paragraph will be one hundred percent

federally funded up to the amount of the federal allotment. The department shall discontinue enrollment into the program when the part B premium payments made pursuant to [such paragraphs] SUBPARAGRAPH ONE OF THIS PARAGRAPH meet the yearly federal allotment.

[(4)] (3) The commissioner of health shall develop a simplified application form, consistent with federal law, for payments pursuant to this section. The commissioner of health, in cooperation with the office for the aging, shall publicize the availability of such payments to medicare beneficiaries.

S 68. Section 2 of chapter 33 of the laws of 1998, amending the social services law relating to authorizing payment of medicare part B premiums to certain medicaid recipients, as amended by chapter 415 of the laws of 2008, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 1998[, provided, however that such provisions shall expire and be deemed repealed December 31, 2010].

S 69. Intentionally omitted.

S 70. 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 71. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 72. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgement shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 73. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, provided that:

(a) section twelve of this act shall take effect June 1, 2010; sections thirty-two and thirty-three of this act shall take effect July 1, 2010; and sections twenty-six, twenty-seven, twenty-eight, twenty-nine, thirty and thirty-seven of this act shall take effect January 1, 2011;

(b) 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;

(c) 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;

(d) 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;

(e) 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;

(f) 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;

(g) the amendments to subdivision 8 of section 272 of the public health law made by section eleven of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(h) the amendments to subparagraph (ii) of paragraph (b) of subdivision 9 of section 367-a of the social services law made by section thirteen of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(i) the amendments to section 2807-j of the public health law made by sections sixteen and forty-five of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(j) the amendments to section 2807-s of the public health law made by section twenty of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(k) the amendments to subdivision 7 of section 2510 of the public health law made by section thirty-two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(l) the amendments to article 2-A of the public health law made by section thirty-eight of this act shall not affect the repeal of such article and shall be deemed repealed therewith;

(m) the amendments to subdivision 1 of section 2802-a of the public health law made by section forty-one of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(n) sections forty-six through forty-six-i of this act shall expire and be deemed repealed on and after March 31, 2011; and

(o) the amendments to paragraph (d) of subdivision 3 of section 367-a of the social services law made by section sixty-seven-a of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith.

PART C

Section 1. Subdivision 17 of section 2808 of the public health law, as added by chapter 433 of the laws of 1997, is amended to read as follows:

17. (A) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-eight, the commissioner shall not be required to revise a certified rate of payment established pursuant to this article based on consideration of rate appeals filed by a residential health care facility or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article. For the period April first, nineteen hundred ninety-eight, through March thirty-first, nineteen hundred nine-

ty-nine, the commissioner shall revise certified rates of payment in an aggregate amount not to exceed twenty million dollars, state share medical assistance. In cases where the commissioner determines that a significant financial hardship exists, he or she may, subject to the approval of the director of the budget, consider an exemption to this subdivision. Beginning April first, nineteen hundred ninety-nine and thereafter, the commissioner shall consider such rate appeals within a reasonable period.

(B) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION TO THE CONTRARY, FOR STATE FISCAL YEAR PERIODS BEGINNING APRIL FIRST, TWO THOUSAND TEN AND ENDING MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, THE COMMISSIONER SHALL NOT BE REQUIRED TO REVISE CERTIFIED RATES OF PAYMENT ESTABLISHED PURSUANT TO THIS ARTICLE FOR RATE PERIODS PRIOR TO APRIL FIRST, TWO THOUSAND TWELVE, BASED ON CONSIDERATION OF RATE APPEALS FILED BY RESIDENTIAL HEALTH CARE FACILITIES OR BASED UPON ADJUSTMENTS TO CAPITAL COST REIMBURSEMENT AS A RESULT OF APPROVAL BY THE COMMISSIONER OF AN APPLICATION FOR CONSTRUCTION UNDER SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, IN EXCESS OF AGGREGATE ANNUAL AMOUNTS OF EIGHTY MILLION DOLLARS FOR EACH SUCH STATE FISCAL YEAR. IN REVISING SUCH RATES WITHIN SUCH FISCAL LIMITS THE COMMISSIONER MAY PRIORITIZE RATE APPEALS FOR FACILITIES WHICH THE COMMISSIONER DETERMINES ARE FACING SIGNIFICANT FINANCIAL HARDSHIP AND, FURTHER, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO AGREEMENTS WITH SUCH FACILITIES TO RESOLVE MULTIPLE PENDING RATE APPEALS BASED UPON A NEGOTIATED AGGREGATE AMOUNT AND MAY OFFSET SUCH NEGOTIATED AGGREGATE AMOUNTS AGAINST ANY AMOUNTS OWED BY THE FACILITY TO THE DEPARTMENT, INCLUDING, BUT NOT LIMITED TO, AMOUNTS OWED PURSUANT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE. RATE ADJUSTMENTS MADE PURSUANT TO THIS PARAGRAPH REMAIN FULLY SUBJECT TO APPROVAL BY THE DIRECTOR OF THE BUDGET IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION TWO OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE.

S 2. Section 2808 of the public health law is amended by adding a new subdivision 25 to read as follows:

25. RESERVED BED DAYS. (A) FOR PURPOSES OF THIS SUBDIVISION, A "RESERVED BED DAY" IS A DAY FOR WHICH A GOVERNMENTAL AGENCY PAYS A RESIDENTIAL HEALTH CARE FACILITY TO RESERVE A BED FOR A PERSON ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW WHILE HE OR SHE IS TEMPORARILY HOSPITALIZED OR ON LEAVE OF ABSENCE FROM THE FACILITY.

(B) NOTWITHSTANDING ANY OTHER PROVISIONS OF THIS SECTION OR ANY OTHER LAW OR REGULATION TO THE CONTRARY, FOR RESERVED BED DAYS PROVIDED ON BEHALF OF PERSONS TWENTY-ONE YEARS OF AGE OR OLDER:

(I) PAYMENTS FOR RESERVED BED DAYS SHALL BE MADE AT NINETY-FIVE PERCENT OF THE MEDICAID RATE OTHERWISE PAYABLE TO THE FACILITY FOR SERVICES PROVIDED ON BEHALF OF SUCH PERSON;

(II) PAYMENT TO A FACILITY FOR RESERVED BED DAYS PROVIDED ON BEHALF OF SUCH PERSON FOR TEMPORARY HOSPITALIZATIONS MAY NOT EXCEED FOURTEEN DAYS IN ANY TWELVE MONTH PERIOD;

(III) PAYMENT TO A FACILITY FOR RESERVED BED DAYS PROVIDED ON BEHALF OF SUCH PERSON FOR NON-HOSPITALIZATION LEAVES OF ABSENCE MAY NOT EXCEED TEN DAYS IN ANY TWELVE MONTH PERIOD.

S 3. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 37 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each resi-

dential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand [eleven] TEN, such assessment shall be six percent, AND PROVIDED FURTHER, HOWEVER, THAT ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, SUCH ASSESSMENT SHALL BE SEVEN PERCENT.

S 4. Paragraph (c) of subdivision 10 of section 2807-d of the public health law, as amended by section 2 of part H of chapter 686 of the laws of 2003, is amended to read as follows:

(c) provided, however, that for the purposes of determining rates of payment pursuant to this article for residential health care facilities, the assessment imposed pursuant to subparagraph (vi) of paragraph (b) of subdivision two of this section shall be a reimbursable cost to be reflected as timely as practicable, and subsequently reconciled to actual cost, in rates of payment applicable within the assessment period, PROVIDED, HOWEVER, THAT SUCH ASSESSMENTS IN EXCESS OF SIX PERCENT SHALL NOT BE A REIMBURSABLE COST FOR THE PURPOSES OF DETERMINING MEDICAID RATES OF PAYMENT.

S 5. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 3 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(i) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine through [March thirty-first, two thousand ten] FEBRUARY TWENTY-EIGHTH, TWO THOUSAND ELEVEN the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which do not receive a per diem add-on adjustment pursuant to subparagraph (ii) of paragraph (a) of this subdivision, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which did not receive a per diem adjustment in accordance with subparagraph (ii) of paragraph (a) of this subdivision shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utiliz-

ing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

S 5-a. The opening paragraph and subparagraph (vi) of paragraph (a), and subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, as added by section 5 of part D of chapter 58 of the laws of 2009, are amended to read as follows:

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 by residential health care facilities on and after [April first, two thousand ten] MARCH FIRST, TWO THOUSAND ELEVEN shall be determined in accordance with the following; PROVIDED, HOWEVER, THAT THE PROVISIONS OF PARAGRAPH (D) OF THIS SUBDIVISION SHALL BE EFFECTIVE ON AND AFTER APRIL FIRST, TWO THOUSAND TEN:

(vi) Notwithstanding subparagraph (i) of this paragraph, the operating cost component of the rates, effective [April first, two thousand ten] MARCH FIRST, TWO THOUSAND ELEVEN for the following categories of facilities, as established pursuant to applicable regulations, shall reflect the rates in effect for such facilities on [March thirty-first, two thousand ten] FEBRUARY TWENTY-EIGHTH, TWO THOUSAND ELEVEN, as adjusted for inflation in accordance with applicable statutes: (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.

(i) Subject to the availability of federal financial participation, the commissioner is authorized to establish a quality of care incentive pool or pools for eligible residential health care facilities and increase Medicaid rates of payment for such eligible facilities from this pool or pools IN AGGREGATE AMOUNTS OF UP TO FIFTY MILLION DOLLARS FOR THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND TEN AND WITHIN AMOUNTS APPROPRIATED FOR EACH STATE FISCAL YEAR THEREAFTER. Within amounts available, 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, survey information, direct care staffing, including labor costs, and other facility data.

S 5-b. Section 2 of part D of chapter 58 of the laws of 2009, amending the public health law and other laws relating to Medicaid reimbursements to residential health care facilities, is amended to read as follows:

S 2. Notwithstanding paragraph (b) of subdivision 2-b of section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to medicaid rates of payment for inpatient services provided by residential health care facilities for the period April 1, 2009 through March 31, 2010, made pursuant to paragraph (b) of subdivision 2-b of section 2808 of the public health law, the commissioner of health and the director of the budget shall, upon a determi-

nation that such adjustments, including the application of adjustments authorized by the provisions of paragraph (g) of subdivision 2-b of section 2808 of the public health law, shall result in an aggregate increase in total Medicaid rates of payment for such services for such period that is less than or more than two hundred ten million dollars ($210,000,000), make such proportional adjustments to such rates as are necessary to result in an increase of such aggregate expenditures of two hundred ten million dollars ($210,000,000), [and provided further, however, that the operating component of such rates for the period April 1, 2009 through March 31, 2010 shall not be subject to case mix adjustments pursuant to subparagraph (ii) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as otherwise scheduled pursuant to such subparagraph for January of 2010,] and provided further, however, that notwithstanding [subdivision 2-c of] section 2808 of the public health law or any other contrary provision of law, with regard to adjustments to inpatient rates of payment made pursuant to [subdivision 2-c of] section 2808 of the public health law for inpatient services provided by residential health care facilities for the period April 1, 2010 through March 31, 2011, the commissioner of health and the director of the budget shall, upon a determination by such commissioner and such director that such rate adjustments shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in total Medicaid rates of payment for such services, INCLUDING PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (I) OF PARAGRAPH (D) OF SUBDIVISION 2-C OF SECTION 2808 OF THE PUBLIC HEALTH LAW, make such proportional adjustments to such rates as are necessary to reduce such total aggregate rate adjustments such that the aggregate total reflects no such increase OR DECREASE, AND PROVIDED FURTHER, HOWEVER, THE CASE MIX ADJUSTMENTS AS OTHERWISE AUTHORIZED BY SUBPARAGRAPH (II) OF PARAGRAPH (B) OF SUBDIVISION 2-B OF SECTION 2808 OF THE PUBLIC HEALTH LAW AND AS SCHEDULED FOR JANUARY OF 2011 SHALL NOT BE MADE. Adjustments made pursuant to this section shall not be subject to subsequent correction or reconciliation.

S 5-c. Section 48 of part C of chapter 109 of the laws of 2006, amending the social services law and other laws relating to the Medicaid reimbursement rate settings, as amended by section 6 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

S 48. Notwithstanding any contrary provision of law, the commissioner of health shall, by no later than May 15, 2007, establish a workgroup pertaining to Medicaid reimbursement rate-setting for residential health care facilities for future periods, including, but not limited to, the following areas:

(a) operating costs that should be considered allowable in the development of regional prices;

(b) identification of appropriate cost differentials among facilities based on factors including, but not limited to, size, affiliation, location, public versus non-public, facility layout, culture exchange initiatives and labor costs, including the most appropriate mechanism to adjust rates of payment to reflect appropriate cost differentials related to direct care staffing, including adjustments to the direct component of the operating cost component of such rate, establishment of a quality care incentive pool pursuant to subdivision [(2-c)] 2-C of section 2808 of the public health law or other mechanisms;

(c) reimbursement for facilities providing care to specialized populations with specialized care needs;

(d) the relationship between facility spending on various costs and quality of care and patient outcomes;

(e) appropriate regions to be utilized;
(f) the reasons underlying the existing proportion of Medicaid patients to non-Medicaid patients in New York facilities;
(g) issues related to Medicare;
(h) impact of planned rightsizing of the acute care system;
(i) impact of planned rightsizing of nursing home system;
(j) impact of using Medicaid only case mix; and
(k) other issues as determined by the commissioner.

The members of the workgroup shall include department of health staff and representatives of statewide associations representing the residential health care facility industry in New York, organizations representing employees, and, by May thirty-first, two thousand nine, advocates for residential health care facility residents and representatives of regional associations representing the residential health care facility industry in New York. The workgroup shall work in consultation with the assembly and the senate. The commissioner of health shall appoint the chair of the workgroup and designate such employees of the department of health as are reasonably necessary to provide necessary data and support services to the workgroup. The commissioner of health shall submit an interim report summarizing the workgroup's deliberations and the commissioner of health's recommendations to the governor, the temporary president of the senate, the speaker of the assembly, and the minority leaders of the senate and the assembly by [December fifteenth, two thousand nine] JULY 1, 2010, and a subsequent report shall be submitted to these individuals no later than [February fifteenth, two thousand ten] NOVEMBER 1, 2010. The workgroup shall continue until December thirty-first, two thousand ten to evaluate the implementation of the new system.

S 6. Section 2808 of the public health law is amended by adding a new subdivision 26 to read as follows:

26. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, RESIDENTIAL HEALTH CARE FACILITY MEDICAID RATES OF PAYMENT SHALL NOT INCLUDE REIMBURSEMENT FOR THE COST OF PRESCRIPTION DRUGS. SUCH REIMBURSEMENT SHALL BE IN ACCORDANCE WITH OTHERWISE APPLICABLE PROVISIONS OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THE SOCIAL SERVICES LAW.

S 7. Paragraph (c) of subdivision 2 of section 3614-a of the public health law, as added by section 1 of part B of chapter 58 of the laws of 2009, is amended 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 thirty-five hundredths 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 April first, two thousand nine, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, SUCH ASSESSMENT FOR SUCH SERVICES SHALL BE SEVEN TENTHS OF ONE PERCENT OF EACH AGENCY'S OR PROVIDER'S GROSS RECEIPTS.

S 8. Subdivision 6 of section 3614-a of the public health law is amended by adding a new paragraph (g) to read as follows:

(G) DELINQUENT AMOUNTS WHICH HAVE BEEN REFERRED FOR RECOUPMENT OR OFFSET PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION, OR WHICH HAVE BEEN REFERRED TO THE OFFICE OF THE ATTORNEY GENERAL FOR COLLECTION, SHALL BE DEEMED FINAL AND NOT SUBJECT TO FURTHER REVISION OR RECONCILIATION BY THE COMMISSIONER BASED ON ANY ADDITIONAL REPORTS OR OTHER INFORMATION SUBMITTED BY THE AGENCY OR PROVIDER, PROVIDED, HOWEVER, THAT SUCH DELIN-

QUENCIES SHALL NOT BE REFERRED FOR SUCH RECOUPMENT OR FOR SUCH COLLECTION BASED ON ESTIMATED AMOUNTS UNLESS THE AGENCY OR THE PROVIDER HAS RECEIVED WRITTEN NOTIFICATION OF SUCH DELINQUENCIES AND HAS BEEN GIVEN NO LESS THAN THIRTY DAYS IN WHICH TO SUBMIT DELINQUENT REPORTS.

S 9. Paragraph (b) of subdivision 2 of section 3614-b of the public health law, as added by section 3 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(b) Notwithstanding any contrary provisions of this section or any other contrary provision of law or regulation, the assessment shall be thirty-five hundredths 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 April first, two thousand nine, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, SUCH ASSESSMENT FOR SUCH SERVICES SHALL BE SEVEN TENTHS OF ONE PERCENT OF EACH SUCH LICENSED HOME CARE SERVICES AGENCY'S GROSS RECEIPTS.

S 10. Subdivision 6 of section 3614-b of the public health law is amended by adding a new paragraph (g) to read as follows:

(G) DELINQUENT AMOUNTS WHICH HAVE BEEN REFERRED FOR RECOUPMENT OR OFFSET PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION, OR WHICH HAVE BEEN REFERRED TO THE OFFICE OF THE ATTORNEY GENERAL FOR COLLECTION, SHALL BE DEEMED FINAL AND NOT SUBJECT TO FURTHER REVISION OR RECONCILIATION BY THE COMMISSIONER BASED ON ANY ADDITIONAL REPORTS OR OTHER INFORMATION SUBMITTED BY THE AGENCY, PROVIDED, HOWEVER, THAT SUCH DELINQUENCIES SHALL NOT BE REFERRED FOR SUCH RECOUPMENT OR FOR SUCH COLLECTION BASED ON ESTIMATED AMOUNTS UNLESS THE AGENCY HAS RECEIVED WRITTEN NOTIFICATION OF SUCH DELINQUENCIES AND HAS BEEN GIVEN NO LESS THAN THIRTY DAYS IN WHICH TO SUBMIT DELINQUENT REPORTS.

S 11. Paragraph (b) of subdivision 2 of section 367-i of the social services law, as added by section 4 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

(b) Notwithstanding any contrary provisions of this section or any other contrary provision of law or regulation, the assessment shall be thirty-five hundredths 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 April first, two thousand nine, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND TEN, SUCH ASSESSMENT FOR SUCH SERVICES SHALL BE SEVEN TENTHS OF ONE PERCENT OF EACH SUCH PROVIDER'S GROSS RECEIPTS.

S 12. Subdivision 6 of section 367-i of the social services law is amended by adding a new paragraph (f) to read as follows:

(F) DELINQUENT AMOUNTS WHICH HAVE BEEN REFERRED FOR RECOUPMENT OR OFFSET PURSUANT TO PARAGRAPH (C) OF SUBDIVISION FIVE OF THIS SECTION, OR WHICH HAVE BEEN REFERRED TO THE OFFICE OF THE ATTORNEY GENERAL FOR COLLECTION, SHALL BE DEEMED FINAL AND NOT SUBJECT TO FURTHER REVISION OR RECONCILIATION BY THE COMMISSIONER OF HEALTH BASED ON ANY ADDITIONAL REPORTS OR OTHER INFORMATION SUBMITTED BY THE PROVIDER, PROVIDED, HOWEVER, THAT SUCH DELINQUENCIES SHALL NOT BE REFERRED FOR SUCH RECOUPMENT OR FOR SUCH COLLECTION BASED ON ESTIMATED AMOUNTS UNLESS THE PROVIDER HAS RECEIVED WRITTEN NOTIFICATION OF SUCH DELINQUENCIES AND HAS BEEN GIVEN NO LESS THAN THIRTY DAYS IN WHICH TO SUBMIT DELINQUENT REPORTS.

S 13. Paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(e) (I) personal care services, including personal emergency response services, shared aide and an individual aide, WHICH, FOR INDIVIDUALS WHO

HAVE ATTAINED THE AGE OF TWENTY-ONE, AND SUBJECT TO THE PROVISIONS OF SUBPARAGRAPH (II) OF THIS PARAGRAPH, SHALL NOT EXCEED AN AVERAGE OF TWELVE HOURS PER DAY IN ANY AUTHORIZATION PERIOD, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance [when cost effective and appropriate in accordance with section three hundred sixty-seven-k and section three hundred sixty-seven-o of this title], and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(II) MEDICALLY NECESSARY PERSONAL CARE SERVICES THAT EXCEED AN AVERAGE OF TWELVE HOURS PER DAY IN ANY AUTHORIZATION PERIOD MAY BE PROVIDED TO AN INDIVIDUAL WHO IS RECEIVING SERVICES FROM A CERTIFIED HOME HEALTH AGENCY, OR IS ENROLLED IN THE LONG TERM HOME HEALTH CARE PROGRAM, A MANAGED LONG TERM CARE PLAN, THE AIDS HOME CARE PROGRAM, OR THE NURSING HOME TRANSITION AND DIVERSION WAIVER, IN ACCORDANCE WITH THE TERMS OF THOSE PROGRAMS.

S 13-a. Section 365-f of the social services law is amended by adding a new subdivision 2-a to read as follows:

2-A. PERSONAL CARE SERVICES PROVIDED UNDER THIS SECTION TO AN INDIVIDUAL WHO HAS ATTAINED THE AGE OF TWENTY-ONE, AND WHO IS NOT RECEIVING SUCH SERVICES FROM A CERTIFIED HOME HEALTH AGENCY, A LONG TERM HOME HEALTH CARE PROGRAM, OR AN AIDS HOME CARE PROGRAM, SHALL NOT EXCEED AN AVERAGE OF TWELVE HOURS PER DAY IN ANY AUTHORIZATION PERIOD.

S 13-b. Subdivision 6-a of section 366 of the social services law is amended by adding a new paragraph i to read as follows:

I. NOTWITHSTANDING THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION AND THE AGGREGATE COST PROVISION OF PARAGRAPH A OF THIS SUBDIVISION, A PERSON MAY PARTICIPATE IN THE NURSING HOME TRANSITION AND DIVERSION PROGRAM SPECIFIED IN THIS SUBDIVISION IF THE PERSON: HAS A MEDICAL NEED FOR SERVICES THAT ARE DESCRIBED IN PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE OR IN SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE BUT THAT EXCEED A LIMIT IMPOSED BY SUCH PROVISIONS; AND IS OTHERWISE INELIGIBLE FOR, OR IS UNABLE TO ACCESS, LONG-TERM COMMUNITY-BASED SERVICES AVAILABLE UNDER THIS TITLE; AND OTHERWISE MEETS THE CRITERIA FOR PARTICIPATION SET FORTH IN THIS SUBDIVISION.

S 14. 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 TWELVE, PAYMENTS BY GOVERNMENT AGENCIES FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES, EXCEPT FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND OTHER DISCRETE GROUPS AS MAY BE DETERMINED BY THE COMMISSIONER PURSUANT TO REGULATIONS, SHALL BE BASED ON EPISODIC PAYMENTS. IN ESTABLISHING SUCH PAYMENTS, THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE FINDINGS OF THE HOME HEALTH CARE REIMBURSEMENT WORKGROUP ESTABLISHED PURSUANT TO SECTION ONE HUNDRED TWENTY-FIVE-D OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND NINE; PROVIDED FURTHER THAT A BASE PRICE SHALL BE ESTABLISHED FOR EACH EPISODE OF CARE AND ADJUSTED BY A WAGE INDEX FACTOR AND AN INDIVIDUAL PATIENT CASE MIX INDEX. SUCH EPISODIC PAYMENTS MAY BE FURTHER ADJUSTED FOR LOW AND 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 APPLICABLE TREND FACTOR ADJUSTMENTS. THE COMMISSIONER MAY REQUIRE AGENCIES TO COLLECT AND SUBMIT ANY DATA REQUIRED TO IMPLEMENT THIS SUBDIVISION. THE COMMISSIONER MAY PROMULGATE REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

(B) WITHIN AMOUNTS APPROPRIATED AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER SHALL ESTABLISH AN INCENTIVE POOL FOR RATE ADJUSTMENTS TO ELIGIBLE AGENCIES THAT MEET QUALITY MEASURES, AS ESTABLISHED BY THE COMMISSIONER. SUCH PAYMENTS SHALL BE MADE IN THE FORM OF ADJUSTMENTS TO MEDICAID RATES OF PAYMENT FOR SERVICES PROVIDED BY AGENCIES MEETING SUCH QUALITY MEASURES.

S 15. Subdivision 2 of section 3616 of the public health law, as amended by chapter 622 of the laws of 1988, is amended to read as follows:

2. Continued provision of a long term home health care program, AIDS home care program or certified home health agency services paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least every one hundred [twenty] EIGHTY days by the provider of a long term home health care program, AIDS home care program or the certified home health agency providing services for the patient and the local department of social services, and shall be reviewed by a physician charged with the responsibility by the commissioner. The commissioner shall prescribe the forms on which the assessment will be made.

S 16. Notwithstanding any provision of law or regulation to the contrary, and subject to the availability of federal financial participation, the commissioner of health shall establish procedures to permit long-term home health care programs and providers of other services covered pursuant to federal waivers, or which provide case management services, to collaborate to jointly serve individuals when the services of both entities are necessary to meet such an individual's needs; provided, however, that such entities shall maintain distinct yet coordinated service and case management responsibilities and shall not duplicate benefits.

S 17. Intentionally omitted.

S 18. Subdivision 3 of section 3612 of the public health law, as amended by chapter 606 of the laws of 2003, is amended to read as follows:

3. Any organization which provides or makes available any home care services to the public in this state, in any organized program developed or rendered under its auspices or provided under contract with any such organization, shall submit annually to the commissioner a complete description of its operation, including name, address, location or principal place of business, ownership, identification of administrative personnel responsible for home care services programs, the nature and extent of such programs, and such other information as the commissioner shall require. For certified home health agencies and licensed home care services agencies such annual report shall include reports on the type, frequency and reimbursement for services provided, including reimbursement from federal and state governmental agencies. The commissioner shall determine the form and content of the information compiled and the annual date for submission of such information. The commissioner shall require certified home health agencies to provide all information necessary to a licensed home care services agency sub-contracting with such

certified home health agency, to allow such licensed home care services agency to file its annual report. The commissioner shall make such information available to the appropriate governmental agencies of the state, the counties and the city of New York so as to make known the availability of home care services to provide data for planning for health needs of the people of the state. This information shall be available to the public and to the health systems agencies. ANY ORGANIZATION SUBJECT TO THE REPORTING REQUIREMENTS OF THIS SUBDIVISION SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS FOR EACH VIOLATION OF SUCH REQUIREMENTS. SUCH PENALTY MAY BE RECOVERED BY AN ACTION BROUGHT BY THE COMMISSIONER IN ANY COURT OF COMPETENT JURISDICTION.

S 19. Federal-state Medicare shared savings partnership program. Notwithstanding any provision of law to the contrary, the commissioner of health shall seek federal approval for the establishment of a federal-state Medicare shared savings partnership program. Such program may include, among others, the following features: (a) an incentive through shared savings to the state for achieving federal cost-savings and efficiencies to Medicare, such as from reduced expenditures for hospital, long-term care and other medical care provided to beneficiaries eligible for both Medicare and Medicaid, which result from state initiatives in the care and management of such beneficiaries; such incentive shall provide for a reinvestment of a portion of such federal savings into the state's health care system; (b) acceptance of risk by the state for the delivery and financing of Medicare-covered services; and (c) an incentive to permit providers of medical services to share in demonstrated Medicare savings.

S 20. The social services law is amended by adding a new section 366-i to read as follows:

S 366-I. LONG-TERM CARE FINANCING DEMONSTRATION PROGRAM. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS THREE HUNDRED SIXTY-SIX OR THREE HUNDRED SIXTY-SIX-C OF THIS TITLE, OR ANY OTHER PROVISION OF LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO DEVELOP THE LONG-TERM CARE FINANCING DEMONSTRATION PROGRAM, AN ALTERNATIVE PROGRAM FOR THE ESTABLISHMENT OF ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM FOR UP TO FIVE THOUSAND PERSONS.

2. THE PROVISIONS OF THIS SECTION 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 HEALTH CARE SERVICES PROVIDED TO PERSONS DETERMINED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THIS SECTION.

3. DEFINED PRIVATE CONTRIBUTION. UPON BEING DETERMINED ELIGIBLE FOR THE DEMONSTRATION, A PERSON SHALL DISCLOSE HIS OR HER HOUSEHOLD'S RESOURCES AND INCOME TO THE LOCAL SOCIAL SERVICES DISTRICT, OR AN ENTITY ACTING ON BEHALF OF SUCH DISTRICT PURSUANT TO SUBDIVISION FIVE OF THIS SECTION, AND SHALL ENTER INTO AN AGREEMENT WITH SUCH DISTRICT OR ENTITY. THE AGREEMENT SHALL REQUIRE THE PERSON TO APPLY A DEFINED PRIVATE CONTRIBUTION TOWARD THE COST OF INSTITUTIONAL OR NON-INSTITUTIONAL LONG-TERM CARE, AS DEFINED BY THE COMMISSIONER IN REGULATIONS. SUCH REGULATIONS SHALL PROVIDE FOR TWO LEVELS OF CONTRIBUTION: (A) A LEVEL THAT WOULD PERMIT A FULL MEDICAL ASSISTANCE RESOURCE EXEMPTION PURSUANT TO PARAGRAPH (A) OF SUBDIVISION FOUR OF THIS SECTION; AND (B) A LEVEL OR LEVELS THAT WOULD PERMIT A MEDICAL ASSISTANCE RESOURCE EXEMPTION THAT IS EQUIVALENT TO THE VALUE OF THE CONTRIBUTION PURSUANT TO PARAGRAPH (B) OF SUBDIVISION FOUR OF THIS SECTION.

4. MEDICAL ASSISTANCE ELIGIBILITY. UPON COMPLETION OF THE DEFINED PRIVATE CONTRIBUTION REQUIRED BY SUCH AGREEMENT, THE PERSON MAY APPLY FOR MEDICAL ASSISTANCE UNDER THIS TITLE AND, IF OTHERWISE ELIGIBLE, SHALL BE ELIGIBLE FOR SUCH ASSISTANCE EITHER: (A) IN THE CASE OF AN INDIVIDUAL WHO OPTS FOR A CONTRIBUTION LEVEL UNDER PARAGRAPH (A) OF SUBDIVISION THREE OF THIS SECTION, WITHOUT REGARD TO OTHERWISE APPLICABLE RESOURCE REQUIREMENTS OF THIS TITLE; OR (B) IN THE CASE OF AN INDIVIDUAL WHO OPTS FOR A CONTRIBUTION LEVEL UNDER PARAGRAPH (B) OF SUBDIVISION THREE OF THIS SECTION, WITHOUT REGARD TO AN AMOUNT OF RESOURCES THAT IS EQUIVALENT TO THE VALUE OF THE CONTRIBUTION. IN EITHER CASE, ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS TITLE SHALL, WITH RESPECT TO THE AMOUNT OF RESOURCES THAT ARE EXEMPT FROM CONSIDERATION UNDER THIS SUBDIVISION, BE WITHOUT REGARD TO THE LIEN AND ESTATE RECOVERY PROVISIONS OF SECTION THREE HUNDRED SIXTY-NINE OF THIS TITLE; PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL PREVENT THE IMPOSITION OF A LIEN OR RECOVERY AGAINST PROPERTY OF AN INDIVIDUAL ON ACCOUNT OF MEDICAL ASSISTANCE INCORRECTLY PAID.

5. THE COMMISSIONER IS AUTHORIZED TO ENTER INTO A CONTRACT WITH A PRIVATE ENTITY TO ASSIST IN THE ADMINISTRATION OF THE DEMONSTRATION PROGRAM ESTABLISHED BY THIS SECTION. SUCH A CONTRACT MAY INCLUDE, WITHOUT LIMITATION, ASSISTANCE IN THE DEVELOPMENT OF THE CRITERIA FOR THE DEFINED PRIVATE CONTRIBUTION, DRAFTING OF THE DEFINED CONTRIBUTION AGREEMENT, ACCEPTING AND PROCESSING APPLICATIONS FOR DEMONSTRATION PARTICIPATION UNDER THIS SECTION, AND ACCEPTING AND PROCESSING APPLICATIONS FOR MEDICAL ASSISTANCE FOR DEMONSTRATION PARTICIPANTS. 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.

6. THE COMMISSIONER SHALL SUBMIT A REPORT TO THE GOVERNOR, PRESIDENT PRO TEM OF THE SENATE AND SPEAKER OF THE ASSEMBLY BY THE FIRST DAY OF NOVEMBER, TWO THOUSAND FIFTEEN, ON THE IMPLEMENTATION OF THIS SECTION. SUCH REPORT SHALL INCLUDE A STATEMENT AS TO THE EXTENT TO WHICH INDIVIDUALS HAVE OPTED TO PARTICIPATE IN THE DEMONSTRATION, AN ANALYSIS OF THE IMPACT OF THE DEMONSTRATION ON MEDICAL ASSISTANCE PROGRAM LONG-TERM CARE COSTS, ANY RECOMMENDATIONS FOR LEGISLATIVE ACTION, AND SUCH OTHER MATTERS AS MAY BE PERTINENT.

S 21. The social services law is amended by adding a new section 367-v to read as follows:

S 367-V. COUNTY LONG-TERM CARE FINANCING DEMONSTRATION PROGRAM. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A LONG-TERM CARE FINANCING DEMONSTRATION PROGRAM, TO OPERATE IN UP TO FIVE COUNTIES, FOR THE PURPOSE OF CREATING INCENTIVES AND FUNDING FOR THE TRANSFORMATION OF COUNTY NURSING HOME BEDS INTO OTHER LONG-TERM CARE SETTINGS.

2. (A) THE DEMONSTRATION PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL PERMIT A PARTICIPATING COUNTY TO REDUCE ITS COUNTY NURSING HOME BED CAPACITY, OR TO CLOSE A COUNTY NURSING HOME, AND TO INVEST ANY RESULTING DEMONSTRATED SAVINGS IN PROGRAMS OR SERVICES THAT WILL, TO THE EXTENT FEASIBLE, ENCOURAGE THE USE OF COMMUNITY-BASED LONG-TERM CARE ALTERNATIVES TO INSTITUTIONAL CARE.

(B) SUCH PROGRAMS OR SERVICES MAY INCLUDE, BUT ARE NOT LIMITED TO:

(I) EXPANSION OF COMMUNITY-BASED SERVICES SUCH AS THE PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE), THE LONG TERM HOME HEALTH

CARE PROGRAM, THE MANAGED LONG TERM CARE PROGRAM, ADULT DAY CARE SERVICES, AND CAREGIVER SUPPORT SERVICES;

(II) EXPANSION OF SENIOR HOUSING;

(III) ASSISTED LIVING PROGRAM;

(IV) PAYMENT OF SUBSIDIES TO ENCOURAGE ASSISTED LIVING PROGRAMS, ADULT CARE FACILITIES, AND NON-PUBLIC NURSING HOMES TO ACCEPT HARD-TO-SERVE RESIDENTS; AND

(V) CONTRACTS WITH NON-PUBLIC NURSING HOMES TO GUARANTEE BEDS FOR THOSE HARD-TO-SERVE PERSONS WHO CHOOSE NURSING HOME CARE OR FOR WHOM OTHER COMMUNITY-BASED OPTIONS ARE NOT FEASIBLE OR ARE UNAVAILABLE.

3. A COUNTY WISHING TO PARTICIPATE IN THE DEMONSTRATION PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL DEVELOP A PLAN AND SUBMIT AN APPLICATION FOR PARTICIPATION TO THE COMMISSIONER OF HEALTH DETAILING SUCH PLAN AT A TIME AND IN A MANNER TO BE DETERMINED BY SUCH COMMISSIONER. THE COMMISSIONER IS AUTHORIZED TO APPROVE OR DISAPPROVE ANY SUCH APPLICATION AND TO CERTIFY THE AMOUNT OF DEMONSTRATED SAVINGS.

4. NOTWITHSTANDING THE CAP ON SOCIAL SERVICES DISTRICT SHARES OF MEDICAL ASSISTANCE EXPENDITURES ESTABLISHED PURSUANT TO SECTION ONE OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, THE DIRECTOR OF THE DIVISION OF THE BUDGET IS AUTHORIZED, IN HIS OR HER SOLE DISCRETION, TO ADJUST A DISTRICT'S CAP AMOUNT TO ACCOUNT FOR CHANGES IN THE NON-FEDERAL SHARE OF MEDICAL ASSISTANCE RESULTING FROM ANY APPROVED DEMONSTRATION PLAN.

5. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO SUBMIT ANY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE AND ANY WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT THAT SUCH COMMISSIONER DETERMINES TO BE NECESSARY TO OBTAIN FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SERVICES PROVIDED PURSUANT TO THIS SECTION.

6. THE COMMISSIONER OF HEALTH SHALL SUBMIT A REPORT TO THE GOVERNOR, PRESIDENT PRO TEM OF THE SENATE AND SPEAKER OF THE ASSEMBLY BY THE FIRST DAY OF NOVEMBER, TWO THOUSAND FIFTEEN, ON THE IMPLEMENTATION OF THIS SECTION. SUCH REPORT SHALL INCLUDE IDENTIFICATION OF THE COUNTIES APPROVED TO PARTICIPATE IN THE DEMONSTRATION, A DESCRIPTION OF SUCH COUNTIES' APPROVED DEMONSTRATION PLANS, AN ANALYSIS OF THE IMPACT OF THE DEMONSTRATION ON LONG-TERM CARE COSTS AND SERVICE DELIVERY, ANY RECOMMENDATIONS FOR LEGISLATIVE ACTION, AND SUCH OTHER MATTERS AS MAY BE PERTINENT.

S 22. Subdivision 6 of section 3614 of the public health law, as amended by chapter 645 of the laws of 2003, is amended by adding a new paragraph (c) to read as follows:

(C) THE DEPARTMENT SHALL CONDUCT A STUDY OF THE USE OF RESIDENT DATA COLLECTED FROM A UNIFORM ASSESSMENT TOOL IDENTIFIED BY THE COMMISSIONER WITH RESPECT TO ITS EFFECTIVENESS IN EVALUATION AND ADJUSTING RATES OF PAYMENT FOR ASSISTED LIVING PROGRAMS. ON OR BEFORE JULY THIRTY-FIRST, TWO THOUSAND ELEVEN, THE COMMISSIONER SHALL PROVIDE THE GOVERNOR, THE SPEAKER OF THE ASSEMBLY, THE TEMPORARY PRESIDENT OF THE SENATE, AND THE CHAIRPERSONS OF THE ASSEMBLY AND SENATE HEALTH COMMITTEES WITH A REPORT SETTING FORTH THE CONCLUSIONS OF SUCH STUDY.

S 23. Subdivision 2 of section 2801-e of the public health law, as added by chapter 750 of the laws of 2004, is amended to read as follows:

2. Notwithstanding any inconsistent provision of law or regulation to the contrary, a residential health care facility, as defined in section twenty-eight hundred one of this article, may apply to temporarily decertify or permanently convert a portion of its existing certified beds to another type of program or service under the voluntary residential health care facility rightsizing demonstration program. The commis-

sioner may approve temporary decertifications and permanent conversions of beds totaling no more than [two thousand five hundred] FIVE THOUSAND residential health care facility beds on a statewide basis under this program. Such approvals shall reflect, to the extent practicable, participation by a variety of residential health care facilities based on geography, size and other pertinent factors.

S 24. 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 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 SUCH 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 SUCH ENROLLEE CONTRACTS ARE TO COVER ANY POPULATION OF ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

S 25. Paragraphs (a), (b) and (c) of subdivision 6 of section 4403-f of the public health law, paragraph (a) as added by section 16 of part C of chapter 58 of the laws of 2007 and paragraphs (b) and (c) as added by chapter 659 of the laws of 1997, are amended to read as follows:

(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 regu-

lations 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.

S 26. 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 27. 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, AND 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 28. Paragraphs (b) and (c) of subdivision 5 of section 2808 of the public health law, paragraph (b) as added by section 12 of part OO of chapter 57 of the laws of 2008, and paragraph (c) as added by section 11 of part D of chapter 58 of the laws of 2009, are amended to read as follows:

(b) On and after April first, two thousand [eight] TEN, no NON-PUBLIC residential health care facility may withdraw equity or transfer assets which in the aggregate exceed three percent of such facility's total [Medicaid] REPORTED ANNUAL revenue [in any calendar year] FOR PATIENT CARE SERVICES, BASED ON THE FACILITY'S MOST RECENTLY AVAILABLE REPORTED DATA, without prior written notification to the commissioner. Notification shall be made in a form acceptable to the department by certified or registered mail.

(c) Notwithstanding any inconsistent provision of this subdivision, on and after April first, two thousand [nine] TEN, no non-public residential health care facility, whether operated as 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] REPORTED ANNUAL revenue [in the prior calendar year] FOR PATIENT CARE SERVICES, BASED ON THE FACILITY'S MOST RECENTLY AVAILABLE REPORTED DATA, 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 reviewing such requests the commissioner shall consider the facility's overall financial condition, any indications of financial distress, whether the facility is delinquent in any payment owed to the department, whether the facility has been cited for immediate jeopardy or substandard quality of care, and such other factors as the commissioner deems appropriate. 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 29. 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 30. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 31. 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 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, provided, however, that:

1. sections thirteen, thirteen-a and thirteen-b of this act shall take effect July 1, 2010;

2. the amendments to subdivisions six, seven and nine of section 4403-f of the public health law made by sections twenty-five, twenty-six and twenty-seven of this act shall not affect the repeal of such subdivisions and shall be deemed repealed therewith;

3. 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;

4. 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;

5. 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;

6. 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;

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

PART D

Section 1. Subsection (e) of 3231 of the insurance law, as added by chapter 501 of the laws of 1992, subparagraph (B) of paragraph 2 as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(e) (1) (A) An insurer desiring to increase or decrease premiums [after April first, nineteen hundred ninety-three] for any policy form subject to this section shall submit a rate filing or application to the superintendent.

AN INSURER SHALL SEND WRITTEN NOTICE OF THE PROPOSED RATE ADJUSTMENT, INCLUDING THE SPECIFIC CHANGE REQUESTED, TO EACH POLICY HOLDER AND CERTIFICATE HOLDER AFFECTED BY THE ADJUSTMENT BETWEEN NINETY AND ONE HUNDRED FIVE DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE. THE NOTICE SHALL PROMINENTLY INCLUDE MAILING AND WEBSITE ADDRESSES FOR BOTH THE INSURANCE DEPARTMENT AND THE INSURER THROUGH WHICH A PERSON MAY CONTACT THE INSURANCE DEPARTMENT OR INSURER TO RECEIVE ADDITIONAL INFORMATION OR TO SUBMIT WRITTEN COMMENTS TO THE INSURANCE DEPARTMENT ON THE RATE FILING OR APPLICATION. The superintendent shall determine whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. THE SUPERINTENDENT MAY MODIFY OR DISAPPROVE THE RATE FILING OR APPLICATION IF THE SUPERINTENDENT FINDS THAT THE PREMIUMS ARE UNREASONABLE, EXCESSIVE, INADEQUATE, OR

UNFAIRLY DISCRIMINATORY, AND MAY CONSIDER THE FINANCIAL CONDITION OF THE INSURER WHEN APPROVING, MODIFYING OR DISAPPROVING ANY PREMIUM ADJUSTMENT. AN INSURER SHALL NOT IMPLEMENT A RATE ADJUSTMENT UNLESS THE INSURER PROVIDES AT LEAST FORTY-FIVE DAYS ADVANCE WRITTEN NOTICE OF THE PREMIUM RATE ADJUSTMENT APPROVED BY THE SUPERINTENDENT TO EACH POLICY HOLDER AND CERTIFICATE HOLDER AFFECTED BY THE RATE ADJUSTMENT.

(B) UPON RECEIPT OF A RATE FILING OR APPLICATION BY OR ON BEHALF OF AN INSURER THAT, TOGETHER WITH ANY OTHER RATE ADJUSTMENTS IMPOSED DURING A CONTINUOUS TWELVE-MONTH PERIOD, WOULD CAUSE AN AGGREGATE INCREASE IN PREMIUMS FOR THAT POLICY FORM OF MORE THAN TEN PERCENT, THE SUPERINTENDENT SHALL ORDER THAT A PUBLIC HEARING BE HELD AT THE INSURER'S EXPENSE. THE WRITTEN NOTICE REQUIRED BY SUBPARAGRAPH (A) OF THIS PARAGRAPH SHALL INCLUDE NOTICE OF THE PUBLIC HEARING. THE INSURER SHALL ALSO PUBLISH NOTICE OF SUCH HEARING ON THREE SUCCESSIVE DAYS IN AT LEAST ONE NEWSPAPER HAVING GENERAL CIRCULATION IN EACH COUNTY WHERE PERSONS AFFECTED BY THE PROPOSED CHANGE RESIDE. THE NOTICE OF HEARING SHALL BE SUBJECT TO THE SUPERINTENDENT'S PRIOR APPROVAL, AND SHALL STATE THE DATE, TIME AND PLACE OF THE HEARING (AS SCHEDULED BY THE SUPERINTENDENT), THE PURPOSE THEREOF, THE CHANGES PROPOSED, THE POLICY FORMS AFFECTED, AND THE PROPOSED EFFECTIVE DATE OF THE CHANGES. THE NOTICE OF HEARING SHALL ALSO PROMINENTLY INCLUDE TOLL-FREE TELEPHONE NUMBERS AND MAILING AND WEBSITE ADDRESSES FOR BOTH THE INSURANCE DEPARTMENT AND THE INSURER THROUGH WHICH A PERSON MAY CONTACT THE INSURANCE DEPARTMENT OR INSURER TO RECEIVE ADDITIONAL INFORMATION OR TO SUBMIT WRITTEN COMMENTS TO THE INSURANCE DEPARTMENT ON THE RATE FILING OR APPLICATION. THE DATE SPECIFIED FOR THE HEARING SHALL NOT BE LESS THAN TEN NOR MORE THAN THIRTY DAYS FROM THE DATE OF THE LAST PUBLICATION OF THE NOTICE OF THE HEARING. UPON CONCLUSION OF THE PUBLIC HEARING, THE SUPERINTENDENT SHALL RENDER A WRITTEN DETERMINATION AS TO WHETHER THE RATE FILING OR APPLICATION SHALL BECOME EFFECTIVE AS FILED, SHALL BECOME EFFECTIVE AS MODIFIED, OR SHALL BE DISAPPROVED.

(C) THE EXPECTED MINIMUM LOSS RATIO FOR A POLICY FORM SUBJECT TO THIS SECTION, FOR WHICH A RATE FILING OR APPLICATION IS MADE PURSUANT TO THIS PARAGRAPH, OTHER THAN A MEDICARE SUPPLEMENTAL INSURANCE POLICY, OR, WITH THE APPROVAL OF THE SUPERINTENDENT, AN AGGREGATION OF POLICY FORMS THAT ARE COMBINED INTO ONE COMMUNITY RATING EXPERIENCE POOL AND RATED CONSISTENT WITH COMMUNITY RATING REQUIREMENTS, SHALL NOT BE LESS THAN EIGHTY-FIVE PERCENT. IN REVIEWING A RATE FILING OR APPLICATION, THE SUPERINTENDENT MAY MODIFY THE EIGHTY-FIVE PERCENT EXPECTED MINIMUM LOSS RATIO REQUIREMENT IF THE SUPERINTENDENT DETERMINES THE MODIFICATION TO BE IN THE INTERESTS OF THE PEOPLE OF THIS STATE. NO LATER THAN JUNE THIRTIETH OF EACH YEAR, EVERY INSURER SUBJECT TO THIS SUBPARAGRAPH SHALL ANNUALLY REPORT THE ACTUAL LOSS RATIO FOR THE PREVIOUS CALENDAR YEAR IN A FORMAT ACCEPTABLE TO THE SUPERINTENDENT. IF AN EXPECTED LOSS RATIO IS NOT MET, THE SUPERINTENDENT MAY DIRECT THE INSURER TO TAKE CORRECTIVE ACTION, WHICH MAY INCLUDE THE SUBMISSION OF A RATE FILING TO REDUCE FUTURE PREMIUMS, OR TO ISSUE DIVIDENDS, PREMIUM REFUNDS OR CREDITS, OR ANY COMBINATION OF THESE.

(2) (A) [Beginning October first, nineteen hundred ninety-four] UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND TEN, as an alternate procedure to the requirements of paragraph one of this subsection, an insurer desiring to increase or decrease premiums for any policy form subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that: (i) the anticipated minimum loss ratio for a policy form shall not be less than [seventy-five] EIGHTY-FIVE percent of the premi-

um[,]; and (ii) the insurer submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that the insurer is in compliance with the provisions of this paragraph, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the insurer in establishing premium rates for policy forms subject to this section. AN INSURER SHALL NOT UTILIZE THE ALTERNATE PROCEDURE PURSUANT TO THIS PARAGRAPH TO IMPLEMENT A CHANGE IN RATES TO BE EFFECTIVE ON OR AFTER OCTOBER FIRST, TWO THOUSAND TEN.

(B) Each calendar year, an insurer shall return, in the form of aggregate benefits for each policy form filed pursuant to the alternate procedure set forth in this paragraph at least [seventy-five] EIGHTY-FIVE percent of the aggregate premiums collected for the policy form during that calendar year. Insurers shall annually report, no later than [May first] JUNE THIRTIETH of each year, the loss ratio calculated pursuant to this paragraph for each such policy form for the previous calendar year. In each case where the loss ratio for a policy form fails to comply with the [seventy-five] EIGHTY-FIVE percent loss ratio requirement, the insurer shall issue a dividend or credit against future premiums for all policy holders with that policy form in an amount sufficient to assure that the aggregate benefits paid in the previous calendar year plus the amount of the dividends and credits shall equal [seventy-five] EIGHTY-FIVE percent of the aggregate premiums collected for the policy form in the previous calendar year. The dividend or credit shall be issued to each policy holder who had a policy which was in effect at any time during the applicable year. The dividend or credit shall be prorated based on the direct premiums earned for the applicable year among all policy holders eligible to receive such dividend or credit. An insurer shall make a reasonable effort to identify the current address of, and issue dividends or credits to, former policy holders entitled to the dividend or credit. An insurer shall, with respect to dividends or credits to which former policy holders that the insurer is unable to identify after a reasonable effort would otherwise be entitled, have the option, as deemed acceptable by the superintendent, of prospectively adjusting premium rates by the amount of such dividends or credits, issuing the amount of such dividends or credits to existing policy holders, depositing the amount of such dividends or credits in the fund established pursuant to section four thousand three hundred twenty-two-a of this chapter, or utilizing any other method which offsets the amount of such dividends or credits. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by this paragraph shall include an insurer's calculation of the dividends and credits, as well as an explanation of the insurer's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a policy holder.

(3) ALL POLICY FORMS SUBJECT TO THIS SUBSECTION, OTHER THAN MEDICARE SUPPLEMENTAL INSURANCE POLICY FORMS, ISSUED OR IN EFFECT DURING CALENDAR YEAR TWO THOUSAND TEN SHALL BE SUBJECT TO A MINIMUM LOSS RATIO REQUIREMENT OF EIGHTY-FIVE PERCENT. INSURERS MAY USE THE ALTERNATE FILING PROCEDURE SET FORTH IN PARAGRAPH TWO OF THIS SUBSECTION TO ADJUST PREMI-

UM RATES IN ORDER TO MEET THE REQUIRED MINIMUM LOSS RATIO FOR CALENDAR YEAR TWO THOUSAND TEN. THE RATE FILING OR APPLICATION SHALL BE SUBMITTED NO LATER THAN SEPTEMBER THIRTIETH, TWO THOUSAND TEN.

S 2. Section 4308 of the insurance law, subsection (b) as amended and subsections (d), (e) and (f) as added by chapter 501 of the laws of 1992, paragraph 3 of subsection (c) as amended by chapter 520 of the laws of 1999, subsections (g), (h), (i) and (j) as added by chapter 504 of the laws of 1995 and paragraph 2 of subsection (h) as amended by chapter 237 of the laws of 2009, is amended to read as follows:

S 4308. Supervision of superintendent; public hearings. (a) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a copy of the contract or certificate and of all applications, riders and endorsements for use in connection with the issuance or renewal thereof, to be formally approved by him as conforming to the applicable provisions of this article and not inconsistent with any other provision of law applicable thereto. The superintendent shall, within a reasonable time after the filing of any such form, notify the corporation filing the same either of his approval or of his disapproval of such form.

(b) No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums or, if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof. The superintendent may refuse such approval if he finds that such premiums, or the premiums derived from the rating formula, are excessive, inadequate or unfairly discriminatory, provided, however, the superintendent may also consider the financial condition of such corporation in approving or disapproving any premium or rating formula. ANY ADJUSTMENTS TO AN APPROVED SCHEDULE OF PREMIUMS OR TO THE APPROVED RATING FORMULA FOR NON-COMMUNITY RATED CONTRACTS SHALL ALSO BE SUBJECT TO THE APPROVAL OF THE SUPERINTENDENT PROVIDED, HOWEVER, SUCH ADJUSTMENTS SHALL NOT BE SUBJECT TO THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION. Any premium or formula approved by the superintendent shall make provision for such increase as may be necessary to meet the requirements of a plan approved by the superintendent in the manner prescribed in section four thousand three hundred ten of this article for restoration of the statutory reserve fund required by such section. Notwithstanding any other provision of law, the superintendent, as part of the rate increase approval process, may defer, reduce or reject a rate increase if, in the judgment of the superintendent, the salary increases for senior level management executives employed at corporations subject to the provisions of this article are excessive or unwarranted given the financial condition or overall performance of such corporation. The superintendent is authorized to promulgate rules and regulations which the superintendent deems necessary to carry out such deferral, reduction or rejection.

(c) (1) [Except for an application pursuant to subsection (f) of section four thousand three hundred four of this article, no] AN increase or decrease in premiums with respect to [individual] COMMUNITY RATED contracts [issued pursuant to the provisions of such section] shall NOT be approved by the superintendent unless it is in compliance with the provisions of this subsection as well as other applicable provisions of law.

(2) [Prior to any such filing or application by or on behalf of a corporation for an increase or decrease in premiums for such contracts,

such corporation, when directed by the superintendent, shall conduct a public hearing with respect to the terms of such filing or application. Notice of such hearing shall be published on three successive days in at least two newspapers having general circulation within the territory or district wherein such corporation seeking approval of the filing is authorized to do business. The date specified for the hearing shall be not less than ten nor more than thirty days from the date of the first publication of the hearing. The notice of hearing shall state the purpose thereof, the time when and the place where the public hearing will be held. The public hearing shall be held at a time and location deemed by the superintendent to be most convenient to the greatest number of persons affected by such filing. At such hearing any person may be heard in favor of, or against, the terms of the filing or application.

(3) Following the public hearing held pursuant to paragraph two of this subsection, a transcript of the testimony therein shall be submitted together with a rate filing or application, to the superintendent. Upon receipt of such filing or application by or on behalf of a corporation, the superintendent shall order that a public hearing be held with respect to the terms of such filing or application. Notice of such hearing shall be published on three successive days in at least two newspapers having general circulation within the territory or district wherein such corporation seeking approval of the filing or application is authorized to do business. For a corporation writing more than three billion dollars in premiums as of December thirty-first, nineteen hundred ninety-six and whose service territory is greater than ten counties, such notice is to be published in at least one newspaper having general circulation in each county where persons in the service territory are affected by the proposed change. The date specified for the hearing shall be not less than ten nor more than thirty days from the date of the last publication of the hearing. The notice of hearing shall also state the purpose thereof, the time when and the place where the public hearing will be held. For those corporations writing more than three billion dollars in premiums as of December thirty-first, nineteen hundred ninety-six, and whose territory is greater than ten counties, the notice of hearing shall also state the changes proposed, the contracts to be affected and the time when such changes would take effect. The notice of hearing shall state, in prominent display, a toll-free telephone number of the insurance department that may be contacted to receive additional information on the subject rate application. The public hearing shall be held at a time and location deemed by the superintendent to be most convenient to the greatest number of persons affected by such filing or application. A copy of such notice of hearing shall be forwarded by the superintendent by registered or certified mail to the principal address of the corporation seeking approval of such filing or application. The hearing may be continued or adjourned from day to day within the discretion of the superintendent. At such hearing any person may be heard in favor of, or against, the terms of the filing or application. After conclusion of the public hearing the superintendent shall render a written decision determining whether the filing or application shall become effective as filed, shall become effective as modified, or shall be disapproved. If, subsequent to the hearing, but prior to the issuing of the superintendent's written decision on a rate increase request, the corporation increases its requested rate for any contract by two percent or more, a re-hearing shall be held. The time,

location, and notice requirements for such re-hearing shall be determined by the superintendent.

(4)] (A) A CORPORATION DESIRING TO INCREASE OR DECREASE PREMIUMS FOR ANY CONTRACT SUBJECT TO THIS SUBSECTION SHALL SUBMIT A RATE FILING OR APPLICATION TO THE SUPERINTENDENT. A CORPORATION SHALL SEND WRITTEN NOTICE OF THE PROPOSED RATE ADJUSTMENT, INCLUDING THE SPECIFIC CHANGE REQUESTED, TO EACH CONTRACT HOLDER AND SUBSCRIBER AFFECTED BY THE ADJUSTMENT BETWEEN NINETY AND ONE HUNDRED FIVE DAYS PRIOR TO THE PROPOSED EFFECTIVE DATE OF SUCH ADJUSTMENT. THE NOTICE SHALL PROMINENTLY INCLUDE MAILING AND WEBSITE ADDRESSES FOR BOTH THE INSURANCE DEPARTMENT AND THE CORPORATION THROUGH WHICH A PERSON MAY CONTACT THE INSURANCE DEPARTMENT OR CORPORATION TO RECEIVE ADDITIONAL INFORMATION OR TO SUBMIT WRITTEN COMMENTS TO THE INSURANCE DEPARTMENT ON THE RATE FILING OR APPLICATION. THE SUPERINTENDENT SHALL DETERMINE WHETHER THE FILING OR APPLICATION SHALL BECOME EFFECTIVE AS FILED, SHALL BECOME EFFECTIVE AS MODIFIED, OR SHALL BE DISAPPROVED. THE SUPERINTENDENT MAY MODIFY OR DISAPPROVE THE RATE FILING OR APPLICATION IF THE SUPERINTENDENT FINDS THAT THE PREMIUMS ARE UNREASONABLE, EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY, AND MAY CONSIDER THE FINANCIAL CONDITION OF THE CORPORATION IN APPROVING, MODIFYING OR DISAPPROVING ANY PREMIUM ADJUSTMENT. A CORPORATION SHALL NOT IMPLEMENT A RATE ADJUSTMENT UNLESS THE CORPORATION PROVIDES AT LEAST FORTY-FIVE DAYS ADVANCE WRITTEN NOTICE OF THE PREMIUM RATE ADJUSTMENT APPROVED BY THE SUPERINTENDENT TO EACH CONTRACT HOLDER AND SUBSCRIBER AFFECTED BY THE RATE ADJUSTMENT.

(B) UPON RECEIPT OF A RATE FILING OR APPLICATION BY OR ON BEHALF OF A CORPORATION THAT, TOGETHER WITH ANY OTHER RATE ADJUSTMENTS IMPOSED DURING A CONTINUOUS TWELVE-MONTH PERIOD, WOULD CAUSE AN AGGREGATE INCREASE IN PREMIUMS FOR THAT CONTRACT FORM OF MORE THAN TEN PERCENT, THE SUPERINTENDENT SHALL ORDER THAT A PUBLIC HEARING BE HELD AT THE CORPORATION'S EXPENSE. THE WRITTEN NOTICE REQUIRED BY SUBPARAGRAPH (A) OF THIS PARAGRAPH SHALL INCLUDE NOTICE OF THE PUBLIC HEARING. THE CORPORATION SHALL ALSO PUBLISH NOTICE OF SUCH HEARING ON THREE SUCCESSIVE DAYS IN AT LEAST ONE NEWSPAPER HAVING GENERAL CIRCULATION IN EACH COUNTY WHERE PERSONS AFFECTED BY THE PROPOSED CHANGE RESIDE. THE NOTICE OF HEARING SHALL BE SUBJECT TO THE SUPERINTENDENT'S PRIOR APPROVAL, AND SHALL STATE THE DATE, TIME AND PLACE OF THE HEARING (AS SCHEDULED BY THE SUPERINTENDENT), THE PURPOSE THEREOF, THE CHANGES PROPOSED, THE CONTRACTS AFFECTED, AND THE PROPOSED EFFECTIVE DATE OF THE CHANGES. THE NOTICE OF HEARING SHALL ALSO PROMINENTLY INCLUDE TOLL-FREE TELEPHONE NUMBERS AND MAILING AND WEBSITE ADDRESSES FOR BOTH THE INSURANCE DEPARTMENT AND THE CORPORATION THROUGH WHICH A PERSON MAY CONTACT THE INSURANCE DEPARTMENT OR CORPORATION TO RECEIVE ADDITIONAL INFORMATION OR TO SUBMIT WRITTEN COMMENTS TO THE INSURANCE DEPARTMENT ON THE RATE FILING OR APPLICATION. THE DATE SPECIFIED FOR THE HEARING SHALL NOT BE LESS THAN TEN NOR MORE THAN THIRTY DAYS FROM THE DATE OF THE LAST PUBLICATION OF THE NOTICE OF THE HEARING. UPON CONCLUSION OF THE PUBLIC HEARING, THE SUPERINTENDENT SHALL RENDER A WRITTEN DETERMINATION AS TO WHETHER THE RATE FILING OR APPLICATION SHALL BECOME EFFECTIVE AS FILED, SHALL BECOME EFFECTIVE AS MODIFIED, OR SHALL BE DISAPPROVED.

(3)(A) THE EXPECTED MINIMUM LOSS RATIO FOR A CONTRACT FORM SUBJECT TO THIS SUBSECTION FOR WHICH A RATE FILING OR APPLICATION IS MADE PURSUANT TO THIS PARAGRAPH, OTHER THAN A MEDICARE SUPPLEMENTAL INSURANCE CONTRACT, OR, WITH THE APPROVAL OF THE SUPERINTENDENT, AN AGGREGATION OF CONTRACT FORMS THAT ARE COMBINED INTO ONE COMMUNITY RATING EXPERIENCE POOL AND RATED CONSISTENT WITH COMMUNITY RATING REQUIREMENTS, SHALL NOT BE LESS THAN EIGHTY-FIVE PERCENT. IN REVIEWING A RATE FILING OR APPLICA-

TION, THE SUPERINTENDENT MAY MODIFY THE EIGHTY-FIVE PERCENT EXPECTED MINIMUM LOSS RATIO REQUIREMENT IF THE SUPERINTENDENT DETERMINES THE MODIFICATION TO BE IN THE INTERESTS OF THE PEOPLE OF THIS STATE. NO LATER THAN JUNE THIRTIETH OF EACH YEAR, EVERY CORPORATION SUBJECT TO THIS SUBPARAGRAPH SHALL ANNUALLY REPORT THE ACTUAL LOSS RATIO FOR THE PREVIOUS CALENDAR YEAR IN A FORMAT ACCEPTABLE TO THE SUPERINTENDENT. IF AN EXPECTED LOSS RATIO IS NOT MET, THE SUPERINTENDENT MAY DIRECT THE CORPORATION TO TAKE CORRECTIVE ACTION, WHICH MAY INCLUDE THE SUBMISSION OF A RATE FILING TO REDUCE FUTURE PREMIUMS, OR TO ISSUE DIVIDENDS, PREMIUM REFUNDS OR CREDITS, OR ANY COMBINATION OF THESE.

(B) THE EXPECTED MINIMUM LOSS RATIO FOR A MEDICARE SUPPLEMENTAL INSURANCE CONTRACT FORM SHALL NOT BE LESS THAN EIGHTY PERCENT. NO LATER THAN MAY FIRST OF EACH YEAR, EVERY CORPORATION SUBJECT TO THIS SUBPARAGRAPH SHALL ANNUALLY REPORT THE ACTUAL LOSS RATIO FOR EACH CONTRACT FORM SUBJECT TO THIS SECTION FOR THE PREVIOUS CALENDAR YEAR IN A FORMAT ACCEPTABLE TO THE SUPERINTENDENT. IN EACH CASE WHERE THE LOSS RATIO FOR THE CONTRACT FORM FAILS TO COMPLY WITH THE EIGHTY PERCENT LOSS RATIO REQUIREMENT, THE CORPORATION SHALL SUBMIT A CORRECTIVE ACTION PLAN TO THE SUPERINTENDENT FOR ASSURING COMPLIANCE WITH THE APPLICABLE MINIMUM LOSS RATIO STANDARD. THE CORRECTIVE ACTION PLAN SHALL BE SUBMITTED TO THE SUPERINTENDENT WITHIN SIXTY DAYS OF THE CORPORATION'S SUBMISSION OF THE ANNUAL REPORT REQUIRED BY THIS SUBPARAGRAPH. THE CORPORATION'S PLAN MAY UTILIZE PREMIUM REFUNDS OR CREDITS, SUBJECT TO THE APPROVAL OF THE SUPERINTENDENT.

(4) In case of conflict between this subsection and any other provision of law, this subsection shall prevail.

(d) The superintendent shall order an independent management and financial audit of corporations subject to the provisions of this article with a combined premium volume exceeding two billion dollars annually in order to develop a detailed understanding of such corporation's financial status and to determine the viability of such corporation's products. Such audit shall be performed by an organization upon submission of a program plan in response to a request for proposal approved by the superintendent in consultation with the commissioner of health and the state comptroller. Such audit shall not be performed by any organization that has in any way performed or furnished services of any kind to the corporation within the past five years, unless it is adequately demonstrated that such services would not compromise that organization's performance and objectivity. The audit shall be completed and a report submitted by May first, nineteen hundred ninety-three to the superintendent, the commissioner of health, and the chairs of the senate and assembly committees on health and insurance. The scope of the audit shall include, but not be limited to, financial and competitive position, corporate structure and governance, organization and management, strategic direction, rate adequacy, and the regulatory and competitive environment in the state of New York. Specifically, the audit shall include, but not be limited to:

(i) determining the corporation's financial and market position, including its reserves, trends in membership, market share, and profitability by market segment;

(ii) evaluating the corporation's product offerings with respect to market requirements and trends, the corporation's responses to the New York health care market, and its management of medical claims costs;

(iii) assessing the effectiveness of the organizational and management structure and performance, including, but not limited to, possible improvement in the size, structure, composition and operation of the

board of directors, productivity improvement, information systems, management development, personnel practices, mix and level of skills, personnel turnover, investment practices and rate of return upon investment activities;

(iv) analyzing the corporation's strategic directions, its adequacy to meet competitive, market, and existing regulatory trends, including an evaluation of the use of brokers in marketing products, and the impact of those strategies on the corporation's future financial performance and on the health care system of New York;

(v) evaluating the adequacy of rates for existing products, particularly (but not limited to) small group, medicare supplemental, and direct payment to identify areas that may need immediate remedial attention;

(vi) identifying any changes to the regulatory and legislative environment that may need to be made to ensure that the corporation can continue to be financially viable and competitive;

(vii) identifying and assessing specific transactions such as the procurement of reinsurance, sale of real property and the sale of future investment income to improve the financial condition of the corporation; and

(viii) evaluating and identifying possible improvements in the corporation's managed care strategies, operations and claims handling.

(e) Notwithstanding any other provision of law, the superintendent shall have the power to require independent management and financial audits of corporations subject to the provisions of this article whenever in the judgment of the superintendent, losses sustained by a corporation jeopardize its ability to provide meaningful coverage at affordable rates or when such audit would be necessary to protect the interests of subscribers. The audit shall include, but not be limited to, an investigation of the corporation's provision of benefits to senior citizens, individual and family, and small group and small business subscribers in relation to the needs of those subscribers. The audit shall also include an evaluation of the efficiency of the corporation's management, particularly with respect to lines of business which are experiencing losses. In every case in which the superintendent chooses to require an audit provided for in this subsection, the superintendent shall have the authority to select the auditor. Any costs incurred as a result of the operation of this subsection shall be assessed on all domestic insurers in the same manner as provided for in section three hundred thirty-two of this chapter.

(f) The results of any audit conducted pursuant to subsections (d) and (e) of this section shall be provided to the corporation and each member of its board of directors. The superintendent shall have the authority to direct the corporation in writing to implement any recommendations resulting from the audit that the superintendent finds to be necessary and reasonable; provided, however, that the superintendent shall first consider any written response submitted by the corporation or the board of directors prior to making such finding. Upon any application for a rate adjustment by the corporation, the superintendent shall review the corporation's compliance with the directions and recommendations made previously by the superintendent, as a result of the most recently completed management or financial audit and shall include such findings in any written decision concerning such application.

(g)(1) [Beginning January first, nineteen hundred ninety-six] UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND TEN, as an alternate procedure to the requirements of subsection (c) of this section, a corporation subject to

the provisions of this article desiring to increase or decrease premiums for any contract subject to this section may instead submit a rate filing or application to the superintendent and such application or filing shall be deemed approved, provided that (A) the anticipated incurred loss ratio for a contract form shall not be less than eighty-five percent for individual direct payment contracts or [seventy-five] EIGHTY-FIVE percent for small group and small group remittance contracts, nor, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent during nineteen hundred ninety-four, shall the loss ratio for any direct payment, group or group remittance contract be more than one hundred five percent of the anticipated earned premium, and (B) the corporation submits, as part of such filing, a certification by a member of the American Academy of Actuaries or other individual acceptable to the superintendent that that corporation is in compliance with the provisions of this subsection, based upon that person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the corporation in establishing premium rates for contracts subject to this section. A CORPORATION SHALL NOT UTILIZE THE ALTERNATE PROCEDURE PURSUANT TO THIS SUBSECTION TO IMPLEMENT A CHANGE IN RATES TO BE EFFECTIVE ON OR AFTER OCTOBER FIRST, TWO THOUSAND TEN. For purposes of this section, a small group is any group whose contract is subject to the requirements of section forty-three hundred seventeen of this article.

(2) Prior to January first, two thousand, no rate increase or decrease may be deemed approved under this subsection if that increase or decrease, together with any other rate increases or decreases imposed on the same contract form, would cause the aggregate rate increase or decrease for that contract form to exceed ten percent during any continuous twelve month period. No rate increase may be imposed PURSUANT TO THIS SUBSECTION unless at least thirty days advance written notice of such increase has been provided to each contract holder and subscriber.

(h)(1) Each calendar year, a corporation subject to the provisions of this article shall return, in the form of aggregate benefits incurred for each contract form filed pursuant to the alternate procedure set forth in subsection (g) of this section, at least eighty-five percent for individual direct payment contracts or [seventy-five] EIGHTY-FIVE percent for small group and small group remittance contracts, but, except in the case of individual direct payment contracts with a loss ratio of greater than one hundred five percent in nineteen hundred ninety-four, for any direct payment, group or group remittance contract, not in excess of one hundred five percent of the aggregate premiums earned for the contract form during that calendar year. Corporations subject to the provisions of this article shall annually report, no later than [May first] JUNE THIRTIETH of each year, the loss ratio calculated pursuant to this subsection for each such contract form for the previous calendar year.

(2) In each case where the loss ratio for a contract form fails to comply with the eighty-five percent minimum loss ratio requirement for individual direct payment contracts, or the [seventy-five] EIGHTY-FIVE percent minimum loss ratio requirement for small group and small group remittance contracts, as set forth in paragraph one of this subsection, the corporation shall issue a dividend or credit against future premiums for all contract holders with that contract form in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year plus the amount of the dividends and credits shall equal no less

than eighty-five percent for individual direct payment contracts, or [seventy-five] EIGHTY-FIVE percent for small group and small group remittance contracts, of the aggregate premiums earned for the contract form in the previous calendar year. The dividend or credit shall be issued to each contract holder or subscriber who had a contract that was in effect at any time during the applicable year. The dividend or credit shall be prorated based on the direct premiums earned for the applicable year among all contract holders or subscribers eligible to receive such dividend or credit. A corporation shall make a reasonable effort to identify the current address of, and issue dividends or credits to, former contract holders or subscribers entitled to the dividend or credit. A corporation shall, with respect to dividends or credits to which former contract holders that the corporation is unable to identify after a reasonable effort would otherwise be entitled, have the option, as deemed acceptable by the superintendent, of prospectively adjusting premium rates by the amount of such dividends or credits, issuing the amount of such dividends or credits to existing contract holders, depositing the amount of such dividends or credits in the fund established pursuant to section four thousand three hundred twenty-two-a of this article, or utilizing any other method which offsets the amount of such dividends or credits. All dividends and credits must be distributed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the dividends and credits, as well as an explanation of the corporation's plan to issue dividends or credits. The instructions and format for calculating and reporting loss ratios and issuing dividends or credits shall be specified by the superintendent by regulation. Such regulations shall include provisions for the distribution of a dividend or credit in the event of cancellation or termination by a contract holder or subscriber.

(3) In each case where the loss ratio for a contract form fails to comply with the one hundred five percent maximum loss ratio requirement of paragraph one of this subsection, the corporation shall institute a premium rate increase in an amount sufficient to assure that the aggregate benefits incurred in the previous calendar year shall equal no more than one hundred five percent of the sum of the aggregate premiums earned for the contract form in the previous calendar year and the aggregate premium rate increase. The rate increase shall be applied to each contract that was in effect as of December thirty-first of the applicable year and remains in effect as of the date the rate increase is imposed. All rate increases must be imposed by September thirtieth of the year following the calendar year in which the loss ratio requirements were not satisfied. The annual report required by paragraph one of this subsection shall include a corporation's calculation of the premium rate increase, as well as an explanation of the corporation's plan to implement the rate increase. The instructions and format for calculating and reporting loss ratios and implementing rate increases shall be specified by the superintendent by regulation.

(i) The alternate procedure described in subsections (g) and (h) of this section shall apply to individual direct payment contracts issued pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of this article on and after January first, nineteen hundred ninety-seven. SHALL NOT BE UTILIZED TO IMPLEMENT A CHANGE IN RATES TO BE EFFECTIVE ON OR AFTER OCTOBER FIRST, TWO THOUSAND TEN.

[(j) The eighty-five percent minimum loss ratio for individual direct payment contracts described in subsections (g) and (h) of this section shall be reduced to eighty-two and one-half percent as of January first, nineteen hundred ninety-seven and shall be further reduced to eighty percent as of January first, nineteen hundred ninety-eight and thereafter. The refund or credit requirements for failure to meet minimum loss ratios will continue, but at these reduced percentages.]

(J) ALL COMMUNITY RATED CONTRACTS, OTHER THAN MEDICARE SUPPLEMENTAL INSURANCE CONTRACTS, ISSUED OR IN EFFECT DURING CALENDAR YEAR TWO THOUSAND TEN SHALL BE SUBJECT TO A MINIMUM LOSS RATIO REQUIREMENT OF EIGHTY-FIVE PERCENT. CORPORATIONS MAY USE THE ALTERNATE PROCEDURE SET FORTH IN SUBSECTION (G) OF THIS SECTION TO ADJUST PREMIUM RATES IN ORDER TO MEET THE REQUIRED MINIMUM LOSS RATIO FOR CALENDAR YEAR TWO THOUSAND TEN. THE RATE FILING OR APPLICATION SHALL BE SUBMITTED NO LATER THAN SEPTEMBER THIRTIETH, TWO THOUSAND TEN.

S 3. If any clause, sentence, paragraph, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered.

S 4. This act shall take effect immediately.

PART E

Section 1. The first undesignated paragraph of section 29.23 of the mental hygiene law is amended to read as follows:

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 committee] 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 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.

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 to read as follows:

(e) A mental hygiene facility which is a representative payee for a patient pursuant to designation by the social security administration or OTHER FEDERAL AGENCY AND which assumes management responsibility over the funds of a patient, INCLUDING BENEFITS FOR WHICH THERE IS A STATE SHARE, 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.

PART F

Section 1. Chapter 119 of the laws of 2007, directing the commissioner of mental health to study, evaluate and report on the unmet mental health service needs of traditionally underserved populations, is REPEALED.

S 2. This act shall take effect immediately.

PART G

Section 1. 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 OTHER THAN A TRIAL CONDUCTED PURSUANT TO SECTION 10.07 OF 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. IT SHALL CONSTITUTE GOOD CAUSE 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 (A) 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 (B) 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. NOTHING IN THIS SUBDIVISION SHALL BE CONSTRUED TO PROHIBIT THE RESPONDENT OR ANY WITNESS FROM MAKING AN ELECTRONIC APPEARANCE IN THE COURT AT A TRIAL CONDUCTED PURSUANT TO SECTION 10.07 OF THIS ARTICLE BY MEANS OF AN INDEPENDENT AUDIO-VISUAL SYSTEM, UPON GOOD CAUSE SHOWN AND CONSENT OF THE PARTIES.

S 2. This act shall take effect immediately.

PART H

Section 1. (a) 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 in state fiscal year 2010-11 to reduce inpatient capacity in the aggregate by no more than 250 beds through closure of wards not to exceed 175 beds, or

through conversion of such beds to transitional placement programs, provided, however, that nothing in this section shall be interpreted as restricting the ability of the office of mental health to reduce inpatient bed capacity beyond 250 beds in state fiscal year 2010-11, but such reductions shall be subject to the provisions of subdivision (e) of section 7.17 and section 41.55 of the mental hygiene law. Determinations concerning the closure of such wards in fiscal year 2010-11 shall be made by the office of mental health based on data related to inpatient census, indicating nonutilization or under utilization of beds, and the efficient operation of facilities. Determinations concerning the conversion of such wards to transitional placement programs in fiscal year 2010-11 shall be made by the office of mental health based upon the identification of patients who have received inpatient care and who are clinically determined to be appropriate for a less restrictive level of mental health treatment. The office of mental health shall provide notice to the legislature as soon as possible, but no later than two weeks prior to the anticipated closure or conversion of wards pursuant to this act.

(b) For the purposes of this act, the term "transitional placement program" shall be defined to include, but not be limited to, a supervised residential program that provides outpatient services, treatment and training, and which supports the transition of patients to more integrated community settings.

S 2. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 1 of part E of chapter 58 of the laws of 2004, is amended to read as follows:

S 7. This act shall take effect immediately and shall expire March 31, [2010] 2011 when upon such date the provisions of this act shall be deemed repealed.

S 3. Subdivision (e) of section 41.55 of the mental hygiene law, as amended by section 1 of part N1 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 USED TO CALCULATE THE PER BED CLOSURE SAVINGS 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 4. Subdivisions (h) and (l) of section 41.55 of the mental hygiene law are REPEALED and subdivisions (i), (j), (k), and (m) are relettered subdivisions (h), (i), (j) and (k).

S 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, provided that the amendments to section 41.55 of the mental hygiene law made by sections three and four of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART I

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010.

S 2. This act shall take effect immediately.

PART J

Section 1. The opening paragraph of subdivision (e) of section 16.23 of the mental hygiene law, as added by chapter 786 of the laws of 1983, is amended to read as follows:

The commissioner shall establish a procedure, subject to the approval of the state comptroller, whereby payments may be made to operators of family care homes for one or more of the following needs of clients residing in such facilities, limited to [two hundred ninety dollars] SUCH AMOUNTS per client per year AS SHALL BE SET BY THE COMMISSIONER AND APPROVED BY THE DIRECTOR OF THE BUDGET and paid [semi-annually] in the manner specified by such procedures:

S 2. The opening paragraph of paragraph 8 of subdivision (h) of section 31.03 of the mental hygiene law, as added by chapter 809 of the laws of 1980, is amended to read as follows:

The commissioner shall establish a procedure, subject to the approval of the state comptroller, whereby payments may be made to operators of family care homes for one or more of the following needs of clients residing in such facilities, limited to [two hundred ninety dollars] SUCH AMOUNTS per client per year AS SHALL BE SET BY THE COMMISSIONER AND

APPROVED BY THE DIRECTOR OF THE BUDGET and paid [semi-annually] in the manner specified by such procedures:

S 3. Subdivision (d) of section 16.23 of the mental hygiene law, as added by chapter 786 of the laws of 1983, is amended to read as follows:

(d) The office shall provide substitute caretakers to each family care home for a maximum of [ten] FOURTEEN days per year, either directly or as a purchase of service.

S 4. Paragraph 7 of subdivision (h) of section 31.03 of the mental hygiene law, as amended by chapter 613 of the laws of 1981, is amended to read as follows:

(7) The department shall provide substitute caretakers to each family care home for a maximum of [ten] FOURTEEN days per year, either directly or as a purchase of service.

S 5. The opening paragraph of subdivision (n) of section 41.36 of the mental hygiene law, as amended by chapter 525 of the laws of 1985, is amended to read as follows:

The commissioner shall establish a procedure, subject to the approval of the state comptroller, whereby payments in addition to the client's personal allowance may be made to providers of services for one or more of the following needs of clients residing in such facilities, limited to [two hundred fifty dollars] SUCH AMOUNTS per client per year AS SHALL BE SET BY THE COMMISSIONER AND APPROVED BY THE DIRECTOR OF THE BUDGET and paid [semi-annually] in the manner specified by such procedures:

S 6. This act shall take effect immediately.

PART K

Section 1. Paragraph 2 of subdivision (a) of section 32.05 of the mental hygiene law, as added by chapter 558 of the laws of 1999, is amended to read as follows:

2. operation of a discrete unit of a hospital or other facility possessing an operating certificate pursuant to article twenty-eight of the public health law for the purpose of providing residential or non-residential chemical dependence services, OR THE PROVISION OF CHEMICAL DEPENDENCE CRISIS SERVICES FOR THE LESSER OF TWO THOUSAND PATIENT DAYS PER YEAR, OR TEN PERCENT OF TOTAL PATIENT DAYS PER YEAR, AS DETERMINED BY THE COMMISSIONER, IN A HOSPITAL OR OTHER FACILITY POSSESSING AN OPERATING CERTIFICATE PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW; or

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010.

PART L

Section 1. Section 19.07 of the mental hygiene law is amended by adding a new subdivision (i) to read as follows:

(I) 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 and 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 OF MOTOR VEHICLES 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 OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES or [deputy] HIS OR HER DESIGNEE 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 estab-

lished 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 OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES or [a deputy] HIS OR HER DESIGNEE 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 OF MOTOR VEHICLES 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 OF MOTOR VEHICLES 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. This act shall take effect January 1, 2011.

PART M

Section 1. Paragraph 1 of subdivision (a) of section 9.60 of the mental hygiene law, as amended by chapter 158 of the laws of 2005, is amended to read as follows:

(1) "assisted outpatient treatment" shall mean categories of outpatient services which have been ordered by the court pursuant to this section. Such treatment shall include case management services or assertive community treatment team services to provide care coordination, and may also include any of the following categories of services: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; educational and vocational training or activities; alcohol or substance abuse treatment and counseling and periodic tests for the presence of alcohol or illegal drugs for persons with a history of alcohol or substance abuse; supervision of living arrangements; and any other services within a local [or unified] services plan developed pursuant to article forty-one of this chapter,

prescribed to treat the person's mental illness and to assist the person in living and functioning in the community, or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in suicide or the need for hospitalization.

S 2. Paragraph 2 of subdivision (b) of section 31.27 of the mental hygiene law, as added by chapter 723 of the laws of 1989, is amended to read as follows:

(2) The commissioner of mental health shall require that each comprehensive psychiatric emergency program submit a plan. The plan must be approved by the commissioner prior to the issuance of an operating certificate pursuant to this article. Each plan shall include: (i) a description of the program's catchment area; (ii) a description of the program's psychiatric emergency services, including crisis intervention services, crisis outreach services, crisis residence services, extended observation beds, and triage and referral services, whether or not provided directly or through agreement with other providers of services; (iii) agreements or affiliations with hospitals, as defined in section 1.03 of this chapter, to receive and admit persons who require inpatient psychiatric services; (iv) agreements or affiliations with general hospitals to receive and admit persons who have been referred by the comprehensive psychiatric emergency program and who require medical or surgical care which cannot be provided by the comprehensive psychiatric emergency program; (v) a description of local resources available to the program to prevent unnecessary hospitalizations of persons, which shall include agreements with local mental health, health, substance abuse, alcoholism or alcohol abuse, mental retardation and developmental disabilities, or social services agencies to provide appropriate services; (vi) a description of the program's linkages with local police agencies, emergency medical services, ambulance services, and other transportation agencies; (vii) a description of local resources available to the program to provide appropriate community mental health services upon release or discharge, which shall include case management services and agreements with state or local mental health and other human service providers; (viii) written criteria and guidelines for the development of appropriate discharge planning for persons in need of post emergency treatment or services[,]; (ix) a statement indicating that the program has been included in an approved local [or unified] services plan developed pursuant to article forty-one of this chapter for each local government located within the program's catchment area; and (x) any other information or agreements required by the commissioner.

S 3. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by chapter 408 of the laws of 1999, is amended to read as follows:

(d) Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local [or unified] services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities. Furthermore, subject to the prior approval of the commissioner of mental health, hospital emergency services licensed pursuant to article twenty-eight of the public health law shall be authorized to exchange information concerning patients or clients electronically or otherwise with other hospital emergency services licensed pursuant to article twenty-eight of the public health law and/or hospitals licensed or operated by the office of mental

health; provided that such exchange of information is consistent with standards, developed by the commissioner of mental health, which are designed to ensure confidentiality of such information. Additionally, information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

S 4. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by chapter 912 of the laws of 1984, is amended to read as follows:

(d) Nothing in this section shall prevent the exchange of information concerning patients or clients, including identification, between (i) facilities or others providing services for such patients or clients pursuant to an approved local [or unified] services plan, as defined in article forty-one, or pursuant to agreement with the department and (ii) the department or any of its facilities. Information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

S 5. The article heading of article 41 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

LOCAL [AND UNIFIED] SERVICES

S 6. The second undesignated paragraph and closing paragraph of section 41.01 of the mental hygiene law, as amended by chapter 978 of the laws of 1977, are amended to read as follows:

[In order to further the development, for each community in this state, of a unified system for the delivery of such services, this article gives to a local governmental unit the opportunity to participate in the state-local development of such services by means of a unified services plan. Such a plan is designed to be a mechanism whereby the department, department facilities, and local government can jointly plan for and deliver unified services to meet the needs of the consumers of such services. The unified services system will strengthen state and local partnership in the determination of the need for and the allocation of services and more easily provide for the most effective and economical utilization of new and existing state, local governmental, and private resources to provide services. A uniform ratio of state and local government responsibility for financing services under a unified services plan is established by this article to eliminate having the types of services provided in a community be determined by the local government's share of the cost of a particular program rather than the needs of the community.

It] EFFECTIVE IMPLEMENTATION OF THIS ARTICLE requires the direction and administration, by each local governmental unit, of a local comprehensive planning process for its geographic area in which all providers of services shall participate and cooperate in the provision of all necessary information. It also initiates a planning effort involving the state, local governments and other providers of service for the purpose of promoting continuity of care through the development of integrated systems of care and treatment for the mentally ill, mentally retarded and developmentally disabled, and for those suffering from the diseases of alcoholism and substance abuse.

S 7. Subdivisions 4 and 14 of section 41.03 of the mental hygiene law are REPEALED, and subdivisions 5, 6, 7, 8, 9, 10, 11, 12, 13 and 15 of

such section, such section as renumbered by chapter 978 of the laws of 1977, are renumbered subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13.

S 8. Subdivision 5 of section 41.03 of the mental hygiene law, as amended by chapter 588 of the laws of 1973 and as renumbered by section seven of this act, is amended to read as follows:

5. "local governmental unit" means the unit of local government given authority in accordance with this chapter by local government to provide local [or unified] services.

S 9. Subdivision (b) of section 41.04 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

(b) Guidelines for the operation of local [and unified] services plans and financing shall be adopted only by rule or regulation. Such rules and regulations shall be submitted at least twenty-one days prior to the effective date thereof to the New York state conference of local mental hygiene directors for comment thereon; provided, however, if a commissioner finds that the public health, welfare or safety requires the prompt adoption of rules and regulations, he may dispense with such submission prior to the effective date thereof but, in such case, such commissioner shall submit such rules and regulations to the conference as soon as possible for their review within sixty days after the effective date thereof.

S 10. Subdivisions (a) and (c) of section 41.07 of the mental hygiene law, as amended by chapter 588 of the laws of 1973 and such section as renumbered by chapter 978 of the laws of 1977, are amended to read as follows:

(a) Local governmental units may provide local [or unified] services and facilities directly or may contract for the provision of those services by other units of local or state government, by voluntary agencies, or by professionally qualified individuals.

(c) Local governments may provide joint local [or unified] services and facilities through agreements, made pursuant to law, which may provide either that one local government provide and supervise these services for other local governments or that a joint board or a joint local department be established to administer these services for the populations of all contracting local governments.

S 11. Subdivision (f) of section 41.10 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

(f) The conference shall have the following powers:

1. To review and comment upon rules or regulations proposed by any of the offices of the department for the operation of local [and unified] service plans and programs. Comments on rules or regulations approved by the conference shall be given to the appropriate commissioner or commissioners for review and consideration; and

2. To propose rules or regulations governing the operation of the local [and unified] services programs, and to forward such proposed rules or regulations to the appropriate commissioner or commissioners for review and consideration.

S 12. Subdivisions (a) and (b) of section 41.11 of the mental hygiene law, as amended by section 5 of part R2 of chapter 62 of the laws of 2003, are amended to read as follows:

(a) In all local governments with a population less than one hundred thousand, community services boards, at the option of the local government, shall have either nine or fifteen members appointed by the local government. In all other local governments, a community services board shall have fifteen members appointed by the local government.

Whenever practicable at least one member shall be a licensed physician and one member shall be a certified psychologist and otherwise at least two members shall be licensed physicians, such members to have demonstrated an interest in the field of services for the mentally disabled. The other members shall represent the community interest in all the problems of the mentally disabled and shall include representatives from community agencies for the mentally ill, the mentally retarded and developmentally disabled, and those suffering from alcoholism and substance abuse. The community services board shall have separate subcommittees for mental health, mental retardation and developmental disabilities, and alcoholism or, at the discretion of the local government, alcoholism and substance abuse. Each separate subcommittee shall have no more than nine members appointed by the local government, except that each subcommittee for mental health shall have no more than eleven members appointed by the local government. Three of each such subcommittee shall be members of the board. Each separate subcommittee shall be composed of persons who have demonstrated an interest in the field of services for the particular class of mentally disabled and shall include former patients, parents or relatives of such mentally disabled persons and community agencies serving the particular class of mentally disabled, except that each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and at least two members who are parents or relatives of persons with mental illness. Each separate subcommittee shall advise the community services board and the director of community services regarding the exercise of all policy-making functions vested in such board or director, as such functions pertain to the field of services for the particular class of mentally disabled individuals represented by such subcommittee. In addition, each subcommittee for mental health shall be authorized to annually evaluate the local services plan [or the unified services plan, as appropriate], and shall be authorized to report on the consistency of such [plans] PLAN with the needs of persons with serious mental illness, including children and adolescents with serious emotional disturbances. Any such report shall be forwarded annually to the community services board and the director of community services and a copy shall also be sent to the commissioner prior to the submission of the local services plan [or unified services plan. Provided], PROVIDED, however, that the provisions of this paragraph shall not apply to cities of over a million in population.

(b) In cities of over a million a community services board shall consist of fifteen members to be appointed by the mayor. There shall be at least two residents of each county within such cities on the board. At least one shall be a licensed physician and at least one shall be a certified psychologist. The other members shall represent the community interest in all of the problems of the mentally disabled and shall include representatives from community agencies for the mentally ill, the mentally retarded and developmentally disabled, and those suffering from alcoholism and substance abuse. The community services board shall have separate subcommittees for mental health, mental retardation and developmental disabilities, and alcoholism or, at the discretion of the local government, alcoholism and substance abuse. Each separate subcommittee shall have no more than nine members appointed by the local government, except that each subcommittee for mental health shall have no more than eleven members appointed by the local government. Three members of each such subcommittee shall be members of the board. Each separate subcommittee shall be composed of persons who have demonstrated

an interest in the field of services for the particular class of mentally disabled and shall include former patients, parents or relatives of such mentally disabled persons and community agencies serving the particular class of mentally disabled, except that each subcommittee for mental health shall include at least two members who are or were consumers of mental health services, and two members who are parents or relatives of persons with mental illness. Each separate subcommittee shall advise the community services board and the director of community services regarding the exercise of all policy-making functions vested in such board or director, as such functions pertain to the field of services for the particular class of mentally disabled individuals represented by such subcommittee. In addition, each subcommittee for mental health shall be authorized to annually evaluate the local services plan [or the unified services plan, as appropriate], and shall be authorized to report on the consistency of such [plans] PLAN with the needs of persons with serious mental illness, including children and adolescents with serious emotional disturbances. Any such report shall be forwarded annually to the community services board and the director of community services, and a copy shall also be sent to the commissioner prior to the submission of the local services plan [or unified services plan].

S 13. Paragraphs 5, 6, 7 and 12 of subdivision (a) of section 41.13 of the mental hygiene law, paragraphs 5 and 7 as amended by chapter 588 of the laws of 1973, paragraph 6 as amended by chapter 746 of the laws of 1986, paragraph 12 as amended by chapter 24 of the laws of 1985 and such section as renumbered by chapter 978 of the laws of 1977, are amended to read as follows:

5. submit annually to the department for its approval and subsequent state aid, a report of long range goals and specific intermediate range plans as modified since the preceding report, along with a local services plan [or unified services plan] for the next local fiscal year.

6. have the power, with the approval of local government, to enter into contracts for the provision of services, including the provision of community support services, and the construction of facilities [including contracts executed pursuant to subdivision (e) of section 41.19 of this article and have the power, when necessary, to approve construction projects].

7. establish procedures for execution of the local services plan [or the unified services plan] as approved by the local government and the commissioner, including regulations to guide the provision of services by all organizations and individuals within its program.

12. seek the cooperation and cooperate with other aging, public health and social services agencies, public and private, in advancing the program of local [or unified] services.

S 14. Section 41.14 of the mental hygiene law is REPEALED.

S 15. Subdivisions (a), (b), (c) and (e) of section 41.15 of the mental hygiene law, subdivisions (a), (c) and (e) as amended by chapter 978 of the laws of 1977 and subdivision (b) as amended by chapter 707 of the laws of 1988, are amended to read as follows:

(a) Net operating costs of programs incurred pursuant to [either] an approved local services plan [or an approved unified services plan] in accordance with the regulations of the commissioner or commissioners of the office or offices of the department having jurisdiction of the services and approved by the commissioner or commissioners of the office or offices of the department having jurisdiction of the services shall be eligible for state aid.

(b) Long range goals, intermediate range plans, and annual plans shall meet requirements for comprehensive services set for each local government by the commissioners of the offices of the department after taking into consideration local needs and available resources. These services shall be concerned with diagnosis, care, treatment, social and vocational rehabilitation, community residential services licensed by the department of mental hygiene, research, consultation and public education, education and training of personnel, control and prevention of mental disabilities, and the general furtherance of mental capability and health. As part of the local services [or unified services plans] PLAN required to establish eligibility for state aid in accordance with the provisions herein, each local governmental unit shall submit a five-year plan and annual implementation plans and budgets which shall reflect local needs and resources, including the needs and resources available for the provision of community support services, and the role of facilities in the department in the provision of required services. [If the local government has developed community services assessments and plans pursuant to subdivision four of section four hundred nine-d and paragraph (b) of subdivision three of section four hundred twenty-three of the social services law covering the same time period covered by the five year plan and annual implementation plans and budgets required by this subdivision, then the five year plan and annual implementation plans and budget shall include those portions of the community services assessments and plans relating to the provision of mental health, alcoholism and substance abuse services and an estimate of funds to be made available by the social services district for the provision or purchase of these services.]

(c) Subject to regulations for special circumstances as established by the commissioner or commissioners of the office or offices of the department having jurisdiction of the services, no annual plan or intermediate range plan of the local governmental unit shall be approved unless it indicates that reasonable efforts are being made to extend or improve local [or unified] services in each succeeding local fiscal year in accordance with the statewide long range goals and objectives of the department for the development and integration of state, regional, and local services for the mentally disabled.

(e) Capital costs incurred by a local government or by a voluntary agency, pursuant to [either] an approved local services plan [or an approved unified services plan] and in accordance with the regulations of the commissioner or commissioners of the office or offices of the department having jurisdiction of the services and with the approval of the commissioner or commissioners having jurisdiction of the services, shall be eligible for state aid pursuant to the provisions of this article. Capital costs incurred by a voluntary agency shall be eligible for state aid only if incurred pursuant to an agreement between the voluntary agency and the local governmental unit where the construction is located. Such agreement shall contain the approval by the local governmental unit of such construction and an agreement by such unit to include the program of the voluntary agency in its plans and proposals.

S 16. Subdivisions (b), (c), (d) and paragraph 2 of subdivision (e) of section 41.16 of the mental hygiene law, as added by chapter 978 of the laws of 1977, paragraph 1 of subdivision (b) as amended by chapter 55 of the laws of 1992 and subdivision (c) as amended by chapter 99 of the laws of 1999, are amended to read as follows:

(b) In accordance with regulations established by the commissioner or commissioners of the offices of the department having jurisdiction of

the services, which shall provide for prompt action on proposed local services [and unified services] plans, each local governmental unit shall:

1. establish long range goals and objectives consistent with statewide goals and objectives developed pursuant to section 5.07 of this chapter and develop or annually update the local services [or unified services] plan of the local governmental unit or units listing providers, estimated costs and proposed utilization of state resources, including facilities and manpower, which shall be used in part to formulate statewide comprehensive plans for services.

2. submit one local services plan [or a unified services plan] to the single agent of the department jointly designated by the commissioners of the offices of the department annually for approval by the commissioner or commissioners of the office or offices of the department having jurisdiction of the services.

(c) A local services plan [or unified services plan] shall be developed, in accordance with the regulations of the commissioner or commissioners of the office or offices of the department having jurisdiction of the services by the local governmental unit or units which shall direct and administer a local comprehensive planning process for its geographic area, consistent with statewide goals and objectives established pursuant to section 5.07 of this chapter. The planning process shall involve the directors of any department facilities, directors of hospital based mental health services, directors of community mental health centers, consumers, consumer groups, voluntary agencies, other providers of services, and local correctional facilities and other local criminal justice agencies. The local governmental unit, or units, shall determine the proposed local services plan [or unified services plan] to be submitted for approval. If any provider of services including facilities in the department, or any representative of the consumer or community interests within the local planning process, disputes any element of the proposed plan for the area which it serves, the objection shall be presented in writing to the director of the local governmental unit. If such dispute cannot be resolved to the satisfaction of all parties, the director shall determine the plan to be submitted. If requested and supplied by the objecting party, a written objection to the plan shall be appended thereto and transmitted to the single agent of the department jointly designated by the commissioners.

(d) Each commissioner of an office in the department shall review the portion of the local services plan [or unified services plan] submitted over which his office has jurisdiction and approve or disapprove such plan in accordance with the procedures of subdivision (e) [hereof] OF THIS SECTION.

2. A commissioner of an office of the department shall not disapprove any portion of the local services plan [or unified services plan] without providing the local governmental unit an opportunity to be heard regarding the proposed disapproval and to propose any modification of the plan. Pending the resolution of any dispute over approval of a portion of the plan, by final determination of the commissioner having jurisdiction over the services, new programs proposed shall not be implemented and programs previously implemented shall continue to be funded at existing levels. If a portion of the plan is disapproved, the commissioner of the office having jurisdiction over such portion shall notify the local governmental unit in writing stating reasons for such action.

S 17. Sections 41.19, 41.21 and 41.23 of the mental hygiene law are REPEALED.

S 18. Subdivision (d) of section 41.36 of the mental hygiene law, as amended by chapter 262 of the laws of 1992, is amended to read as follows:

(d) Each local governmental unit shall include in its annual local [or unified services] plan a review of existing community residential facilities providing reimbursable services and a recommendation of anticipated needs for the development of such facilities, consistent with the needs of the mentally retarded and developmentally disabled within the jurisdiction of the local governmental unit.

S 19. Subdivision (b) of section 41.39 of the mental hygiene law, as amended by chapter 515 of the laws of 1992, is amended to read as follows:

(b) Notwithstanding any other provisions of this article, income realized by a voluntary not-for-profit agency from industrial contracts entered into pursuant to its operation of a sheltered workshop shall be matched dollar for dollar by an office of the department of mental hygiene through direct contract with the agency provided that no part of the expenses of such sheltered workshop are claimed through a contract with the local governmental unit which is receiving funding for reimbursement of such expenses from the same office of the department provided that such sheltered workshop is operating in accordance with an approved local [or unified] services plan. In no event shall any combination of income including state aid exceed the total cost of operation of such sheltered workshop.

S 20. Paragraph 2 of subdivision (e), paragraph 6 of subdivision (f), and subdivisions (g), (h) and (i) of section 41.47 of the mental hygiene law, as added by chapter 746 of the laws of 1986, are amended to read as follows:

(2) The commissioner shall establish revenue goals for services, provided, however, the commissioner may approve local [or unified] services plans or may enter into direct contracts with providers of services which substitute alternative revenue goals for individual providers of services based upon appropriate documentation and justification, as required by the commissioner.

(6) the extent to which the community support services authorized by the contract are consistent and integrated with the applicable local [or unified] services plan of the area to be served; and

(g) The commissioner may enter into a direct contract for the provision of community support services when the commissioner determines, after the approval of the local [or unified] services plan and the allocation of state aid therefore, that such direct contract is necessary to assure that additional community support services are available to persons who are functionally disabled as a result of mental illness and are eligible for community support services. Before entering into a direct contract with a provider located within the geographic area of a local governmental unit which receives state aid for community support services pursuant to this section, the commissioner shall notify the local governmental unit and give the director of the local governmental unit an opportunity to appeal the need for such direct contract. Such appeals shall be informal in nature and the rules of evidence shall not apply.

(h) In order to qualify for one hundred percent state aid pursuant to this section in any local fiscal year local governmental units shall assure that the local tax levy share of expenditures for net operating

costs pursuant to an approved local services plan for services provided to mentally ill persons pursuant to section 41.18 of this article[, when applicable,] shall be equal to or greater than the local tax levy share of such expenditures under an approved local services plan in the last complete local fiscal year preceding the effective date of this section, [and when applicable, such local tax levy share of net operating costs for local governmental units submitting unified services plans pursuant to section 41.23 of this article, as adjusted to reflect changes in the rate of state reimbursement for approved expenditures, shall be equal to or greater than the local tax levy share of the net operating costs for expenditures under the approved unified services plan in the last complete local fiscal year preceding the effective date of this section,] provided, however, any such required maintenance of expenditures under this subdivision for local governmental units may be reduced to reflect the local governmental share of revenue applicable to increased payments made by governmental agencies pursuant to title eleven of article five of the social services law, which are a result of increased efficiencies in the collection of such revenue and which represent an increased proportion of the total local [or unified] services operating costs from the prior local fiscal year. The commissioner shall be authorized to reduce payments made to local governmental units pursuant to this article, in the following local fiscal year, for failure to maintain expenditures in accordance with this subdivision.

(i) The provisions of subdivision (h) of this section shall not apply to a local governmental unit in any local fiscal year in which the total amount of state aid granted to the local governmental unit for net operating costs under section 41.18 [or section 41.23] of the article is less than such amount of state aid granted in the local fiscal year preceding the effective date of this section, or in any local fiscal year in which the total amount of state aid granted to the local governmental unit under this section, plus the total amount of direct contracts entered into between the commissioner and providers of services for the provision of community support services to eligible residents of such local governmental unit, shall be less than the total amount of such aid and direct contracts in the first local fiscal year following the effective date of this section.

S 21. Subdivision 4 of section 41.49 of the mental hygiene law, as added by chapter 499 of the laws of 1988, is amended to read as follows:

4. Notwithstanding any other provision of this article, in order to qualify for one hundred percent state aid pursuant to this section, local governmental units shall assure that local contributions for expenditures in any local fiscal year for local [or unified] services provided to mentally ill persons made pursuant to this article, as applicable, shall be equal to or greater than the amount expended by such local governmental unit in the last complete local fiscal year preceding the effective date of this section. The commissioner shall be authorized to reduce payments made to local governmental units which have received grants pursuant to this section, in the following local fiscal year, for failure to maintain expenditures in accordance with this subdivision.

S 22. Subdivision (d) of section 41.53 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

(d) No such grant will be awarded unless the community residence is consistent with the local services plan [or the unified services plan, as appropriate], pursuant to this article.

S 23. This act shall take effect July 1, 2010; provided, however, that the amendments made to sections 9.60 and 31.27 of the mental hygiene law by sections one and two of this act shall not affect the repeal of such sections and shall be deemed repealed therewith; the amendments to subdivision (d) of section 33.13 of the mental hygiene law made by section three of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 18 of chapter 408 of the laws of 1999, as amended when upon such date the provisions of section four of this act shall take effect; and the amendments to subdivisions (a) and (b) of section 41.11 of the mental hygiene law made by section twelve of this act shall not affect the expiration of such subdivisions and shall be deemed to expire therewith.

PART N

Section 1. Subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, subdivision 3-b as added and subdivision 3-c as amended by section 1 of part L of chapter 58 of the laws of 2009, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [2010] 2011, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [2010] 2011 and ending March 31, [2013] 2014, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

S 2. Section 4 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 7 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

S 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided section one of this act shall expire and be deemed repealed April 1, [2012] 2014; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010; 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.

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 N of this act shall be as specifically set forth in the last section of such Parts.