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

9708--B

I N A S S E M B L Y

January 19, 2010

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

AN ACT to amend the insurance law and the public health law, in relation to early intervention services; to amend the public health law, in relation to inspections not otherwise occurring under the state uniform fire prevention and building code; to amend the social services law, in relation to amendments to the state plan for medical assistance; to amend the elder law, in relation to information necessary for Medicare savings programs; to amend the elder law, in relation to elderly pharmaceutical insurance coverage programs and emergency supplies of prescribed medication; to amend the county law, in relation to requests for documents by the state commissioner of health; to amend the public health law, in relation to report submissions; to amend the public health law, in relation to registration by physicians practicing in the state; to amend the public health law, in relation to cardiac services information; to amend the public health law, in relation to health information technology demonstration program (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 public health law, in relation to covering medically necessary orthodontia, covering persons declaring to be a citizen for child health insurance; 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, in relation to

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

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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 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 the New York state 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 twenty; 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; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend the public health 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, in relation to such reimbursements; 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, matters regarding fiscal solvency, certificates of authority, reporting requirements and the voluntary residential health care facility rightsizing demonstration program; to repeal subdivision 2-c of section 2808 of the public health law relating to rates of payment for real property costs of residential health care facilities and to repeal subdivision 4 of section 4403-f of the public health law relating to premium rates for managed long term care plans (Part C); to amend the insurance law, in relation to prior approval of health insurance premium rates (Part D); Intentionally omitted (Part E); Intentionally omitted (Part F); Intentionally omitted (Part G); to authorize the office of mental health to close adult 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 extending the effectiveness of the provisions thereof (Part H); Intentionally omitted (Part I); Intentionally omitted (Part J); Intentionally omitted (Part K); Intentionally omitted (Part L); to amend the mental hygiene law, in relation to unified services; and repealing certain provisions of such law relating thereto (Part M); to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to foregoing such adjustment during the 2010-2011 state fiscal year (Part N); to amend chapter 119 of the laws of 1997, relating to authorizing the department of health to establish certain payments to general hospitals, in relation thereto (Part O); to increase Medicaid payments to providers through managed care organizations and provide equivalent fees through an ambulatory patient group methodology relating thereto (Part P); to amend the mental hygiene law, in relation to shared services of the commissioners of the office of mental health, office of mental retardation and developmental disabilities, and office of alcoholism and substance abuse (Part Q); Intentionally omitted (Part R); to amend the social services law and the public health law, in relation to medical assistance compliance programs (Part S); and to direct the commissioner of health to create and implement a plan for the state administration of the medical assistance program performed by social services districts (Part T)

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 T. 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. Intentionally omitted.

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

(c) Any right of subrogation to benefits which a municipality [is] AND THE STATE ARE 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 acci-

dent and health insurance policy prior to receipt by the insurer of written notice from the municipality OR THE STATE.

S 1-b. Paragraphs (a) and (d) of subdivision 3 of section 2559 of the public health law, paragraph (a) as amended and paragraph (d) as added by chapter 231 of the laws of 1993, are amended to read as follows:

(a) Providers of early intervention services and transportation services shall in the first instance and where applicable, seek payment from all third party payors including governmental agencies prior to claiming payment from a given municipality for services rendered to eligible children, provided that, for the purpose of seeking payment from the medical assistance program or from other third party payors, the municipality AND THE STATE 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.

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

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. Intentionally omitted.

S 9. Intentionally omitted.

S 9-a. Intentionally omitted.

S 10. Intentionally omitted.

S 11. Intentionally omitted.

S 12. Intentionally omitted.

S 13. Intentionally omitted.

S 13-a. Intentionally omitted.

S 14. Intentionally omitted.

S 14-a. Intentionally omitted.

S 15. Intentionally omitted.

S 16. Intentionally omitted.

S 17. Intentionally omitted.

S 18. Intentionally omitted.

S 19. Intentionally omitted.

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. Intentionally omitted.

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. Intentionally omitted.

S 29. Intentionally omitted.

S 30. Intentionally omitted.

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 32-a. Subparagraph 1 of paragraph (d) of subdivision 3 of section 367-a of the social services law, as amended by section 2 of part G of chapter 23 of the laws of 2002, is amended to read as follows:

(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 OR EQUAL TO one hundred [thirty-five] EIGHTY-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;

S 32-b. Subdivision 1 of section 246 of the elder law is amended to read as follows:

1. Provide for a process of determining and redetermining eligibility for participation in this program including provisions for submission of proof of income, age, [and] residency [and], information on existing complete or partial coverage of prescription drug expenses under a third party assistance or insurance plan, AS WELL AS ANY INFORMATION REQUIRED TO APPLY ON BEHALF OF PARTICIPANTS FOR MEDICARE SAVINGS PROGRAMS WHICH SHALL BE FORWARDED IN THE PROPER FORMAT DIRECTLY TO THE APPROPRIATE ENTITY RESPONSIBLE FOR APPROVING SUCH APPLICATIONS. IT SHALL BE MADE CLEAR ON THE APPLICATION THAT SUCH ADDITIONAL INFORMATION NECESSARY TO APPLY FOR MEDICARE SAVINGS PROGRAMS ON BEHALF OF PARTICIPANTS IS ONLY REQUIRED TO BE PROVIDED WHEN THE APPLICANT'S INCOME IS AT OR BELOW A CERTAIN AMOUNT, WHICH SHALL BE THE AMOUNT THAT WOULD INDICATE THE APPLICANT'S ELIGIBILITY FOR THE MEDICARE SAVINGS PROGRAMS;

S 32-c. 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]: (1) 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, BUT ONLY AFTER THE PARTICIPANT HAS FIRST EXHAUSTED THE FIRST TWO LEVELS OF APPEAL AVAILABLE UNDER PART D OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND THE APPEAL HAS BEEN UNSUCCESSFUL. (2) THE PHARMACIST SHALL INFORM THE PRESCRIBER THAT THE PARTICIPANT'S MEDICARE PART D PLAN HAS DENIED PAYMENT FOR THE PRESCRIBED MEDICATION, THAT IF THE PRESCRIBER DOES NOT CHOOSE TO CHANGE THE PRESCRIPTION, AN APPEAL MUST BE PURSUED, AND THAT THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE ASSISTANCE WITH SUCH APPEALS UPON REQUEST. THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM SHALL PROVIDE SUCH ASSISTANCE WITH APPEALS AS REQUESTED BY THE PARTICIPANT OR THE PARTICIPANT'S PHYSICIAN. (3) THE STATE SHALL PROVIDE FOR A THIRTY DAY EMERGENCY SUPPLY OF THE PRESCRIBED MEDICATION, OR LESS IF THE PRESCRIPTION IS FOR LESS. IN INSTANCES WHERE THE PARTICIPANT'S APPEAL IS STILL PENDING AT THE END OF THE FIRST THIRTY DAYS, THE STATE SHALL PROVIDE FOR AN ADDITIONAL FOURTEEN DAY SUPPLY, OR LESS IF THE PRESCRIPTION IS FOR LESS. [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.] (4) 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 32-d. Paragraph (g) of subdivision 3 of section 242 of the elder law, as added by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(g) The elderly pharmaceutical insurance coverage program is authorized and directed to conduct an enrollment program to facilitate, in as prompt and streamlined a fashion as possible, the enrollment into Medicare part D of program participants who are required by the provisions of this section to enroll in part D. Provided, however, that a participant shall not be prevented from receiving his or her drugs [immediately] at the pharmacy under the elderly pharmaceutical insurance coverage program as a result of such participant's enrollment in Medicare part D PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION.

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. Intentionally omitted.

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. Intentionally omitted.

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) the amendments to subparagraph 1 of paragraph (d) of subdivision 3 of section 367-a of the social services law made by section thirty-two-a of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith;

(b) section 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-two-d of this act shall take effect July 1, 2010; and

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

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 2-a. Subdivision 10 of section 2807-d of the public health law is amended by adding a new paragraph (f) to read as follows:

(F) PROVIDED, HOWEVER, THAT, SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PURPOSES OF DETERMINING RATES OF

PAYMENT PURSUANT TO THIS ARTICLE FOR GENERAL HOSPITALS, THE ASSESSMENT IMPOSED PURSUANT TO SUBPARAGRAPH (VI) OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION SHALL, INSOFAR AS SUCH ASSESSMENT IS IN EXCESS OF THIRTY-FIVE HUNDREDTHS OF ONE PERCENT OF EACH SUCH GENERAL HOSPITAL'S GROSS RECEIPTS, 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.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

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. (A) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN, DISTRIBUTIONS PURSUANT TO THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE, SHALL REFLECT AN AGGREGATE REDUCTION OF FIFTY-FOUR MILLION NINE HUNDRED THOUSAND DOLLARS, BASED ON THE PROPORTION OF EACH HOSPITAL'S INDIGENT CARE ALLOCATION TO THE TOTAL ALLOCATIONS OF ALL HOSPITALS' INDIGENT CARE ALLOCATIONS PRIOR TO APPLICATION OF THIS REDUCTION, PROVIDED, HOWEVER, THAT SUCH REDUCTIONS SHALL NOT BE APPLIED TO DISTRIBUTIONS TO MAJOR PUBLIC HOSPITALS, INCLUDING MAJOR PUBLIC HOSPITALS OPERATED BY PUBLIC BENEFIT CORPORATIONS, AND SHALL ALSO NOT BE APPLIED TO DISTRIBUTIONS MADE PURSUANT TO SUBPARAGRAPHS (II), (III) OR (IV) OF PARAGRAPH (B) OF SUBDIVISION FIVE-B OF THIS SECTION.

(B) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND ELEVEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND ELEVEN AND EACH CALENDAR YEAR THEREAFTER, DISTRIBUTIONS PURSUANT TO THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE SHALL REFLECT AN AGGREGATE REDUCTION OF SEVENTY-THREE MILLION TWO HUNDRED THOUSAND DOLLARS, BASED ON THE PROPORTION OF EACH HOSPITAL'S INDIGENT CARE ALLOCATION TO THE TOTAL ALLOCATIONS OF ALL HOSPITALS' INDIGENT CARE ALLOCATIONS PRIOR TO APPLICATION OF THIS REDUCTION, PROVIDED, HOWEVER, THAT SUCH REDUCTIONS SHALL NOT BE APPLIED TO DISTRIBUTIONS TO MAJOR PUBLIC HOSPITALS, INCLUDING MAJOR PUBLIC HOSPITALS OPERATED BY PUBLIC BENEFIT CORPORATIONS, AND SHALL ALSO NOT BE APPLIED TO DISTRIBUTIONS MADE PURSUANT TO SUBPARAGRAPHS (II), (III) OR (IV) OF PARAGRAPH (B) OF SUBDIVISION FIVE-B OF THIS SECTION.

S 7-a. Subdivision 35 of section 2807-c of the public health law is amended by adding a new paragraph (i) to read as follows:

(I) (I) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER SHALL, FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, AND THEN FOR EACH SUBSEQUENT ANNUAL PERIOD THEREAFTER, SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, MAKE ADDITIONAL PAYMENTS OF TWO HUNDRED EIGHTY-ONE MILLION DOLLARS TO CERTAIN NON-PUBLIC GENERAL HOSPITALS AS MEDICAL ASSISTANCE PAYMENTS FOR IMPATIENT SERVICES PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW FOR PATIENTS ELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT. THE COMMISSIONER SHALL ESTABLISH A METHODOLOGY FOR DISTRIBUTION OF THESE FUNDS NO LATER THAN JUNE FIRST, TWO THOUSAND TEN, PROVIDED:

(A) THE COMMISSIONER SHALL PROVIDE THE CHAIRMAN OF THE SENATE FINANCE COMMITTEE AND THE CHAIRMAN OF THE ASSEMBLY WAYS AND MEANS COMMITTEE WITH A REPORT DESCRIBING THE METHODOLOGY FOR ALLOCATION OF SUCH FUNDS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, BY NO LATER THAN MAY FIFTEENTH, TWO THOUSAND TEN, AND AT LEAST FIFTEEN DAYS PRIOR TO IMPLEMENTING SUBSEQUENT CHANGES TO THE METHODOLOGY;

(B) THE METHODOLOGY FOR THE ADDITIONAL PAYMENTS:

(I) SHALL NOT BE DESIGNED TO PROVIDE ANY ELIGIBLE GENERAL HOSPITAL WITH AN ANNUAL PAYMENT AMOUNT IN EXCESS OF THE SUM OF THE ANNUAL AMOUNTS DUE THAT HOSPITAL PURSUANT TO SECTIONS TWENTY-EIGHT HUNDRED SEVEN-K AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE;

(II) MAY RESULT IN SOME HOSPITALS RECEIVING NO PAYMENTS UNDER THIS SUBDIVISION;

(III) MAY BE CHANGED BY THE COMMISSIONER NO MORE THAN ANNUALLY;

(C) SUBJECT TO FEDERAL FINANCIAL PARTICIPATION AND IN CONFORMANCE WITH APPLICABLE FEDERAL STATUTES AND REGULATIONS, PAYMENTS SHALL BE MADE AS UPPER PAYMENT LIMIT PAYMENTS AND SHALL BE PROVIDED AS AGGREGATE MONTHLY PAYMENTS TO ELIGIBLE GENERAL HOSPITALS;

(D) IN THE EVENT THAT THE SECRETARY OF HEALTH AND HUMAN SERVICES DETERMINES PAYMENTS MADE PURSUANT TO CLAUSE (C) OF THIS SUBPARAGRAPH ARE NOT ELIGIBLE FOR FEDERAL FINANCIAL PARTICIPATION, PAYMENTS PURSUANT TO THIS PARAGRAPH SHALL BE INCLUDED AS A RATE ADD-ON TO MEDICAL ASSISTANCE INPATIENT RATES OF PAYMENT ESTABLISHED PURSUANT TO THIS SUBDIVISION BASED ON MEDICAL ASSISTANCE UTILIZATION DATA REPORTED ON THE FACILITY'S ANNUAL INSTITUTIONAL COST REPORT FROM TWO YEARS PRIOR TO THE RATE YEAR;

(E) IF SUCH PAYMENTS ARE ADDED TO RATES OF PAYMENT PURSUANT TO CLAUSE (D) OF THIS SUBPARAGRAPH, THE COMMISSIONER SHALL ESTABLISH A PROCEDURE TO RECONCILE PAYMENT AMOUNTS TO REFLECT CHANGES IN MEDICAL ASSISTANCE UTILIZATION BETWEEN TWO YEARS PRIOR TO THE RATE YEAR AND THE ACTUAL RATE YEAR AS REPORTED ON EACH HOSPITAL'S ANNUAL INSTITUTIONAL COSTS REPORT FOR THE RESPECTIVE RATE YEAR.

(II) REVENUE FROM PAYMENTS PURSUANT TO THIS SECTION SHALL NOT BE INCLUDED IN GROSS REVENUE RECEIVED FOR PURPOSES OF THE ASSESSMENTS PURSUANT TO SUBDIVISION EIGHTEEN OF THIS SECTION, SUBJECT TO THE PROVISIONS OF PARAGRAPH (E) OF SUBDIVISION EIGHTEEN OF THIS SECTION, AND SHALL NOT BE INCLUDED IN GROSS REVENUE RECEIVED FOR PURPOSES OF THE ASSESSMENTS PURSUANT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE, SUBJECT TO THE PROVISIONS OF SUBDIVISION TWELVE OF SUCH SECTION TWENTY-EIGHT HUNDRED SEVEN-D.

S 7-b. Section 2807-k of the public health law is amended by adding a new subdivision 17 to read as follows:

17. INDIGENT CARE REDUCTIONS. FOR EACH HOSPITAL RECEIVING PAYMENTS PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE, THE COMMISSIONER SHALL REDUCE THE SUM OF ANY AMOUNTS PAID PURSUANT TO THIS SECTION AND ANY AMOUNTS PAID PURSUANT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE BY AN AMOUNT EQUAL TO THE LOWER OF SUCH SUM OR EACH SUCH HOSPITAL'S PAYMENTS PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE.

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

5. FOR EACH HOSPITAL RECEIVING PAYMENTS PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE, THE COMMISSIONER SHALL REDUCE THE SUM OF ANY AMOUNTS PAID PURSUANT TO THIS SECTION AND ANY AMOUNTS PAID PURSUANT TO SECTION TWEN-

TY-EIGHT HUNDRED SEVEN-K OF THIS ARTICLE BY AN AMOUNT EQUAL TO THE LOWER OF SUCH SUM OR EACH SUCH HOSPITAL'S PAYMENTS PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE.

S 7-d. Paragraph (d) of subdivision 18 of section 2807-c of the public health law, as amended by section 12 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(d) Gross revenue received shall mean all moneys received for or on account of inpatient hospital service, provided, however, that subject to the provisions of paragraph (e) of this subdivision gross revenue received shall not include distributions from bad debt and charity care regional pools, health care services pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with this section or distributions from funds allocated in accordance with section twenty-eight hundred seven-l, twenty-eight hundred seven-k, twenty-eight hundred seven-v or twenty-eight hundred seven-w of this article and shall not include the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c of this section, the adjustment provided in accordance with subdivision fourteen-a of this section, the adjustment provided in accordance with subdivision fourteen-d of this section, the adjustment for health maintenance organization reimbursement rates provided in accordance with former subdivision two-a of this section, PAYMENTS MADE PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF THIS SECTION or, if effective, the adjustment provided in accordance with subdivision fifteen of this section, the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended, revenue received from physician practice or faculty practice plan discrete billings for private practicing physician services, revenue from affiliation agreements or contracts with public hospitals for the delivery of health care services at such public hospitals, revenue received as disproportionate share hospital payments in accordance with title nineteen of the federal social security act, or revenue from government deficit financing, provided, however, that funds received as medical assistance payments which include state share amounts authorized pursuant to section twenty-eight hundred seven-v of this article that are not disproportionate share hospital payments shall be included within the meaning of gross revenue for purposes of this subdivision.

S 7-e. Paragraph (a) of subdivision 3 of section 2807-d of the public health law, as amended by section 13 of part D of chapter 57 of the laws of 2006, is amended to read as follows:

(a) for general hospitals, all monies received for or on account of inpatient hospital service, outpatient service, emergency service, referred ambulatory service and ambulatory surgical service, or other hospital or health-related services, excluding, subject to the provisions of subdivision twelve of this section: distributions from bad debt and charity care regional pools, primary health care services regional pools, bad debt and charity care for financially distressed hospitals statewide pools and bad debt and charity care and capital statewide pools created in accordance with section twenty-eight hundred seven-c of this article and the components of rates of payment or charges related to the allowances provided in accordance with subdivisions fourteen, fourteen-b and fourteen-c, the adjustment provided in accordance with subdivision fourteen-a, the adjustment provided in accordance

with subdivision fourteen-d, the adjustment for health maintenance organization reimbursement rates provided in accordance with section twenty-eight hundred seven-f of this article, the adjustment for commercial insurer reimbursement rates provided in accordance with paragraph (i) of subdivision eleven of section twenty-eight hundred seven-c of this article or, if effective, the adjustment provided in accordance with subdivision fifteen of section twenty-eight hundred seven-c of this article or the adjustment provided in accordance with section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as amended and physician practice or faculty practice plan revenue received by a general hospital based on discrete billings for private practicing physician services, revenue received by a general hospital from a public hospital pursuant to an affiliation agreement contract for the delivery of health care services to such public hospital, REVENUE RECEIVED PURSUANT TO PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE, revenue received pursuant to section twenty-eight hundred seven-w of this article, all revenue received as disproportionate share hospital payments, in accordance with title nineteen of the federal Social Security Act, revenue received pursuant to sections eleven, twelve, thirteen and fourteen of part A of chapter one of the laws of two thousand two, revenue received pursuant to sections thirteen and fourteen of part B of chapter one of the laws of two thousand two, revenue from patient personal fund allowances, revenue from income earned on patient funds, investment income from externally restricted funds, revenue from investment sinking funds, revenue from investment operating escrow accounts, investment income from funded depreciation, investment income from mortgage repayment escrow accounts, revenue derived from the operation of schools leading to licensure, and revenue from the collection of sales and excise taxes;

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

S 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, IF AN ELIGIBLE PARTICIPANT HAS EXHAUSTED THE FIRST TWO LEVELS OF APPEALS AVAILABLE UNDER SUCH TITLE AND THE APPEAL HAS BEEN UNSUCCESSFUL, THEN 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 12-a. Intentionally omitted.

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] THIRTEEN AND SIX-HUNDREDTHS 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] FIFTEEN AND TWENTY-FIVE HUNDREDTHS percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision.

S 14. Intentionally omitted.

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 SUBMITTED BY EACH THIRD PARTY PAYOR TO THE COMMISSIONER OR THE COMMISSIONER'S DESIGNEE IN ACCORDANCE WITH THIS SECTION. SUCH PAYMENTS SHALL BE SUBJECT TO AUDIT BY THE COMMISSIONER IN THE SAME MANNER AS THE OTHER PAYMENTS OTHERWISE SUBMITTED AND REPORTED PURSUANT TO THIS SECTION. THE COMMISSIONER MAY TAKE ALL MEASURES TO COLLECT DELINQUENT PAYMENTS DUE PURSUANT TO THIS SUBDIVISION AS ARE OTHERWISE PERMITTED WITH REGARD TO DELINQUENT PAYMENTS DUE PURSUANT TO OTHER SUBDIVISIONS OF THIS SECTION.

(C) SURCHARGES PURSUANT TO THIS SUBDIVISION SHALL NOT APPLY TO PAYMENTS MADE BY THIRD PARTY PAYORS FOR SERVICES PROVIDED TO PATIENTS INSURED BY MEDICAID OR BY THE CHILD HEALTH PLUS PROGRAM OR TO ANY PATIENT IN A CATEGORY THAT IS EXEMPT FROM SURCHARGE OBLIGATIONS ASSESSED PURSUANT TO SUBDIVISIONS ONE THROUGH TWELVE OF THIS SECTION.

S 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 administering the long-term care insurance education and outreach program [and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long-term care insurance resource centers with the necessary resources to carry out their operations; 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-EIGHT million [one] THREE 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] TWENTY-ONE million [five] SIX 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. Intentionally omitted.

S 25-a. Intentionally omitted.

S 26. Intentionally omitted.

S 27. Intentionally omitted.

S 28. Intentionally omitted.

S 29. Intentionally omitted.

S 30. Intentionally omitted.

S 31. Intentionally omitted.

S 31-a. Section 365-a of the social services law is amended by adding a new subdivision 9 to read as follows:

9. (A) NOTWITHSTANDING INCONSISTENT PROVISION OF LAW, ANY UTILIZATION CONTROLS ON OCCUPATIONAL THERAPY OR PHYSICAL THERAPY, INCLUDING BUT NOT LIMITED TO, PRIOR APPROVAL OF SERVICES, UTILIZATION THRESHOLDS OR OTHER LIMITATIONS IMPOSED ON SUCH THERAPY SERVICES IN RELATION TO A CHRONIC CONDITION IN CLINICS CERTIFIED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW OR ARTICLE SIXTEEN OF THE MENTAL HYGIENE LAW SHALL BE DEVELOPED BY THE DEPARTMENT OF HEALTH IN CONCURRENCE WITH THE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES.

(B) IN THE CASE OF ANY DENIAL OF OCCUPATIONAL THERAPY OR PHYSICAL THERAPY SERVICES UNDER THIS SUBDIVISION, IF THE PRESCRIBING HEALTH CARE PROFESSIONAL DETERMINES IN HIS OR HER REASONABLE PROFESSIONAL JUDGMENT THAT THE SERVICE OR SERVICES ARE WARRANTED, THE DEPARTMENT OF HEALTH SHALL PROVIDE A REASONABLE OPPORTUNITY FOR THE PRESCRIBER TO REASONABLY PRESENT HIS OR HER JUSTIFICATION OF PRIOR AUTHORIZATION. IF, AFTER CONSULTATION WITH THE DEPARTMENT OF HEALTH, THE PRESCRIBER, IN HIS OR HER REASONABLE PROFESSIONAL JUDGMENT, DETERMINES THAT THE PRESCRIBED THERAPY IS WARRANTED, THE PRESCRIBER'S DETERMINATION SHALL BE FINAL.

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.

S 34. Intentionally omitted.

S 34-a. Intentionally omitted.

S 34-b. Intentionally omitted.

S 34-c. Intentionally omitted.

S 34-d. Intentionally omitted.

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 ENROLLMENT AND RENEWAL 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 ENROLLMENT AND RENEWAL IMPLEMENTED IN ACCORDANCE WITH SECTION 1902(E)(13) 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) AND (H) 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) AND (H) 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. Intentionally omitted.

S 38. Intentionally omitted.

S 38-a. Intentionally omitted.

S 39. Intentionally omitted.

S 39-a. Intentionally omitted.

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. Intentionally omitted.

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. The commissioner of health may 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. Intentionally omitted.

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 forty-seven and forty-seven-a of this act shall take effect November 1, 2010;

(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 paragraph (d) of subdivision 18 of section 2807-c of the public health law made by section seven-d of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(h) 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;

(i) 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;

(j) 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;

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

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

(n) 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 ninety-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 SHALL 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 residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand [eleven] 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. Intentionally omitted.

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

S 5-a. Intentionally omitted.

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 determination that such adjustments, including the application of adjustments authorized by the provisions of paragraph (g) of subdivision 2-b of section 2808 of the public health law, shall result in an aggregate increase in total Medicaid rates of payment for such services for such period that is less than or more than two hundred ten million dollars ($210,000,000), make such proportional adjustments to such rates as are necessary to result in an increase of such aggregate expenditures of two hundred ten million dollars ($210,000,000), [and provided further, however, that 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, 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. Adjustments made pursuant to this section shall not be subject to subsequent correction or reconciliation.

S 5-c. Intentionally omitted.

S 5-d. Subdivision 2-c of section 2808 of the public health law is REPEALED.

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 ACCORD-

ANCE 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 and a new paragraph (d) is added 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.

(D) PROVIDED, HOWEVER, THAT, SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR THE PURPOSES OF DETERMINING RATES OF PAYMENT PURSUANT TO THIS ARTICLE FOR CERTIFIED HOME HEALTH AGENCIES AND LONG-TERM HOME HEALTH CARE PROGRAMS, THE ASSESSMENT IMPOSED PURSUANT TO THIS SECTION SHALL, INSOFAR AS SUCH ASSESSMENT IS IN EXCESS OF THIRTY-FIVE HUNDREDTHS OF ONE PERCENT OF EACH SUCH CERTIFIED HOME HEALTH AGENCY AND LONG-TERM HOME HEALTH CARE PROGRAM'S GROSS RECEIPTS, 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.

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 DELINQUENCIES 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. Intentionally omitted.

S 13-a. Intentionally omitted.

S 13-b. Intentionally omitted.

S 14. Intentionally omitted.

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. Intentionally omitted.

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 commissioner 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 regulations of the superintendent of insurance as stated in this section,] that such demonstration complies with the operating requirements for a managed long term care plan under this section. Except as otherwise expressly provided in paragraphs (d) and (e) of subdivision seven of this section, nothing in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

(c) An approved managed long term care demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner[, subject to the necessary evaluations, approvals and regulations of the superintendent of insurance set forth in this section,] that such demonstration complies with the operating

requirements for a managed long term care plan under this section. Notwithstanding any inconsistent provision of law to the contrary, all authority for the operation of approved managed long term care demonstrations which have not been issued a certificate of authority as a managed long term care plan, shall expire one year after the adoption of regulations implementing managed long term care plans.

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. Intentionally omitted.

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. 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;

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

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

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

5. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of insurance and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

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

PART D

Section 1. Subsection (e) of section 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 AT LEAST NINETY 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. THE DETERMINATION OF THE SUPERINTENDENT SHALL BE SUPPORTED BY SOUND ACTUARIAL ASSUMPTIONS AND METHODS, AND SHALL BE RENDERED IN WRITING WITHIN NINETY DAYS FOLLOWING THE DATE UPON WHICH THE RATE FILING OR APPLICATION IS RECEIVED. SHOULD THE SUPERINTENDENT REQUIRE ADDITIONAL INFORMATION FROM THE INSURER IN ORDER TO MAKE A DETERMINATION, HE OR SHE SHALL REQUEST SUCH INFORMATION IN WRITING WITHIN FORTY-FIVE DAYS OF RECEIPT OF THE RATE FILING OR APPLICATION. IN THE EVENT THE SUPERINTENDENT HAS REQUESTED ADDITIONAL INFORMATION, HE OR SHE MAY TAKE AN ADDITIONAL TWENTY DAYS FROM THE DATE UPON WHICH SUCH ADDITIONAL INFORMATION IS RECEIVED. THE APPLICATION OR RATE FILING WILL BE DEEMED APPROVED IF A DETERMINATION IS NOT RENDERED WITHIN THE TIME ALLOTTED UNDER THIS SECTION. AN INSURER SHALL NOT IMPLEMENT A RATE ADJUSTMENT UNLESS THE INSURER PROVIDES AT LEAST SIXTY 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 PUBLIC HEARING SHALL BE HELD NO LATER THAN SIXTY DAYS FROM THE DATE UPON WHICH THE RATE FILING OR APPLICATION WAS RECEIVED. 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-TWO PERCENT. IN REVIEWING A RATE FILING OR APPLICATION, THE SUPERINTENDENT MAY MODIFY THE EIGHTY-TWO PERCENT EXPECTED MINIMUM LOSS RATIO REQUIREMENT IF THE SUPERINTENDENT DETERMINES THE MODIFICATION TO BE IN THE INTERESTS OF THE PEOPLE OF THIS STATE OR IF THE SUPERINTENDENT DETERMINES THAT A MODIFICATION IS NECESSARY TO MAINTAIN INSURER SOLVENCY. NO LATER THAN JUNE THIRTIETH 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-TWO percent of the premium[,]; 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-TWO 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-TWO 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-TWO 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-TWO PERCENT. INSURERS MAY USE THE ALTERNATE FILING PROCEDURE SET FORTH IN PARAGRAPH TWO OF THIS SUBSECTION 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 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 appli-
cation.

(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 AT LEAST NINETY 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. THE DETERMINATION OF THE SUPERINTENDENT SHALL BE SUPPORTED BY SOUND ACTUARIAL ASSUMPTIONS AND METHODS, AND SHALL BE RENDERED IN WRITING WITHIN NINETY DAYS FOLLOWING THE DATE UPON WHICH THE RATE FILING OR APPLICATION IS RECEIVED. SHOULD THE SUPERINTENDENT REQUIRE ADDITIONAL INFORMATION FROM THE INSURER IN ORDER TO MAKE A DETERMINATION, HE OR SHE SHALL REQUEST SUCH INFORMATION IN WRITING WITHIN FORTY-FIVE DAYS OF RECEIPT OF THE RATE FILING OR APPLICATION. IN THE EVENT THE SUPERINTENDENT HAS REQUESTED ADDITIONAL INFORMATION, HE OR SHE MAY TAKE AN ADDITIONAL TWENTY DAYS FROM THE DATE UPON WHICH SUCH ADDITIONAL INFORMATION IS RECEIVED. THE APPLICATION OR RATE FILING WILL BE DEEMED APPROVED IF A DETERMINATION IS NOT RENDERED WITHIN THE TIME ALLOTTED UNDER THIS SECTION. A CORPORATION SHALL NOT IMPLEMENT A RATE ADJUSTMENT UNLESS THE CORPORATION PROVIDES AT LEAST SIXTY 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 PUBLIC HEARING SHALL BE HELD NO LATER THAN SIXTY DAYS FROM THE DATE UPON WHICH THE RATE FILING OR APPLICATION WAS RECEIVED. 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-TWO PERCENT. IN REVIEWING A RATE FILING OR APPLICATION, THE SUPERINTENDENT MAY MODIFY THE EIGHTY-TWO PERCENT EXPECTED MINIMUM LOSS RATIO REQUIREMENT IF THE SUPERINTENDENT DETERMINES THE MODIFICATION TO BE IN THE INTERESTS OF THE PEOPLE OF THIS STATE OR IF THE SUPERINTENDENT DETERMINES THAT A MODIFICATION IS NECESSARY TO MAINTAIN INSURER SOLVENCY. NO LATER THAN JUNE THIRTIETH 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-TWO 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-TWO 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-TWO 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-TWO 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. SUCH ALTERNATE PROCEDURE 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.] ALL COMMUNITY RATED CONTRACTS, OTHER THAN MEDICARE SUPPLEMENTAL INSURANCE CONTRACTS, ISSUED OR IN EFFECT DURING CALENDAR YEAR TWO THOUSAND TEN AND THEREAFTER SHALL BE SUBJECT TO A MINIMUM LOSS RATIO REQUIREMENT OF EIGHTY-TWO 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

Intentionally omitted.

PART F

Intentionally omitted.

PART G

Intentionally omitted.

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 adult 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] 2013 when upon such date the provisions of this act shall be deemed repealed.

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.

PART I

Intentionally omitted.

PART J

Intentionally omitted.

PART K

Intentionally omitted.

PART L

Intentionally omitted.

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 combi-

nation 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.

PART O

Section 1. Subdivision 6 of section 1 of chapter 119 of the laws of 1997 relating to authorizing the department of health to establish certain payments to general hospitals, as amended by section 1 of part S2 of chapter 62 of the laws of 2003, is amended to read as follows:

6. Payment limitations set forth in [paragraph] SUBDIVISION 2 of this section related to costs incurred by general hospitals in providing services to uninsured patients and patients eligible for medical assistance pursuant to title 11 of article 5 of the social services law shall, for state fiscal [year periods commencing April 1, 1997 through March 31, 2002, be based initially on reported 1995 reconciled data as further reconciled to actual reported 1997, 1998, 1999, 2000 and 2001 reconciled data, respectively. Such payment limitations for state fiscal year periods commencing April 1, 2002 through March 31, 2006, shall be based initially on reported 2000 reconciled data as further reconciled to actual reported 2002, 2003, 2004 and 2005 reconciled data, respectively] YEARS BEGINNING ON AND AFTER APRIL 1, 2010, BE BASED INITIALLY ON REPORTED RECONCILED DATA FROM THE BASE YEAR TWO YEARS PRIOR TO THE PAYMENT YEAR, AND FURTHER RECONCILED TO ACTUAL REPORTED DATA FROM SUCH PAYMENT YEAR. The payments may be made as quarterly aggregate payments to an eligible general hospital.

S 2. This act shall take effect April 1, 2010; provided, however, that the amendments to subdivision 6 of section 1 of chapter 119 of the laws of 1997 made by section one of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART P

Section 1. Notwithstanding any contrary provision of law, the commissioner of mental health is authorized, subject to the approval of the

director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing hospital-based and free-standing clinics licensed pursuant to article 28 of the public health law, pursuant to article 31 of the mental hygiene law or pursuant to both such provisions of law for outpatient mental health services, as determined by the commissioner of health in consultation with the commissioner of mental health, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioner of mental health, be greater than the increased funds made available pursuant to this section. The commissioner of health may, in consultation with the commissioner of mental health, promulgate regulations, including emergency regulations, as are necessary to implement the provisions of this section.

S 2. This act shall take effect April 1, 2010.

PART Q

Section 1. Section 5.01 of the mental hygiene law, as added by chapter 978 of the laws of 1977, is amended to read as follows:

S 5.01 Department of mental hygiene.

(A) There shall continue to be in the state government a department of mental hygiene. Within the department there shall be the following autonomous offices:

(1) office of mental health;

(2) office of mental retardation and developmental disabilities;

(3) office of alcoholism and substance abuse.

(B) WITHIN THE DEPARTMENT, THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, THE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES SHALL, TO THE GREATEST EXTENT POSSIBLE, CENTRALIZE DUPLICATIVE ADMINISTRATIVE FUNCTIONS, INCLUDING BUT NOT LIMITED TO, CLERICAL, PAYROLL, BOOKKEEPING, PROCUREMENT AND HUMAN RESOURCE FUNCTIONS IN AN EFFORT TO CREATE GREATER EFFICIENCIES AND COST SAVINGS FOR THE PUBLIC. SUCH FUNCTIONS MAY BE PHYSICALLY LOCATED AS DETERMINED BY THE COMMISSIONERS TO RENDER THE GREATEST EFFICIENCIES.

S 2. This act shall take effect January 1, 2011.

PART R

Intentionally omitted.

PART S

Section 1. Subdivision 3 of section 363-d of the social services law, as amended by section 44 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

3. Upon enrollment in the medical assistance program, a provider shall certify to the department that the provider satisfactorily meets the requirements of this section. Additionally, the commissioner of health and Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that satisfactorily meets the requirements of this section. IT SHALL BE A REBUTTABLE PRESUMPTION THAT A COMPLIANCE PROGRAM THAT CONTAINS THE ELEMENTS LISTED IN SUBDIVISION TWO OF THIS SECTION SATISFACTORILY MEETS THE REQUIREMENTS OF THIS SECTION.

(a) A compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this section, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(b) In the event that the commissioner of health or the Medicaid inspector general finds that the provider does not have a satisfactory program within ninety days after the effective date of the regulations issued pursuant to subdivision four of this section, THE PROVIDER SHALL BE NOTIFIED PROMPTLY AND DEFICIENCIES IDENTIFIED. THE PROVIDER SHALL THEN BE GIVEN AN OPPORTUNITY, NOT TO EXCEED THIRTY DAYS, TO CURE SUCH DEFICIENCIES TO THE SATISFACTION OF THE COMMISSIONER OF HEALTH, HIS OR HER DESIGNEE, OR THE MEDICAID INSPECTOR GENERAL. IF THE PROVIDER FAILS TO CURE THE DEFICIENCIES WITHIN THIRTY DAYS AFTER THE RECEIPT OF AN INITIAL NOTICE, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

S 2. Subdivision 6 of section 32 of the public health law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

6. to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the medical assistance program, including but not limited to: (a) referral of information and evidence to regulatory agencies and licensure boards; (b) withholding payment of medical assistance funds in accordance with state and federal laws and regulations, PROVIDED THAT ANY FUNDS AND INTEREST THEREON DETERMINED BY THE INSPECTOR, THE COMMISSIONER OR DESIGNEE, OR A COURT OF LAW TO HAVE BEEN IMPROPERLY WITHHELD OR RECOUPED FROM A PROVIDER OF MEDICAL ASSISTANCE SHALL BE REFUNDED TO THE PROVIDER AS SOON AS PRACTICABLE BUT IN NO EVENT MORE THAN SIXTY DAYS AFTER SUCH DETERMINATION; (c) imposition of administrative sanctions and penalties in accordance with state and federal laws and regulations; (d) exclusion of providers, vendors and contractors from participation in the program; (e) initiating and maintaining actions for civil recovery and, where authorized by law, seizure of property or other assets connected with improper payments; and entering into civil settlements; and (f) recovery of improperly expended medical assistance program funds from those who engage in fraud or abuse, or illegal or improper acts perpetrated within the medical assistance program. In the pursuit of such civil and administrative enforcement actions under this subdivision, the inspector shall consider the quality and availability of medical care and services and the best interest of both the medical assistance program and recipients;

S 3. Paragraph (b) of subdivision 1 of section 365-j of the social services law, as added by chapter 442 of the laws of 2006, is amended to read as follows:

(b) Areas in which advisory opinions may be requested. An advisory opinion may be sought with respect to a substantive question, or a procedural matter. Advisory opinions may be requested with respect to questions arising prior to an audit or investigation with respect to questions relating to a provider's claim for payment or reimbursement. ONCE A PROVIDER HAS REQUESTED AN ADVISORY OPINION, THE COMMISSIONER OR HIS OR HER DESIGNEE SHALL ISSUE AN OPINION WITHIN SIXTY DAYS OF SUCH REQUEST. UPON ISSUANCE OF SUCH OPINION, THE PROVIDER SHALL BE HELD HARMLESS FROM ANY INTEREST OR PENALTIES THAT MIGHT OTHERWISE BE IMPOSED, PROVIDED, THE PROVIDER HAS REIMBURSED OR OTHERWISE ENTERED INTO A SETTLEMENT AGREEMENT WITH THE MEDICAL ASSISTANCE PROGRAM IF SUCH AGREEMENT WAIVES INTEREST OR PENALTIES FOR ANY OVERPAYMENTS AS A RESULT OF THE ADVISORY OPINION WITHIN FORTY-FIVE DAYS OF THE ISSUANCE OF SUCH OPINION. Advisory opinions may also be utilized for purposes of service planning. Thus, they may be requested with respect to a hypothetical or projected future set of facts.

S 4. This act shall take effect immediately.

PART T

Section 1. (a) The commissioner of health shall create and implement a plan for the state to assume the administrative responsibilities of the medical assistance program performed by social services districts.

(b) In developing such plan, the commissioner of health shall: (i) define the scope of administrative services performed by social services districts and expenditures related thereto; (ii) require social services districts to provide any information necessary to determine the scope of services currently provided and expenditures related thereto; (iii) review administrative processes and make determinations necessary for the state to assume responsibility for such services; and (iv) establish a process for a five-year implementation for state assumption of administrative services to begin April 1, 2011, with full implementation by April 1, 2016.

(c) Such plan developed by the commissioner of health shall include, but is not limited to: (i) a definition of administrative services; (ii) a cost analysis related to the delivery of such administrative services; (iii) operational objectives that create efficiency in administrative functions; (iv) standards that provide greater uniformity in eligibility criteria and continued enrollment; (v) a plan to transition social services district employees to state employment and to ensure that such transition shall not interfere with existing collective bargaining contracts; (vi) a statewide informational system that facilitates and monitors enrollment and promotes efficient transfer of information; (vii) a streamlined approach to communicating medical assistance policy changes; and (viii) other critical issues as determined by the commissioner of health to increase efficiency in administration of the medical assistance program.

(d) The commissioner of health shall submit a report to the governor, temporary president of the senate and speaker of the assembly by January 1, 2011, on the anticipated implementation of such plan, its elements, a timeline for such implementation, any recommendations for legislative action, and such other matters as may be pertinent.

(e) The commissioner of health shall promulgate regulations addressing the elements described in subdivision (c) of this section. Such regulations to implement the plan to assume state administration of services in social services districts shall become effective on April 1, 2011.

(f) For expenditures related to the costs of administering the medical assistance program occurring on or after April 1, 2011, the state shall annually assume a proportionate share of local administrative expenditures with full assumption of such expenditures beginning April 1, 2016.

(g) Beginning state fiscal year April 1, 2011, reimbursement for expenditures made on or after such date, by or on behalf of social services districts for medical assistance pursuant to section 368-a of the social services law and chapter 58 of the laws of 2005 shall be adjusted to reflect the state assumption of local administrative functions and the expenditures thereto pursuant to this section.

S 2. This act shall take effect immediately.

S 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 3. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through T of this act shall be as specifically set forth in the last section of such Parts.