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

5179

2009-2010 Regular Sessions

I N S E N A T E

April 27, 2009

Introduced by Sen. C. JOHNSON -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT to amend the public health law, the social services law, the education law, the insurance law and the state finance law, in relation to enacting the Home Care Accessibility and Efficiency Improvement Act (HCA-EIA)

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

Section 1. Short title. This act shall be known and may be cited as the "Home Care Accessibility and Efficiency Improvement Act" (HCA-EIA).

S 2. Section 3616 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. (A) THE COMMISSIONER, IN CONSULTATION WITH REPRESENTATIVES OF HOME CARE PROVIDERS AND CONSUMERS, SHALL ESTABLISH AN ASSESSMENT INSTRUMENT, OR SIMILARLY PURPOSED ELECTRONIC DATA-SET, FOR THE PURPOSE OF IDENTIFYING:

(I) PATIENTS' INDIVIDUALIZED HOME CARE SERVICES NEEDS; AND

(II) BASED ON THESE NEEDS, THE HOME CARE PROGRAM OR PROGRAMS WHICH APPEAR TO MOST APPROPRIATELY AND COST-EFFECTIVELY MEET EACH PATIENT'S NEEDS AND TO WHICH A REFERRAL SHOULD BE MADE, CONSISTENT WITH THE PATIENT'S CONSENT.

(B) SUCH ASSESSMENT OR DATA-SET SHALL ALSO DISTINGUISH, FOR PURPOSES OF SECTION THIRTY-SIX HUNDRED SIXTEEN-C OF THIS ARTICLE, THOSE PATIENTS WHOSE COSTS OR SERVICE USE EXCEED, RESPECTIVELY, ONE HUNDRED FIFTY PERCENT OF THE MEDICAL ASSISTANCE RATE FOR NURSING HOME CARE ON A MONTHLY BASIS IN THE COUNTY IN WHICH THE PATIENT RESIDES OR SIXTY HOURS OF PERSONAL CARE AIDE OR HOME HEALTH AIDE SERVICES ON A WEEKLY BASIS.

(C) THE INSTRUMENT OR DATA-SET SHALL UTILIZE EXISTING FEDERALLY REQUIRED ASSESSMENT INSTRUMENTS OR DATA-SETS SO AS NOT TO DUPLICATE OR ADD TO PROVIDERS' AND PATIENTS' ASSESSMENT REQUIREMENTS, AND SHALL REPLACE OR INCORPORATE ANY EXISTING NON-FEDERALLY REQUIRED ASSESSMENT

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

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FOR HOME CARE SERVICES, PERSONAL CARE SERVICES OR SERVICES OF A MANAGED LONG TERM CARE PLAN OTHERWISE REQUIRED BY THE DEPARTMENT, INCLUDING INSTRUMENTS ESTABLISHED BY DEPARTMENTAL RULE, REGULATION OR ADMINISTRATIVE DIRECTIVE INCLUDING THE DMS-1, THE HOME ASSESSMENT ABSTRACT AND THE SEMI-ANNUAL ASSESSMENT OF MEMBERS.

(D) THE COMMISSIONER SHALL COMPLETE WORK ON THE ASSESSMENT INSTRUMENT OR DATA-SET SUFFICIENT TO FIELD TEST SUCH INSTRUMENT OR DATA-SET BY NO LATER THAN SEPTEMBER FIRST, TWO THOUSAND NINE. THE COMMISSIONER SHALL COMPLETE THE FIELD TEST AND REPORT THE RESULTS TO THE GOVERNOR AND THE LEGISLATURE BY NO LATER THAN DECEMBER FIRST, TWO THOUSAND NINE. THE COMMISSIONER SHALL MAKE ANY REVISIONS TO THE INSTRUMENT OR DATA-SET AS A RESULT OF THE FIELD TEST AND IMPLEMENT SUCH INSTRUMENT OR DATA-SET BY NO LATER THAN APRIL FIRST, TWO THOUSAND TEN. THE COMMISSIONER SHALL REPORT TO THE GOVERNOR AND THE LEGISLATURE, BY NO LATER THAN SEPTEMBER FIRST, TWO THOUSAND TEN, ON THE INITIAL EXPERIENCES WITH THE ASSESSMENT INSTRUMENT OR DATA-SET, INCLUDING THE ABILITY OF SUCH INSTRUMENT OR DATA-SET TO EFFECTIVELY IDENTIFY PATIENTS' NEEDS AND IDENTIFY THOSE PROGRAMS WHICH MOST APPROPRIATELY AND COST-EFFECTIVELY MEET PATIENTS' NEEDS.

(E) BEGINNING TWO YEARS AFTER THE DATE OF IMPLEMENTATION OF THE PATIENT ASSESSMENT DEVELOPED PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER, IN CONSULTATION WITH REPRESENTATIVES OF HOME CARE PROVIDERS AND CONSUMERS, SHALL UNDERTAKE A STUDY OF HOME CARE REIMBURSEMENT UNDER THE MEDICAL ASSISTANCE PROGRAM. THE STUDY SHALL BE BASED ON THE DATA DERIVED PURSUANT TO SUCH PATIENT ASSESSMENT IN COMBINATION WITH AN EXAMINATION OF PROVIDER COSTS REPORTED FOR THE PROVISION OF SERVICES ON CERTIFIED COST REPORTS FOR THE MOST RECENT YEAR AVAILABLE. THE STUDY SHALL DETERMINE WHETHER ALTERNATE METHODS OF REIMBURSEMENT FOR SUCH SERVICES WOULD RESULT IN IMPROVED: ADEQUACY OF PAYMENT; PATIENT ACCESS; QUALITY OF CARE AND PERFORMANCE INCENTIVES; RECRUITMENT AND RETENTION OF PERSONNEL; PROVIDER FINANCIAL STABILITY; WORKING CAPITAL FOR HOME CARE CLINICAL AND INFORMATION TECHNOLOGY INFRASTRUCTURE; COST-EFFECTIVENESS; AND SUCH OTHER ELEMENTS ESSENTIAL TO THE OPERATION AND DELIVERY OF HOME CARE SERVICES IN THE STATE. SUCH ALTERNATIVE METHODS SHALL PROVIDE FOR WEIGHTED REIMBURSEMENT LEVELS ACCORDING TO SEVERITY AND COMPLEXITY OF PATIENT NEEDS.

THE COMMISSIONER, FOLLOWING REVIEW AND COMMENT BY REPRESENTATIVES OF HOME CARE PROVIDERS AND CONSUMERS, SHALL REPORT TO THE GOVERNOR AND THE LEGISLATURE ON HIS OR HER FINDINGS RESULTING FROM SUCH STUDY.

S 3. Subdivision 1 of section 367-c of the social services law, as added by chapter 895 of the laws of 1977, is amended to read as follows:

1. (A) If a long term home health care program as defined under article thirty-six of the public health law is provided in the social services district for which he has authority, the local social services official, before he authorizes care in a nursing home or intermediate care facility for a person eligible to receive services under this title, shall notify the person in writing of the provisions of this section.

(B) THE DEPARTMENT IN CONSULTATION WITH REPRESENTATIVES OF HOME CARE PROVIDERS, CONSUMERS, LOCAL DEPARTMENTS OF SOCIAL SERVICES, HOSPITALS, NURSING HOMES AND PHYSICIANS, SHALL PRESCRIBE THE FORMS AND RELATED COMMUNICATIONS, WHICH MAY BE IN ELECTRONIC FORMAT, REQUIRED TO PROVIDE FOR THIS NOTIFICATION AND THE NOTIFICATION REQUIRED PURSUANT TO SUBDIVISIONS TWO, THREE, FIVE AND SIX OF THIS SECTION, SUBJECT TO THE AVAILABILITY OF SERVICES IN THE PATIENT'S AREA OF RESIDENCE. THE DEPARTMENT SHALL MONITOR LOCAL SOCIAL SERVICES DISTRICTS AND OTHER APPLICABLE ENTITIES AND PROCEDURES TO ENSURE COMPLIANCE WITH THESE REQUIREMENTS SO THAT

PERSONS ARE NOT DISCHARGED TO, OR OTHERWISE ADMITTED TO, NURSING FACILITIES OR OTHER INSTITUTIONAL SETTINGS WITHOUT FIRST BEING NOTIFIED OF THE OPTION FOR CARE AT HOME AND REFERRED FOR ASSESSMENT, PROVIDED THAT THE PERSON'S PHYSICIAN DEEMS THAT HOME CARE IS AN APPROPRIATE OPTION FOR THE PERSON AND THE PERSON DESIRES SUCH CARE. IN ADDITION, THE DEPARTMENT SHALL ESTABLISH PERFORMANCE STANDARDS FOR LOCAL DISTRICTS FOR SUCH NURSING HOME DIVERSION PURSUANT TO THIS SECTION AND SUBPARAGRAPH (II) OF PARAGRAPH (B-1) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FOUR OF THIS CHAPTER.

S 4. Section 367-c of the social services law is amended by adding a new subdivision 6-a to read as follows:

6-A. NOTWITHSTANDING THE PROVISIONS OF SUBDIVISIONS ONE THROUGH FIVE OF THIS SECTION, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE MAXIMUM BUDGETED EXPENDITURES FOR PERSONS RECEIVING CARE UNDER THE PROVISIONS OF THIS SECTION SHALL BE AS FOLLOWS:

(A) TOTAL MONTHLY EXPENDITURES MADE UNDER THIS TITLE FOR ALL SUCH PERSONS SERVED BY EACH PROVIDER OF A LONG TERM HOME HEALTH CARE PROGRAM SHALL NOT, BASED ON REASONABLE EXPECTATIONS, EXCEED A MAXIMUM OF SEVENTY-FIVE PERCENT OF THE AVERAGE OF THE RATES PAYABLE UNDER THIS TITLE FOR A COMPARABLE LEVEL OF CARE IN A NURSING FACILITY OR A NURSING FACILITY FOR CHILDREN, AS APPLICABLE, FOR SUCH PERSONS WITHIN THE SOCIAL SERVICES DISTRICT, WHEN CALCULATED OVER THE SAME PERIOD;

(B) PROVIDED HOWEVER THAT, SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, IN THE CASE OF PERSONS WITH SPECIAL NEEDS AS DEFINED IN SUBDIVISION THREE OF THIS SECTION, SUCH MAXIMUM AGGREGATE EXPENDITURE SHALL BE ADJUSTED TO REFLECT A LIMITATION OF ONE HUNDRED PERCENT OF SUCH RATES FOR THE PROPORTION OF SUCH PERSONS; AND

(C) PROVIDED FURTHER, HOWEVER, THAT SUBJECT TO FEDERAL FINANCIAL PARTICIPATION THE COMMISSIONER SHALL IDENTIFY INDIVIDUALS AND/OR POPULATIONS WITH CONDITIONS OR CIRCUMSTANCES FOR WHOM EXEMPTION FROM THE AGGREGATE MAXIMUM EXPENDITURE LIMITATIONS PROVIDED FOR PURSUANT TO THIS SECTION IS NECESSARY TO PERMIT THE MOST APPROPRIATE AND COST-EFFECTIVE CARE OF SUCH INDIVIDUALS THROUGH THE LONG TERM HOME HEALTH CARE PROGRAM.

S 5. 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 5-a. Discontinuation of local social services districts' role in assessment and authorization for home care. 1. The commissioner of health shall report to the governor and the legislature on the feasibility, appropriateness and cost-effectiveness of eliminating the involvement of local social services districts in the assessment and authorization for home care services, and consolidating such responsibilities within home care providers and programs as well as managed long term care plans, considering:

(a) The capacity of the assessment implemented pursuant to subdivision 5 of section 3616 of the public health law to identify patient needs and to direct referrals toward the most appropriate home care programs based on those needs;

(b) The capacity of modifications to the reimbursement methodology recommended pursuant to paragraph (e) of such subdivision 5 to provide for adequate cost controls;

(c) The capacity for adequate oversight of home care providers by the department of health given the modification of the local districts' role;

(d) Duplicative expenses in the medical assistance expenditures associated with the local social services district's responsibilities and the responsibilities of home care agencies, and the opportunity for cost savings to the medical assistance program by eliminating such duplication;

(e) Opportunity for more efficient and streamlined access to care and more efficient use of home care personnel resources; and

(f) Such other factors as the commissioner of health shall deem necessary to consider.

2. As applicable, the report shall include a process and timetable for the discontinuation of local social services districts' involvement in home care services assessment and authorization.

3. In the interim, in accordance with sections six and seven of this act, the commissioner of health shall establish and enforce performance standards for local district responsibilities with regard to home care services.

S 6. Subdivision 2 of section 364 of the social services law is amended by adding a new paragraph (b-1) to read as follows:

(B-1) ESTABLISHING, MAINTAINING AND AUDITING TO ENSURE COMPLIANCE WITH PERFORMANCE STANDARDS FOR LOCAL SOCIAL SERVICES DISTRICTS FOR ANY STATUTORILY REQUIRED DUTIES IN THE ASSESSMENT AND AUTHORIZATION OF HOME CARE SERVICES TO ENSURE THAT:

(I) SUCH ASSESSMENTS AND AUTHORIZATIONS ARE TIMELY AND DO NOT OTHERWISE OBSTRUCT ACCESS TO HOME CARE SERVICES OR PROGRAMS;

(II) LOCAL DISTRICT PERFORMANCE DOES NOT RESULT IN EXTENDED HOSPITAL OR NURSING FACILITY STAYS OR IN AVOIDABLE NURSING HOME PLACEMENTS AND THAT LOCAL SOCIAL SERVICES DISTRICTS ACHIEVE AND MAINTAIN STANDARDS IN FULFILLMENT OF THE PATIENT NOTIFICATION AND NURSING HOME DIVERSION PROVISIONS PURSUANT TO SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SEVEN-C OF THIS CHAPTER;

(III) DETERMINATIONS AND DIRECTIVES BY LOCAL DISTRICTS ARE CONSISTENT WITH STATE REQUIREMENTS; AND

(IV) IN THE CASE OF PERSONAL CARE PROGRAM SERVICES, THAT LOCAL DISTRICT MANAGEMENT OF SUCH SERVICES MEETS THE DEPARTMENT'S PERFORMANCE GOALS FOR APPROPRIATENESS AND COST-EFFECTIVENESS OF SERVICES AUTHORIZED.

S 7. Notwithstanding any inconsistent provision of law, the commissioner shall establish annual medical assistance savings targets for each local social services district based on the district's adherence to performance standards for nursing home avoidance in accordance with subparagraph (ii) of paragraph (b-1) of subdivision 2 of section 364 of the social services law and the district's adherence to performance standards for personal care services established in accordance with subparagraph (iv) of such paragraph (b-1). The department is authorized to audit and intercept funds, otherwise payable to a local social services district, for failure to meet the district's savings target, in

an amount up to the difference between the target and any savings toward the target that the district has achieved.

S 8. The social services law is amended by adding a new section 367-v to read as follows:

S 367-V. BENCHMARKS FOR PERSONAL CARE SERVICES. 1. THE COMMISSIONER SHALL ESTABLISH BENCHMARKS FOR PERSONAL CARE SERVICES HOURS TO PROMOTE THE EFFICIENCY AND ACCESSIBILITY OF SUCH SERVICES AND TO ELIMINATE UNJUSTIFIED VARIATION IN AUTHORIZED HOURS.

2. BENCHMARKS SHALL INITIALLY BE ESTABLISHED BASED ON THE AVERAGE AUTHORIZED PERSONAL CARE HOURS PER PATIENT ON A COUNTY-TO-COUNTY BASIS. IN ESTABLISHING AND APPLYING SUCH BENCHMARKS, THE COMMISSIONER SHALL CONSIDER DIFFERENCES IN LOCAL HEALTH DELIVERY SYSTEMS AS WELL AS OTHER FACTORS WHICH MAY RESULT IN JUSTIFIABLE VARIATION. THE COMMISSIONER MAY ESTABLISH COUNTY PEER GROUPS FOR PURPOSES OF ESTABLISHING REGIONAL AVERAGES AND MAY ALSO UTILIZE A METHODOLOGY WHICH SELECTS AN AVERAGE AT A SPECIFIED PERCENTILE.

3. LOCAL DISTRICTS SHALL BE MONITORED AND ANNUALLY COMPARED TO THE ESTABLISHED BENCHMARKS FOR PURPOSES OF STATE SHARE REIMBURSEMENT.

4. AFTER INITIALLY ESTABLISHING BENCHMARKS BASED ON COUNTY AVERAGES, THE COMMISSIONER SHALL EXPLORE AND REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE FEASIBILITY AND ADVISABILITY OF ESTABLISHING AND IMPLEMENTING BENCHMARKS BASED ON CASE-SENSITIVE CRITERIA.

S 9. Subdivision 1 of section 3614 of the public health law, as amended by chapter 622 of the laws of 1988, is amended to read as follows:

1. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for services provided by a home care services agency, a provider of a long term home health care program or a provider of an AIDS home care program unless, at the time the services were provided, the home care services agency possessed a valid certificate of approval or the provider of a long term home health care program or AIDS home care program had been authorized by the commissioner to provide such program. However, contractual arrangements between a certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency and any home care services agency shall not be prohibited, provided that the certified home health agency, provider of a long term home health care program, provider of an AIDS home care program, or government agency maintains full responsibility for the plan of treatment and the care rendered AND CONTRACTS ARE CONSISTENT WITH THE TERMS PROVIDED FOR IN SECTION THIRTY-SIX HUNDRED SIXTEEN-B OF THIS ARTICLE.

S 10. The public health law is amended by adding a new section 3616-b to read as follows:

S 3616-B. CONTRACTS BETWEEN HOME CARE SERVICES AGENCIES. 1. CONTRACTS BETWEEN CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS OR AIDS HOME CARE PROGRAMS AND LICENSED HOME CARE SERVICES AGENCIES FOR THE PROVISION OF HOME HEALTH AIDE OR PERSONAL CARE AIDE SERVICES SHALL INCLUDE BUT NOT BE LIMITED TO THE FOLLOWING ASSURANCES OR PROVISIONS:

(A) AUDITS BY CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS AND AIDS HOME CARE PROGRAMS TO ENSURE THAT CONTRACTED LICENSED HOME CARE SERVICES AGENCIES ARE IN COMPLIANCE WITH CONTRACTED CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR AIDS HOME CARE PROGRAM PROVIDER POLICIES AND PROCEDURES, AND CONTRACT REQUIREMENTS, AS WELL AS APPLICABLE FEDERAL AND STATE LAWS; INCLUDING:

(I) ONSITE AUDIT REVIEW OF PERSONNEL RECORDS, PARAPROFESSIONAL PROFILES, SCHEDULING COORDINATOR KNOWLEDGE OF PATIENT REFERRAL AND CONTRACT GUIDELINES AND ADHERENCE TO PARAPROFESSIONAL VISIT DOCUMENTATION STANDARDS;

(II) ESTABLISHMENT OF AUDIT AREA THRESHOLDS AND STIPULATION THAT FAILURE TO ACHIEVE THE ESTABLISHED THRESHOLDS IN ANY AREA WILL RESULT IN FOLLOW-UP FOCUSED AUDITS TO ENSURE THAT THERE IS IMPROVEMENT;

(III) REQUIREMENT FOR CORRECTIVE ACTION PLANS WHEN THE CONTRACTED LICENSED HOME CARE SERVICES AGENCY DOES NOT MEET THE ESTABLISHED THRESHOLDS.

(B) A CALL-IN OR OTHER TRACKING SYSTEM REQUIRING THAT:

(I) CONTRACTED LICENSED HOME CARE SERVICES AGENCIES REQUIRE HOME CARE AIDES TO COMMUNICATE TELEPHONICALLY, ELECTRONICALLY OR THROUGH OTHER MEANS FOR PATIENT CARE VISIT VERIFICATION;

(II) THE TRACKING SYSTEM RECORDS THE START OF THE VISIT, END OF THE VISIT AND EACH OF THE SPECIFIC TASKS PERFORMED DURING THE HOME CARE AIDE'S VISIT OR THE PERSONAL CARE AIDE'S VISIT AND, WHEN NEW TASKS ARE ADDED TO THE TRACKING SYSTEM, THE CONTRACTED LICENSED HOME CARE SERVICES AGENCIES ARE MANDATED TO TRAIN ALL OF THEIR HOME CARE AIDES ON THE NEW TASKS;

(III) BILLING AUDITS ARE CONDUCTED REGULARLY AT EACH CONTRACTED LICENSED HOME CARE SERVICES AGENCY TO ENSURE COMPLIANCE WITH STANDARDS FOR PATIENTS WITHOUT PHONES OR FOR THOSE SITUATIONS WHEN THE TRACKING SYSTEM IS UNAVAILABLE AND A MANUAL VISIT ENTRY IS REQUIRED.

(C) TRAINING PROGRAM AUDITS, INCLUDING:

(I) CONFIRMATION THAT THE CONTRACTED LICENSED HOME CARE AGENCY TRAINING PROGRAM IS ON THE APPROVED LISTS REGULARLY PUBLISHED ON THE DEPARTMENT'S HEALTH PROVIDER NETWORK AND/OR THE DEPARTMENT OF EDUCATION;

(II) EXAMINATION OF THE PROGRAM'S MOST RECENT DEPARTMENTAL SURVEY AND ANY PLAN OF CORRECTION;

(III) AUDIT OF THE ADMINISTRATION OF THE CONTRACTED LICENSED HOME CARE AGENCY TRAINING PROGRAM TO ENSURE THAT SUCH AGENCIES HAVE DEVELOPED AND ARE FOLLOWING POLICY AND PROCEDURE AS IT RELATES TO TRAINING CERTIFICATE SECURITY AND TRACKING AND TRAINING PROGRAM ATTENDANCE;

(IV) REQUIREMENT FOR CONTRACTED LICENSED HOME CARE AGENCY CONTRACT MANAGERS OR AGENCY ADMINISTRATORS TO ATTEND, ON A PERIODIC BASIS, MANAGEMENT MEETINGS AT THE CONTRACTING CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR AIDS HOME CARE PROGRAM RELATED TO THE CONTRACTED SERVICES;

(D) TRAINING PROGRAMS FOR IN-SERVICE REQUIREMENTS COVERING STATE MANDATED TRAINING REQUIREMENTS AND INCLUDING THOSE ADDRESSING PRIORITY AREAS RELATED TO QUALITY OF CARE, PATIENT REHABILITATION, REDUCED HOSPITALIZATION AND INFECTION CONTROL;

(E) PERFORMANCE REVIEW AND IMPROVEMENT PROCESS OF THE CONTRACTED LICENSED HOME CARE SERVICES AGENCY, INCLUDING PERFORMANCE MONITORING AT LEAST BIANNUALLY:

(F) VISIT VERIFICATION SYSTEM THAT INCLUDES A STANDARDIZED PROCESS FOR VISIT VERIFICATION THROUGH RANDOM ATTENDANCE CHECKS VIA TELEPHONE AND RANDOM VISITS TO THE HOME DURING HOME CARE AIDE SERVICE DELIVERY;

(G) BENCHMARKING FOR PURPOSES OF MEASUREMENT AND IMPROVEMENT OF QUALITY CARE AMONG CONTRACTED AGENCIES;

(H) A THEFT-INVESTIGATION AND REPAYMENT PROCESS TO ENSURE CONSISTENT RESPONSE TO REPORTS OF THEFT BY HOME CARE PERSONNEL, INCLUDING A REQUIREMENT TO HAVE A THEFT LIAISON TO RESPOND TO AGENCY-RELATED THEFT ALLEGATIONS, AND RESPONSIBILITY FOR COST SHARING ASSOCIATED WITH INVESTIGATIONS AND REPAYMENT; AND

(I) PROVISIONS FOR PAYMENTS BETWEEN THE CERTIFIED HOME CARE AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR AIDS HOME CARE PROGRAM AND THE CONTRACTED LICENSED HOME CARE SERVICES AGENCY THAT EFFECTIVELY ALLOW FOR PROMPT PAYMENT ACCORDING TO NEGOTIATED CONTRACT PAYMENT TERMS.

2. THE COMMISSIONER SHALL CONSIDER AGENCY CASELOAD SIZE IN DETERMINING THE APPLICABILITY TO AGENCIES OF SOME OR ALL OF THE REQUIREMENTS SPECIFIED IN THIS SECTION TO THE EXTENT THAT THE FULFILLMENT OF SUCH REQUIREMENTS WOULD NOT BE PRACTICABLE OR WOULD BE BURDENSOME DUE TO SMALL AGENCY SIZE.

S 11. The public health law is amended by adding a new section 3616-c to read as follows:

S 3616-C. TARGETED INTERVENTION TO PATIENTS WITH HIGH COST/HIGH SERVICE USE. 1. THE DEPARTMENT SHALL ASSIST, THROUGH SHARED DATA, BEST PRACTICES, REIMBURSEMENT AND OTHER MEANS, CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS AND MANAGED LONG TERM CARE PROGRAMS TO IMPROVE AND CUSTOMIZE INTERVENTIONS RELATING TO THE CARE AND MANAGEMENT OF POPULATIONS IDENTIFIED PURSUANT TO SECTION THIRTY-SIX HUNDRED SIXTEEN OF THIS ARTICLE IN ORDER TO PROMOTE THE HIGHEST QUALITY, ACCESSIBLE AND COST-EFFECTIVE CARE FOR SUCH INDIVIDUALS.

2. IN ADDITION, THE DEPARTMENT SHALL ASSIST PROVIDERS TO UNDERTAKE EFFORTS TO FACILITATE COLLABORATION BETWEEN LEVELS OF CARE, INCLUDING HOSPITAL, PHYSICIAN AND HOME CARE, AS WELL AS FIELDS OF CARE, INCLUDING MEDICAL, MENTAL HEALTH AND ALCOHOL AND DRUG TREATMENT, TO PROMOTE THE COORDINATED MANAGEMENT AND CARE OF SUCH PATIENTS.

3. AS MAY BE NECESSARY TO FACILITATE THE ENROLLMENT AND CARE IN PROGRAMS DETERMINED BY THE ASSESSMENT TO BE MOST APPROPRIATE AND COST-EFFECTIVE TO MEET THE NEEDS OF SUCH PATIENTS, THE DEPARTMENT SHALL IDENTIFY PROGRAM AND SYSTEM BARRIERS TO SUCH ENROLLMENT AND CARE AND SHALL BE AUTHORIZED TO WAIVE PROVISIONS OF THIS CHAPTER AND THE SOCIAL SERVICES LAW, AS WELL AS THE RESPECTIVE REGULATION, FOR SUCH PURPOSE. THE DEPARTMENT SHALL REPORT TO THE LEGISLATURE WITH REGARD TO SUCH WAIVERS IN ORDER THAT THE LEGISLATURE MAY CONSIDER STATUTORY REVISIONS AS NECESSARY.

4. TO THE EXTENT THAT FUNDS ARE MADE AVAILABLE THEREFOR, THE DEPARTMENT SHALL MAKE GRANTS TO FACILITATE THE PURPOSES OF THIS SECTION.

S 12. Clause (iii) of paragraph a of subdivision 1 of section 6908 of the education law, as amended by chapter 160 of the laws of 2003, is amended to read as follows:

(iii) the providing of care by a person acting in the place of a person exempt under clause (i) of this paragraph, but who does hold himself or herself out as one who accepts employment for performing such care, where nursing services are under the instruction of a licensed nurse, or under the instruction of a patient or family or household member determined by a registered professional nurse to be self-directing and capable of providing such instruction, and any remuneration is provided under section three hundred sixty-five-f of the social services law OR FOR SERVICES UNDER AN ENTITY CERTIFIED, APPROVED OR LICENSED UNDER ARTICLE THIRTY-SIX OF THE PUBLIC HEALTH LAW; or

S 13. The public health law is amended by adding a new section 3621-a to read as follows:

S 3621-A. HOME TELEHEALTH MEDICAL ASSISTANCE EFFICIENCY INITIATIVE. 1. THE COMMISSIONER IS HEREBY AUTHORIZED AND DIRECTED TO ESTABLISH A HOME TELEHEALTH CARE INITIATIVE FOR THE PURPOSE OF APPLYING SUCH SERVICES IN A MANNER TO ACHIEVE EFFICIENCIES IN THE MEDICAL ASSISTANCE PROGRAM. PURSUANT TO SUCH INITIATIVE, HOME TELEHEALTH SERVICES SHALL BE APPLIED IN TECHNIQUES AND TO TARGETED POPULATIONS TO IMPROVE PATIENT CARE

MANAGEMENT, TREATMENT COMPLIANCE, OUTCOMES AND/OR PREVENTION OF FURTHER ILLNESS OR INJURY SO AS TO SPECIFICALLY REDUCE OR OFFSET THE NEED FOR OTHER, MORE COSTLY MEDICAL ASSISTANCE SERVICES.

2. THE COMMISSIONER SHALL CONSULT WITH REPRESENTATIVES OF HOME CARE PROVIDERS, CONSUMERS AND OTHER INDIVIDUALS WITH EXPERTISE IN HOME TELE-HEALTH CARE TO DETERMINE THE POPULATIONS AND/OR CONDITIONS MOST LIKELY TO BENEFIT AND ACHIEVE COST-EFFECTIVE RESULTS PURSUANT TO THIS SECTION, AS WELL AS THE SPECIFIC TECHNOLOGY AND APPROACHES TO HOME TELEHEALTH WHICH CONSTITUTE THE BEST PRACTICES TO EMPLOY FOR SUCH GOALS.

3. THE COMMISSIONER SHALL EXPEDITIOUSLY CONSIDER PROVIDER APPLICATIONS FOR PARTICIPATION IN SUCH INITIATIVE BY HOME CARE AGENCIES AND PROGRAMS.

4. THE COMMISSIONER SHALL PROVIDE REIMBURSEMENT TO PARTICIPATING PROVIDERS PURSUANT TO SUBDIVISION THREE-A OF SECTION THIRTY-SIX HUNDRED FOURTEEN OF THIS ARTICLE AND SUCH OTHER METHODS AS THE COMMISSIONER DEEMS APPROPRIATE TO ACHIEVE THE PURPOSES OF THIS SECTION. THE COMMIS-SIONER MAY ALSO PROVIDE OTHER POSITIVE FINANCIAL INCENTIVES FOR PROVIDER PARTICIPATION IN SUCH INITIATIVE INCLUDING GRANTS TO FACILITATE THE DEVELOPMENT AND OPERATION OF SUCH INITIATIVES.

S 14. The public health law is amended by adding a new section 3616-d to read as follows:

S 3616-D. LOW VISION ASSESSMENT AND INTERVENTION. 1. THERE IS HEREBY ESTABLISHED A PROGRAM TO ASSESS HOME CARE PATIENTS FOR LOW VISION AND THE NEED FOR INTERVENTION TO ENABLE THEIR SAFE AND OPTIMAL FUNCTIONING AT HOME, INCLUDING THEIR REDUCED RISK OF ACCIDENTS, INJURY AND PREVENTA-BLE HIGH COST HEALTH SERVICES UTILIZATION, INCLUDING INSTITUTIONALIZA-TION.

2. PURSUANT TO SUCH PROGRAM, THE COMMISSIONER SHALL INCORPORATE, AS PART OF THE BASIC HOME CARE ASSESSMENT PROCESS, CRITERIA FOR SCREENING FOR LOW VISION AS WELL AS CRITERIA WHICH INDICATE THE NEED FOR INTER-VENTION. IN ESTABLISHING SUCH CRITERIA, THE COMMISSIONER SHALL CONSULT WITH REPRESENTATIVES OF HOME CARE SERVICES PROVIDERS, CONSUMERS AND PROFESSIONALS WITH EXPERTISE IN THE SCREENING, DIAGNOSIS AND TREATMENT OF VISION LOSS AND IN VISION REHABILITATION.

3. UPON A DETERMINATION THAT INTERVENTION IS WARRANTED, PROVIDERS OF HOME CARE SERVICES SHALL, WITH THE PATIENT'S CONSENT AND SUBJECT TO AVAILABILITY, ARRANGE FOR THE NECESSARY SERVICES WITH AGENCIES ESTAB-LISHED TO ASSIST THE VISUALLY IMPAIRED. SUCH SERVICES SHALL BE REFLECTED WITHIN THE PATIENT'S PLAN OF CARE APPROVED BY THE PHYSICIAN.

4. THE COMMISSIONER, IN CONSULTATION WITH THE AFOREMENTIONED REPRESEN-TATIVES, SHALL ISSUE ANY GUIDELINES AS MAY BE REASONABLY NECESSARY FOR THE IMPLEMENTATION OF THIS PROGRAM.

S 15. Federal-state Medicare shared savings partnership program. 1. Notwithstanding any provision of law to the contrary, the commissioner of health shall seek federal approval for the establishment of a feder-al-state Medicare shared savings partnership program. Such program shall provide an incentive through shared savings to the state for achieving federal cost-savings and efficiencies to Medicare, such as from reduced expenditures for hospital and other medical care, which result from state initiatives in the care and management of Medicare beneficiaries. Such incentive shall provide for a reinvestment of a proportion of such federal savings into the state's health care system.

2. The commissioner of health shall provide at least forty-five days notice to the legislature prior to the submission of any formal proposal to federal officials for such program in order to afford the legislature an opportunity for input.

S 16. The state finance law is amended by adding a new section 97-jjjj to read as follows:

S 97-JJJJ. FEDERAL-STATE MEDICARE SHARED SAVINGS PARTNERSHIP PROGRAM FUND. 1. THERE IS HEREBY ESTABLISHED IN THE SOLE CUSTODY OF THE STATE COMPTROLLER A FUND TO BE KNOWN AS THE "FEDERAL-STATE MEDICARE SHARED SAVINGS PARTNERSHIP PROGRAM FUND".

2. THE FUND SHALL CONSIST OF THOSE MONIES RECEIVED FROM THE FEDERAL GOVERNMENT FOR SAVINGS ACHIEVED UNDER THE FEDERAL-STATE MEDICARE SHARED SAVINGS PARTNERSHIP PROGRAM RESULTING FROM STATE INITIATIVES IN THE CARE AND MANAGEMENT OF MEDICARE BENEFICIARIES.

3. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, WHERE AND TO THE EXTENT THAT FEDERAL REVENUES OR SAVINGS UNDER SUBDIVISION TWO OF THIS SECTION ARE MADE AVAILABLE TO THE STATE, SUCH REVENUES OR SAVINGS SHALL BE DEPOSITED IN THE FUND WHICH SHALL BE USED TO SUPPORT THE HEALTH CARE SYSTEM IN THE STATE.

4. ALL MONIES SHALL REMAIN IN SUCH FUND UNLESS OTHERWISE DISBURSED PURSUANT TO APPROPRIATION BY THE LEGISLATURE.

S 17. 1. Notwithstanding any provision of law or regulation to the contrary, the commissioner of education, in consultation with the state board for nursing and the state board of pharmacy, shall promulgate guidelines which allow for the prefill of up to a fifteen day supply of medication prescribed by a physician or other authorized practitioner and provided to an individual by a registered professional nurse for individuals receiving home care services ordered by an authorized practitioner and provided under the supervision of a registered professional nurse.

2. The commissioner of education, in consultation with such state boards, shall examine the experiences pursuant to such guidelines and, on or before April 1, 2010, recommend to the governor and the legislature any changes as may be necessary to this section.

S 18. 1. The superintendent of insurance shall examine the feasibility and benefit of establishing a mechanism to ensure voluntary access to long term care insurance coverage through the state's long term care insurance partnership program for individuals unable to access the voluntary market. In conducting such examination, the superintendent of insurance shall consider similar mechanisms utilized by New York state or other states to provide access to insurance coverage when the voluntary market is inaccessible due to price or underwriting, including the model provided through the medical malpractice insurance program implemented by the state department of insurance.

2. In considering the benefits of such a mechanism, the superintendent of insurance shall examine the benefit of long term care insurance access for the potentially covered population as well as the benefit to the state's medical assistance program resulting from the increase in private financing of such care through such mechanism. The superintendent of insurance shall also consider the impact of such a mechanism on the voluntary long term care insurance market in the state. The superintendent of insurance shall submit his written findings and proposals to the governor and the legislature no later than June 1, 2009.

S 19. Subparagraphs (C), (D) and (E) of paragraph 1 of subsection (k) of section 3221 of the insurance law, subparagraphs (C) and (D) as amended by chapter 557 of the laws of 2000, are amended to read as follows:

(C) Home care means the care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the federal

Social Security Act, 42 U.S.C. SS 1395 et seq, would otherwise have been required if home care was not provided, OR IF THE PROVISION OF HOME CARE IS NECESSARY FOR THE PERSON'S CONDITION IN ORDER TO PREVENT HOSPITALIZATION OR NURSING FACILITY CONFINEMENT, and the plan covering the home health service is established and approved in writing by such physician.

(D) Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law and shall consist of one or more of the following:

(i) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.).

(ii) Part-time or intermittent home health aide services which consist primarily of caring for the patient.

(iii) Physical, occupational or speech therapy, SOCIAL WORK, RESPIRATORY THERAPY AND NUTRITIONAL COUNSELING, if provided by the home health service or agency.

(iv) Medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency or licensed home care services agency to the extent such items would have been covered under the contract if the covered person had been hospitalized or confined in a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, 42 U.S.C. SS 1395 et seq.

(E) For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit; the contract may contain a limitation on the number of home care visits, but not less than [forty] ONE HUNDRED FOUR such visits in any calendar year or in any continuous period of twelve months, for each person covered under the contract; four hours of home health aide service shall be considered as one home care visit.

S 20. Paragraph 3 of subsection (a) of section 4303 of the insurance law, subparagraphs (A), (B) and (C) as amended by chapter 557 of the laws of 2000 and subparagraph (D) as amended by chapter 21 of the laws of 1990, is amended to read as follows:

(3) For home care to residents in this state. Such home care coverage shall be included at the inception of all new contracts and, with respect to all other contracts, added at any anniversary date of the contract subject to evidence of insurability. Such coverage may be subject to an annual deductible of not more than fifty dollars for each covered person and may be subject to a coinsurance provision which provides for coverage of not less than seventy-five percent of the reasonable cost of services for which payment may be made. No such corporation need provide such coverage to persons eligible for medicare.

(A) Home care shall mean the care and treatment of a covered person who is under the care of a physician but only if:

(i) hospitalization or confinement in a nursing facility as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. S 1395 et seq, would otherwise have been required if home care was not provided, OR IF THE PROVISION OF HOME CARE IS NECESSARY FOR THE PERSON'S CONDITION IN ORDER TO PREVENT HOSPITALIZATION OR NURSING FACILITY CONFINEMENT, and

(ii) the plan covering the home health service is established and approved in writing by such physician.

(B) Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to article thirty-six of the public health law.

(C) Home care shall consist of one or more of the following:
(i) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.),
(ii) part-time or intermittent home health aide services which consist primarily of caring for the patient,
(iii) physical, occupational or speech therapy, SOCIAL WORK, RESPIRATORY THERAPY AND NUTRITIONAL COUNSELING, if provided by the home health service or agency, and
(iv) medical supplies, drugs and medications prescribed by a physician, and laboratory services by or on behalf of a certified home health agency or licensed home care services agency to the extent such items would have been covered or provided under the contract if the covered person had been hospitalized or confined in a skilled nursing facility as defined in subchapter XVIII of the Social Security Act, 42 U.S.C. S 1395 et seq.
(D) For the purpose of determining the benefits for home care available to a covered person, each visit by a member of a home care team shall be considered as one home care visit. The contract may contain a limitation on the number of home care visits, but not less than [forty] ONE HUNDRED FOUR such visits in any calendar year or in any continuous period of twelve months, for each covered person. Four hours of home health aide service shall be considered as one home care visit. Every contract issued by a hospital service corporation or health service corporation which provides coverage supplementing part A and part B of subchapter XVIII of the Social Security Act, 42 U.S.C. S 1395 et seq, must make available and, if requested by a subscriber holding a direct payment contract or by all subscribers in a group remittance group or by the contract holder in the case of group contracts issued pursuant to section four thousand three hundred five of this article, provide coverage of supplemental home care visits beyond those provided by part A and part B, sufficient to produce an aggregate coverage of three hundred sixty-five home care visits per contract year. Such coverage shall be provided pursuant to regulations prescribed by the superintendent. Written notice of the availability of such coverage shall be delivered to the group remitting agent or group contract holder prior to inception of such contract and annually thereafter[, except that this notice shall not be required where a policy covers two hundred or more employees or where the benefit structure was the subject of collective bargaining affecting persons who are employed in more than one state.
The provisions of this subsection shall not apply to a contract issued pursuant to section four thousand three hundred five of this article which covers persons employed in more than one state or the benefit structure of which was the subject of collective bargaining affecting persons who are employed in more than one state].
S 21. Paragraph c of subdivision 8 of section 3602 of the public health law, as amended by chapter 622 of the laws of 1988, is amended to read as follows:
c. Approved long term home health care program providers may include, as part of their long term home health care program, upon approval by the commissioner, a discrete AIDS home care program as defined in this section; SUCH PROVIDERS MAY ALSO COORDINATE WITH A HOSPICE APPROVED UNDER ARTICLE FORTY OF THIS CHAPTER FOR THE PROVISION OF HOSPICE AND PALLIATIVE CARE SERVICES IN CONJUNCTION WITH THE LONG TERM HOME HEALTH CARE PROGRAM.
S 22. The public health law is amended by adding a new section 3616-e to read as follows:

S 3616-E. COLLABORATIVE CARE OF SELF-DIRECTING PATIENTS. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS CHAPTER OR SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW RELATED TO THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM, ANY CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR MANAGED LONG TERM CARE PLAN OPERATING PURSUANT TO THIS CHAPTER SHALL BE PERMITTED TO COLLABORATE FOR THE PROVISION OF PATIENT CARE WITH CONSUMER DIRECTED PERSONAL ASSISTANCE PROVIDERS.

2. ANY SERVICES PROVIDED BY A CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR MANAGED LONG TERM CARE PLAN TO A PATIENT COLLABORATIVELY SERVED WITH A CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM PROVIDER SHALL NOT BE DUPLICATIVE. THE PROVIDER OF CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES TOGETHER WITH THE SELF-DIRECTING PATIENT OR DIRECTING CAREGIVER SHALL, CONSISTENT WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, BE RESPONSIBLE FOR ANY CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES THAT ARE PROVIDED. THE CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR MANAGED LONG TERM CARE PLAN SHALL BE RESPONSIBLE FOR ALL OTHER SERVICES AS REQUIRED PURSUANT TO THIS ARTICLE AND THE REGULATIONS OF THE DEPARTMENT.

3. THE COMMISSIONER IS AUTHORIZED TO PROMULGATE SUCH REGULATIONS OR GUIDELINES AS MAY BE NECESSARY TO ENSURE THE APPROPRIATENESS OF MEDICAL ASSISTANCE EXPENDITURES PURSUANT TO THIS SECTION.

S 23. Notwithstanding any provision of law or regulation to the contrary, 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 the two entities shall maintain distinct yet coordinated service and case management responsibilities and shall not duplicate benefits.

S 24. The commissioner of health shall provide that as part of the terms of the department of health's contracts for managed long term care plans and Medicaid Advantage Plus plans that such plans shall be permitted to contract with providers of long term home health care programs for the provision of home and community based services to the plan's enrollees. Notwithstanding any provision of law or regulation to the contrary, the commissioner may waive the patient service budgeting requirements and expenditure limits applicable to the care of long term home health care program patients in order to avoid conflict or duplication with the capitation provisions of managed long term care plans or Medicaid Advantage Plus plans.

S 25. Paragraph (c) of subdivision 3 of section 364-j of the social services law is amended by adding a new subparagraph (vii) to read as follows:

(VII) A PERSON RECEIVING SERVICES PROVIDED BY A LONG TERM HOME HEALTH CARE PROGRAM.

S 26. Subparagraph (ix) of paragraph (e) of subdivision 3 of section 364-j of the social services law, as amended by chapter 648 of the laws of 1999, is amended to read as follows:

(ix) HIV COBRA case management; [and]

S 27. Subparagraph (x) of paragraph (e) of subdivision 3 of section 364-j of the social services law, as amended by chapter 648 of the laws of 1999, is renumbered (xi) and a new subparagraph (x) is added to read as follows:

(X) SERVICES PROVIDED PURSUANT TO A LONG TERM HOME HEALTH CARE PROGRAM PURSUANT TO ARTICLE THIRTY-SIX OF THE PUBLIC HEALTH LAW AND SECTION THREE HUNDRED SIXTY-SEVEN-C OF THIS TITLE; AND

S 28. Subparagraph (i) of paragraph (d) of subdivision 3 of section 364-j of the social services law, as amended by section 67 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(i) [a person receiving services provided by a long term home health care program, or] a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

S 29. Subdivisions 1 and 3 of section 2807-h of the public health law, as amended by chapter 255 of the laws of 1994, are amended to read as follows:

1. The commissioner shall authorize health occupation development and workplace demonstration programs and is directed to make rate adjustments, subject to the availability of funds therefor, to cover the costs of such programs; PROVIDED THAT THE COMMISSIONER MAY ALSO AUTHORIZE SUCH PROGRAMS WITHOUT SUCH RATE ADJUSTMENTS, UPON APPLICATION BY PROVIDERS, TO PROMOTE THE HEALTH OCCUPATION DEVELOPMENT AND WORKPLACE IMPROVEMENT PURPOSES SPECIFIED IN THIS SECTION. Providers shall be eligible for rate adjustments to develop, implement and evaluate programs to test new models of organization and delivery of services, and the use of new technologies to improve efficiency, utilization and productivity of existing health care personnel; to reduce time that patient care staff spend meeting documentation requirements; and to improve the recruitment and retention of health personnel. Eligible providers shall consult with staff, professional associations, unions and other affected organizations in the development of proposals. The commissioner is authorized to waive, modify or suspend the respective provisions of rules and regulations promulgated pursuant to this chapter OR THE SOCIAL SERVICES LAW if the commissioner determines that such waiver, modification or suspension is necessary for the successful implementation of a demonstration program and provided that the commissioner determines that the health, safety and general welfare of people receiving health care under such demonstration program will not be impaired as a result of such waiver, modification or suspension. The commissioner shall consult with the professional associations appropriate to the rule or regulation proposed for waiver, modification or suspension prior to approval or disapproval of the program. Such waiver, modification or suspension may be granted for up to two years, OR SUCH LONGER PERIOD AS MAY BE NECESSARY TO SUPPORT THE PURPOSES OF THE DEMONSTRATION PROGRAM. Waivers, modifications and suspensions granted under this subdivision must be specific to the program approved by this subdivision.

3. The commissioner shall conduct evaluations of the health occupation development and workplace demonstration programs and shall report his findings to the governor and the chairs of the senate and assembly committees on health. Such evaluations shall include an examination of the effectiveness of the program to improve productivity, efficiency, development and utilization of personnel. Such report shall be due on April thirtieth, nineteen hundred ninety-five, ON JANUARY FIRST, TWO THOUSAND ELEVEN, AND BIENNIALLY THEREAFTER. TO FACILITATE THE COMMISSIONER'S EVALUATIONS AND REPORTS, PROVIDERS IMPLEMENTING HEALTH OCCUPATION DEVELOPMENT AND WORKPLACE DEMONSTRATION PROGRAMS SHALL EXAMINE THE EFFECTIVENESS OF THEIR PROGRAM AND REPORT THEIR EXPERIENCES TO THE COMMISSIONER.

S 30. Subdivision 6 of section 3614 of the public health law, as amended by chapter 255 of the laws of 1994, is amended to read as follows:

6. Subject to the [availability of funds] PROVISIONS OF SECTION TWENTY-EIGHT HUNDRED SEVEN-H OF THIS CHAPTER, the commissioner shall authorize health occupation development and workplace demonstration programs [pursuant to the provisions of section twenty-eight hundred seven-h of this chapter] for certified home health agencies, long term home health care programs [and], AIDS home care programs AND LICENSED HOME CARE SERVICES AGENCIES, and, SUBJECT TO THE AVAILABILITY OF FUNDS, the commissioner is hereby directed to make rate adjustments to cover the cost of such programs.

S 31. The public health law is amended by adding a new section 3606-b to read as follows:

S 3606-B. SPECIAL PROVISIONS FOR ESTABLISHMENT OR CONSTRUCTION OF CERTIFIED HOME HEALTH AGENCIES AND LONG TERM HOME HEALTH CARE PROGRAMS. 1. PRIORITY ESTABLISHMENT AND CONSTRUCTION. APPLICATIONS FOR HOME CARE CONSTRUCTION OR ESTABLISHMENT SHALL BE PROCESSED AS A PRIORITY BY THE DEPARTMENT, THE STATE HOSPITAL REVIEW AND PLANNING COUNCIL AND THE PUBLIC HEALTH COUNCIL, AS APPLICABLE, WHEN THE APPLICATION IS:

(A) FILED FOR AN EXPANSION OF A LONG TERM HOME HEALTH CARE PROGRAM WHEN THE APPLICANT'S PATIENT CENSUS IS AT SEVENTY-FIVE PERCENT OF CAPACITY OR GREATER, NOTWITHSTANDING THE CENSUS TO CAPACITY RATIO OF OTHER PROVIDERS IN THE SERVICE AREA;

(B) FILED BY AN APPLICANT TO MEET AN EXPANDED NEED FOR HOME CARE CREATED BY AN AGENCY OR FACILITY CLOSURE OR SERVICE CAPACITY REDUCTION IMPACTING THE NEED FOR HOME CARE;

(C) FILED PURSUANT TO THE RURAL HOME CARE FLEXIBILITY PROGRAM PURSUANT TO SECTION THIRTY-SIX HUNDRED TWENTY-TWO OF THIS ARTICLE; OR

(D) FILED PURSUANT TO SUCH OTHER CRITERIA AS THE COMMISSIONER DETERMINES MEET THE NEED FOR PRIORITY CONSIDERATION.

2. FACILITATION OF MULTILEVEL SERVICE PROVIDERS. (A) THE COMMISSIONER SHALL ENCOURAGE AND FACILITATE THE PROVISION OF HOME CARE SERVICES BY MULTILEVEL SERVICE PROVIDERS FOR THE PURPOSES OF PROMOTING EFFICIENCY AND CONTINUITY OF CARE. FOR PURPOSES OF THIS SECTION, MULTILEVEL SERVICE PROVIDERS SHALL MEAN PROVIDERS WITH EXISTING APPROVAL OR LICENSURE FOR TWO OR MORE OPERATING CERTIFICATES PURSUANT TO ARTICLE TWENTY-EIGHT, THIRTY-SIX OR FORTY OF THIS CHAPTER WHICH INCLUDE A GENERAL HOSPITAL, A NURSING FACILITY, A CERTIFIED HOME HEALTH AGENCY, A LONG TERM HOME HEALTH CARE PROGRAM, A HOSPICE OR A MANAGED LONG TERM CARE PLAN.

(B) THE PROVISION OF HOME CARE BY MULTILEVEL SERVICE PROVIDERS MAY BE THROUGH DIRECT MEANS OR THROUGH THE FORMATION OF NETWORKS OR OTHER CLINICAL OR CORPORATE AFFILIATIONS AMONG EXISTING PROVIDERS.

(C) THE DEPARTMENT AND, AS APPLICABLE, THE STATE HOSPITAL REVIEW AND PLANNING COUNCIL AND THE PUBLIC HEALTH COUNCIL, SHALL BE AUTHORIZED TO GIVE PRIORITY CONSIDERATION IN OR OTHERWISE MODIFY THE CERTIFICATE OF NEED PROCESS, EXPAND LONG TERM HOME HEALTH CARE PROGRAM CAPACITY, INSTITUTE POSITIVE FINANCIAL INCENTIVES OR TAKE SUCH OTHER STEPS THAT FULFILL THE PURPOSES OF THIS SECTION IN FACILITATING EFFICIENCY AND CONTINUITY OF CARE THROUGH MULTILEVEL SERVICE PROVIDERS.

S 32. Section 3622 of the public health law, as renumbered by section 22 of part C of chapter 58 of the laws of 2004, is renumbered section 3623 and a new section 3622 is added to read as follows:

S 3622. RURAL HOME HEALTH FLEXIBILITY PROGRAM. 1. THE LEGISLATURE FINDS AND DECLARES THAT THE PROVISION AND ACCESSIBILITY OF HOME HEALTH CARE AND LONG TERM HOME HEALTH CARE PROGRAM SERVICES IN RURAL AREAS

NECESSITATES REGULATORY FLEXIBILITY IN ORDER FOR LIMITED RESOURCES TO BE BEST UTILIZED AND MAXIMIZED TO MEET THE HEALTH CARE NEEDS OF RURAL CITIZENS AND TO PROMOTE THE EFFICIENCY OF THE DELIVERY OF SERVICES IN RURAL AREAS. THE LEGISLATURE THEREFORE ESTABLISHES A RURAL HOME HEALTH FLEXIBILITY PROGRAM FOR SUCH PURPOSES.

2. PURSUANT TO THE PURPOSES OF THIS SECTION, THE COMMISSIONER, NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION, SHALL CONSIDER FOR APPROVAL PROPOSALS FROM PROVIDERS OPERATING UNDER THIS ARTICLE AND SERVING RURAL COUNTIES TO:

(A) CREATE AND OPERATE A LONG TERM HOME HEALTH CARE PROGRAM WHICH DOES NOT PROVIDE ALL THE REQUIRED SERVICES SPECIFIED IN REGULATIONS OF THE DEPARTMENT, PROVIDED THAT:

(I) THERE IS DEMONSTRATED NEED FOR SUCH PROGRAM IN THE SERVICE AREA; AND

(II) THE APPLICANT TO PROVIDE SUCH PROGRAM DEMONSTRATES TO THE COMMISSIONER'S SATISFACTION THAT SUCH APPLICANT HAS MADE, AND CONTINUES TO MAKE, ALL APPROPRIATE EFFORTS TO PROVIDE ALL REQUIRED SERVICES BUT THAT THE LACK OF AVAILABLE HEALTH PERSONNEL WITHIN THE SERVICE AREA IS AN OBSTACLE;

(B) ESTABLISH OR OPERATE A CERTIFIED HOME HEALTH AGENCY OR LONG TERM HOME HEALTH CARE PROGRAM WHICH SERVES A GEOGRAPHIC AREA LESS THAN AN ENTIRE PLANNING AREA WHEN:

(I) NO OTHER PROVIDER OTHERWISE SERVES THE ENTIRE PLANNING AREA;

(II) COLLABORATIVE APPROACHES TO THE SERVICE OF CITIZENS IN THE PLANNING AREA IS APPROPRIATE FOR FEASIBILITY AND EFFICIENCY; AND

(III) THE DEPARTMENT IS SATISFIED THAT SUCH COLLABORATION WILL RESULT IN ACCESSIBLE AND ECONOMICALLY-FEASIBLE SERVICES WITHIN THE PLANNING AREA;

(C) QUALIFY FOR HOME TELEHEALTH REIMBURSEMENT, OR FOR THE PROVISION OF TELEMEDICINE SERVICES, PURSUANT TO THIS ARTICLE WHEN ALL OF THE CONDITIONS ORDINARILY REQUIRED FOR SUCH REIMBURSEMENT OR SERVICES ARE UNABLE TO BE MET, PROVIDED THAT THE APPLICANT DEMONSTRATES, AND CONTINUES TO UNDERTAKE, BEST EFFORTS TO MEET SUCH REQUIREMENTS AND THAT THE QUALITY OR SAFETY OF PATIENT CARE WILL NOT BE DIMINISHED AS A RESULT;

(D) BE EXEMPTED FROM THE APPLICABILITY OF NEW REGULATORY REQUIREMENTS THAT ARE IDENTIFIED AS BURDENSOME TO RURAL PROVIDERS BY THE DEPARTMENT IN ITS SMALL BUSINESS, REGULATORY IMPACT OR RURAL FLEXIBILITY ANALYSES FILED IN ACCORDANCE WITH THE STATE ADMINISTRATIVE PROCEDURE ACT; AND

(E) RECEIVE APPROVAL FOR SUCH OTHER AREAS OF FLEXIBILITY AS THE COMMISSIONER DEEMS APPROPRIATE TO THE PURPOSES OF THIS SECTION, INCLUDING PROPOSALS TO ENHANCE THE ADMINISTRATION, SERVICES AND QUALITY OF CARE PROVIDED BY A HOME CARE AGENCY OR PROGRAM, PROVIDED THAT SUCH FLEXIBILITY DOES NOT COMPROMISE THE QUALITY AND SAFETY OF SERVICES PROVIDED.

3. IN EFFECTUATING THE PROVISIONS OF SUBPARAGRAPH (E) OF THIS SECTION, THE COMMISSIONER SHALL CONVENE A TEMPORARY WORKGROUP COMPRISED OF REPRESENTATIVES OF CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS AND LICENSED HOME CARE SERVICES AGENCIES SERVING RURAL COUNTIES, AS WELL AS RURAL CONSUMERS AND RURAL WORKFORCE REPRESENTATIVES, TO ASSIST IN IDENTIFYING ADDITIONAL AREAS FOR FLEXIBILITY IN THE DEPARTMENT'S RULES, REGULATIONS AND ADMINISTRATIVE REQUIREMENTS, CONSISTENT WITH THE PURPOSES OF THIS SECTION.

S 33. This act shall take effect immediately, provided that:

1. section ten of this act shall take effect January 1, 2010 or upon the renewal date of contacts regulated pursuant to such section, whichever is later;

2. sections nineteen and twenty of this act shall take effect January 1, 2010 or upon the renewal date of contracts or policies regulated pursuant to such sections;

3. the amendments to section 364-j of the social services law made by sections twenty-five, twenty-six, twenty-seven and twenty-eight of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

4. the amendments to subdivisions 1 and 3 of section 2807-h of the public health law, made by section twenty-nine of this act shall not affect the expiration of such subdivisions and shall be deemed to expire therewith;

5. the amendments to subdivision 6 of section 3614 of the public health law made by section thirty of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith; and

6. for purposes of section ten of this act, the commissioner of health, and for purposes of sections nineteen and twenty of this act, the superintendent of insurance shall notify the legislative bill drafting commission of the renewal date of such contracts or policies in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law.