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

S. 58--B A. 158--B

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

(PREFILED)

January 7, 2009

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

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

AN ACT to amend the public health law and the elder law, in relation to the financing for certain provisions of the public health law, making modifications to the childhood lead poisoning primary prevention program and amending provisions relating to the long term care insurance education and outreach program (Part A); to amend the public health law and the social services law, in relation to long term home health care programs; to amend part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to the effectiveness of certain provisions of such chapter; to amend the public health law, in relation to payments under the medical assistance program; to amend the public health law and chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to reimbursements; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend chapter 639 of the laws of 1996, amending the public health law and other laws relating to welfare

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

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reform, in relation to reimbursements; to amend the public health law and part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to rates of payment by state governmental agencies; to amend chapter 629 of the laws of 1986, amending the social services law relating to establishing a demonstration program for the delivery of long term home health care services to certain persons, in relation to extending the provisions thereof; to amend chapter 451 of the laws of 2007 amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to extending the effectiveness of certain provisions thereof; to amend chapter 55 of the laws of 1992, amending the tax law and other laws relating to taxes, surcharges, fees and funding, in relation to the effectiveness thereof; to amend chapter 942 of the laws of 1983 and chapter 541 of the laws of 1984, relating to foster family care demonstration programs, and to amend chapter 256 of the laws of 1985, amending the social services law and other laws relating to foster family care demonstration programs, in relation to extending the expirations thereof; to amend chapter 693 of the laws of 1996, amending the social services law relating to authorizing patient discharge to hospices and residential health care facilities, under the medical assistance presumptive eligibility program, in relation to extending the provisions of such chapter; to amend chapter 631 of the laws of 1997, amending the social services law relating to authorizing medical assistance payments to certain clinics or diagnostic and treatment centers, in relation to extending the effectiveness thereof; to amend chapter 119 of the laws of 1997 relating to authorizing the department of health to establish certain payments to general hospitals, in relation to making such authorization permanent; to amend chapter 519 of the laws of 1999, amending the alcoholic beverage control law and the public health law relating to the sale of alcohol and tobacco products to minors, in relation to the effectiveness thereof; and to amend chapter 58 of the laws of 2008 amending the social services law and the public health law relating to adjustments of rates and the public health law, in relation to hospitals and the distribution of monies; providing for rates of payment by state agencies for certain health care services; to amend the public health law, in relation to assessments on general hospitals and patient service payments; to amend chapter 703 of the laws of 1988 relating to enacting the expanded health care coverage act of nineteen hundred eighty-eight and amending the insurance law and other laws relating to expanded health care and catastrophic health care coverage, in relation to extending certain provisions thereof; to amend part G of chapter 56 of the laws of 2000, amending the public health law relating to the sale and possession of hypodermic syringes and needles, in relation to making permanent the expanded syringe access demonstration program; and to amend chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, in relation to extending the effectiveness thereof; and to repeal certain provisions of part G of chapter 56 of the laws of 2000 amending the public health law and other laws relating to the sale and possession of hypodermic syringes and needles relating to the effectiveness thereof (Part B); to amend the public health law, in relation to payment by governmental agencies for general hospital inpatient services, inpatient medical

assistance rates for non-public general hospitals, grants to public general hospitals, tobacco control and insurance initiatives pool distributions, health care initiatives pool distributions and payments made on behalf of persons enrolled in Medicaid managed care or family health plus; to direct the commissioners of health and mental health to enhance funding of the ambulatory patient group methodology and expand certain programs; to direct the commissioners of health, and mental retardation and developmental disabilities to enhance funding of the ambulatory patient group methodology; to amend the social services law, in relation to establishing the statewide patient-centered medical home; to amend the public health law, in relation to establishing the Adirondack medical home multipayor demonstration program; to amend the social services law, in relation to medicaid coverage of smoking cessation, cardiac rehabilitation services and substance abuse intervention; to amend the social services law, in relation to the primary care case management program; to amend the public health law, in relation to establishing the state electronic health records loan program; to amend the public authorities law, in relation to the authorization of the dormitory authority to issue bonds for health care; to amend the public health law, in relation to defining certain terms and designating pharmaceutical manufacturers; to amend the social services law, in relation to directing the commissioner of health to negotiate pharmaceutical rebates, retrospective and prospective drug utilization review, and the duration of drug therapy, the development of clinical prescribing guidelines, drug coverage for persons who are beneficiaries under Part D; to amend the social services law, in relation to electronic transmission of prescriptions; to amend the social services law, in relation to eligibility for medical assistance and the family health plus program; to amend the welfare reform act of 1997, in relation to applicants for public assistance; to amend the public health law, in relation to child insurance plans; to amend the public health law, in relation to fees for the establishment of hospitals, approval of the construction of hospitals, licensure of home care services agencies, the establishment of certified home health agencies, changes in the ownership of a home health agency hospice construction, distribution of the professional education pools, the general hospital indigent care pool and the comprehensive diagnostic and treatment centers indigent care program; to amend the elder law, in relation to the program for elderly pharmaceutical insurance coverage; to amend the insurance law, in relation to examinations and appraisals of authorized insurers and employee welfare funds; to amend the tax law and the state finance law, in relation to the sales of cigarettes and tobacco products and the health care reform act (HCRA) resources fund; to repeal certain provisions of the public health law relating to the preferred drug program and the telemedicine demonstration program; to repeal certain provisions of chapter 62 of the laws of 2003, amending the social services law and the public health law relating to expanding Medicaid coverage and rates of payment for residential health care facilities, relating thereto; to repeal certain provisions of the social services law relating to specialized HIV pharmacies, the family health plus program, eligibility for medical assistance; to repeal certain provisions of the elder law relating to the program for elderly pharmaceutical insurance coverage; and providing for the repeal of certain provisions upon the expiration thereof; to repeal a certain provision of the insurance law relating to records made available by corpo-

rations (Part C); to amend the public health law, in relation to reimbursement to residential health care facilities, to community service plans, to payments for certified home health agency services; to amend chapter 109 of the laws of 2006, amending the social services law and other laws relating to Medicaid reimbursement rate settings, in relation to establishing a workgroup pertaining to Medicaid reimbursement rate-setting for residential health care facilities for future periods and providing for periodic reports by such group; to amend the social services law, in relation to assisted living programs, to payment for AIDS home care programs, to establishing regional long-term care assessment centers, and in relation to Medicaid extended coverage for the partnership for long-term care program; to amend the social services law, in relation to the consumer directed personal assistance program; to amend chapter 58 of the laws of 2007, amending the social services law and the public health law relating to adjustments of rates, in relation to determination of eligibility; to amend chapter 58 of the laws of 2008, amending the social services law and the public health law relating to adjustments of rates, in relation to determination of eligibility; to amend chapter 1 of the laws of 1999, amending the public health law and other laws, relating to enacting the New York Health Care Reform Act of 2000, in relation to adult day health care services; and authorizing the commissioner of health to expend certain funds to improve the working conditions of certain pediatric facilities (Part D); Intentionally omitted (Part E); in relation to the establishment of the authority of the office of mental health to reduce inpatient capacity through the closure of such wards or through the conversion of beds to develop transitional placement programs, notwithstanding certain provisions of the mental hygiene law (Part F); Intentionally omitted (Part G); to amend the mental hygiene law, in relation to civil commitment of sex offenders (Part H); Intentionally omitted (Part I); to amend the mental hygiene law, in relation to the consolidation of certain developmental disabilities services officers (Part J); to amend the mental hygiene law, in relation to the closure of the Manhattan Addiction Treatment Center (Part K); to amend chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services programs, in relation to foregoing such adjustment during the 2009--2010 state fiscal year (Part L); Intentionally omitted (Part M); to amend chapter 119 of the laws of 1997 authorizing the department of health to establish certain payments to general hospitals, in relation to extending the authorization for the department of health to continue certain payments to general hospitals (Part N); authorizing the commissioner of mental health and the city of New York to extend the lease of certain portions of Ward's Island; and to amend the administrative code of the city of New York, in relation to permitting the extension of such lease for a period not to exceed fifty years for the continued purposes of the Manhattan psychiatric center and the Kirby forensic psychiatric center and related programs (Part O); Intentionally omitted (Part P); Intentionally omitted (Part Q); and to amend the social services law, in relation to recertification for medical assistance for a recipient of medicaid waiver services authorized by the office of mental retardation and developmental disabilities (Part R)

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 2009-2010 state fiscal year. Each component is wholly contained within a Part identified as Parts A through R. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Subdivisions 9 and 10 of section 225 of the public health law, subdivision 9 as added by chapter 612 of the laws of 1990, and subdivision 10 as added by chapter 446 of the laws of 1991, are amended to read as follows:

9. Notwithstanding the provisions of any general, special or local law to the contrary, in cities having a population of one million or more, the sanitary code shall provide that any installation, service, maintenance, testing, repair or modification of a backflow prevention device or any related work shall be performed in conformance with the plumbing code of any such city. All employees of a licensed plumber who perform testing of backflow prevention devices shall satisfactorily complete an approved course in backflow prevention device testing. NOTHING IN THIS SUBDIVISION SHALL REQUIRE THE COMMISSIONER TO CERTIFY THE COMPLETION OF SUCH APPROVED COURSE BY SUCH EMPLOYEES. For the purposes of this subdivision, "backflow prevention device" means an acceptable air gap, reduced pressure zone device, double check valve assembly or equivalent protective device acceptable to the commissioner that is designed to prevent or contain potential contamination of a public water system by means of cross-connection control.

10. Notwithstanding the provisions of any general, special or local law to the contrary, the sanitary code of the state of New York shall provide that in any county, city having a population of less than one million, town or village having a plumbing code, the installation, service, maintenance, testing, repair or modification of a backflow prevention device or any related work shall be performed in accordance with such plumbing code. A person licensed under such plumbing code and any of his employees who perform testing of backflow prevention devices shall satisfactorily complete a course in backflow prevention device testing that has been approved by the department. NOTHING IN THIS SUBDIVISION SHALL REQUIRE THE COMMISSIONER TO CERTIFY THE COMPLETION OF SUCH APPROVED COURSE BY SUCH LICENSEE OR EMPLOYEES. For the purposes of this subdivision, "backflow prevention device" means an acceptable air gap, reduced pressure zone device, double check valve assembly or equivalent protective device acceptable to the commissioner that is designed to prevent or contain potential contamination of a public water system by means of cross-connection control.

S 2. Subdivision 4 of section 1352 of the public health law, as added by chapter 635 of the laws of 2007, is amended to read as follows:

4. [The] TO THE EXTENT THAT FUNDS ARE AVAILABLE FOR THE PURPOSES SET FORTH IN THIS SUBDIVISION, THE commissioner shall require that the following food service establishments: restaurants, bars, membership organizations, fraternal organizations, and private clubs, excepting

establishments licensed pursuant to section sixty-four-a of the alcoholic beverage control law, that are not regulated by the department of agriculture and markets, at all times have in their employment at least one individual who has been trained and certified by an organization, approved by the commissioner, which specializes in and provides instruction concerning the safe and proper handling, preparation, cooking, storage, serving, delivery, removal and disposal of food. Attendance at any course established pursuant to this section shall be in person, through distance learning methods, or through an Internet based online program. Such training shall meet the standards set forth by the commissioner pursuant to section thirteen hundred fifty-five of this title, either: (a) pursuant to a program approved by the commissioner under such section, or (b) pursuant to a course that shall address but not be limited to the following topics:

(i) Contamination, food allergies and foodborne illness.

(ii) Purchasing and receiving safe food.

(iii) Keeping food safe in storage.

(iv) Protecting food during preparation.

(v) Protecting food during service.

(vi) Sanitary facilities and equipment.

(vii) Cleaning and sanitizing.

(viii) Integrated pest management.

(ix) Food-safety regulations and standards.

(x) Employee food-safety training.

The commissioner shall allow a licensee a period of up to thirty days to come into compliance with this subdivision where an employee who has been certified as having completed the approved food safety training program separates from his or her place of employment.

S 3. Paragraph (m) of subdivision 1 of section 201 of the public health law, as relettered by chapter 571 of the laws of 1976, is amended to read as follows:

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

S 4. Paragraphs (a) and (c) of subdivision 2 and subdivision 3 of section 1370-a of the public health law, paragraphs (a) and (c) of subdivision 2 as added by chapter 485 of the laws of 1992 and subdivision 3 as added by section 23 of part B of chapter 58 of the laws of 2007, are amended to read as follows:

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

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

3. The department shall identify and designate [a zip code in certain counties] AREAS IN THE STATE with significant concentrations of children identified with elevated blood lead levels AS COMMUNITIES OF CONCERN for purposes of implementing a [pilot] CHILDHOOD LEAD POISONING PRIMARY PREVENTION program [to work in cooperation with local health officials to develop a primary prevention plan for each such zip code identified to prevent exposure to lead-based paint], AND MAY, WITHIN AMOUNTS APPROPRIATED, PROVIDE GRANTS TO IMPLEMENT APPROVED PROGRAMS. THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, SHALL DEVELOP AND IMPLEMENT A CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM TO PREVENT EXPOSURE TO LEAD-BASED PAINT HAZARDS FOR THE COMMUNITIES OF CONCERN IN THEIR JURISDICTION. THE DEPARTMENT SHALL PROVIDE FUNDING TO THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE OR COUNTY HEALTH DEPARTMENTS TO IMPLEMENT THE APPROVED WORK PLAN FOR A CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM. THE WORK PLAN AND BUDGET, WHICH SHALL BE SUBJECT TO THE APPROVAL OF THE DEPARTMENT, SHALL INCLUDE, BUT NOT BE LIMITED TO: (A) IDENTIFICATION AND DESIGNATION OF AN AREA OR AREAS OF HIGH RISK WITHIN COMMUNITIES OF CONCERN; (B) A HOUSING INSPECTION PROGRAM THAT INCLUDES PRIORITIZATION AND INSPECTION OF AREAS OF HIGH RISK FOR LEAD HAZARDS, CORRECTION OF IDENTIFIED LEAD HAZARDS USING EFFECTIVE LEAD-SAFE WORK PRACTICES AND, APPROPRIATE OVERSIGHT OF REMEDIATION WORK; (C) PARTNERSHIPS WITH OTHER COUNTY OR MUNICIPAL AGENCIES OR COMMUNITY-BASED ORGANIZATIONS TO BUILD COMMUNITY AWARENESS OF THE CHILDHOOD LEAD POISONING PRIMARY PREVENTION PROGRAM AND ACTIVITIES, COORDINATE REFERRALS FOR SERVICES, AND SUPPORT REMEDIATION OF HOUSING THAT CONTAINS LEAD HAZARDS; (D) A MECHANISM TO PROVIDE EDUCATION AND REFERRAL FOR LEAD TESTING FOR CHILDREN AND PREGNANT WOMEN TO FAMILIES WHO ARE ENCOUNTERED IN THE COURSE OF CONDUCTING PRIMARY PREVENTION INSPECTIONS AND OTHER OUTREACH ACTIVITIES; AND (E) A MECHANISM AND OUTREACH EFFORTS TO PROVIDE HOUSING INSPECTIONS FOR LEAD HAZARDS UPON REQUEST. THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, SHALL ALSO ENTER INTO AN AGREEMENT OR SUBCONTRACT WITH A MUNICIPAL GOVERNMENT REGARDING INSPECTION OF THE PAINT CONDITIONS IN DWELLINGS BUILT PRIOR TO NINETEEN HUNDRED SEVENTY-EIGHT FOR THE AREA DEFINED AS THE COMMUNITY OF CONCERN AND MAY, WHEN QUALIFIED STAFF EXISTS, DESIGNATE THE LOCAL HOUSING MAINTENANCE CODE ENFORCEMENT AGENCY IN WHICH THE COMMUNITY OF CONCERN IS LOCATED AS AN AGENCY AUTHORIZED TO ADMINISTER THE PROVISIONS OF THIS TITLE PURSUANT TO SUBDIVISION ONE OF SECTION THIRTEEN HUNDRED SEVENTY-FIVE OF THIS TITLE. A PORTION OF GRANT FUNDING RECEIVED TO SUPPORT THE LOCAL PRIMARY PREVENTION PLAN MAY BE USED TO REDUCE BARRIERS TO LEAD TESTING OF CHILDREN AND PREGNANT WOMEN WITHIN THE COMMUNITIES OF CONCERN, INCLUDING THE PURCHASE OF LEAD TESTING DEVICES AND SUPPLIES WHEN THE NEED FOR SUCH RESOURCES IS IDENTIFIED WITHIN THE COMMUNITY. The commissioner, THE COMMISSIONER OF HEALTH OF A COUNTY OR PART-COUNTY HEALTH DISTRICT, A COUNTY HEALTH DIRECTOR OR A PUBLIC HEALTH DIRECTOR AND, IN THE CITY OF NEW YORK, THE COMMISSIONER OF THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE, is authorized to enter into agreements, CONTRACTS, SUBCONTRACTS or memoranda of understanding with, and provide technical and other resources to, local health officials, local building code officials, real property owners, and community organizations in such areas to create and implement policies, education

and other forms of community outreach to address lead exposure, detection and risk reduction. [Such primary] PRIMARY prevention plans shall target children less than six years of age living in the highest risk housing in the [zip code] COMMUNITIES OF CONCERN identified. [Such primary prevention] THE plans shall also take into consideration the extent the weatherization assistance [or] PROGRAM AND other such programs can be used in [collaboration] CONJUNCTION with lead-based paint hazard risk reduction. FUNDING PROVIDED FOR THIS PROGRAM SHALL BE USED FOR THE ACTIVITIES DESCRIBED IN THIS SECTION AND SHALL NOT BE USED FOR OTHER ACTIVITIES REQUIRED BY THIS TITLE.

S 5. Subdivision 1 and paragraph (i) of subdivision 3 of section 1370-b of the public health law, as added by chapter 485 of the laws of 1992, is amended to read as follows:

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

(i) To report on or before [January] DECEMBER first of each year to the governor and the legislature concerning the PREVIOUS YEAR'S development and implementation of the statewide plan and operation of the program, together with recommendations it deems necessary AND THE MOST CURRENTLY AVAILABLE LEAD SURVEILLANCE MEASURES, INCLUDING THE ACTUAL NUMBER AND ESTIMATED PERCENTAGE OF CHILDREN TESTED FOR LEAD IN ACCORDANCE WITH NEW YORK STATE REGULATIONS, INCLUDING AGE-SPECIFIC TESTING REQUIREMENTS, AND THE ACTUAL NUMBER AND ESTIMATED PERCENTAGE OF CHILDREN IDENTIFIED WITH ELEVATED BLOOD LEAD LEVELS. SUCH REPORT SHALL BE MADE AVAILABLE ON THE DEPARTMENT'S WEBSITE.

S 6. Subdivision 3 of section 1370-e of the public health law, as added by chapter 485 of the laws of 1992, is amended to read as follows:

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

S 7. Section 2168 of the public health law, as added by chapter 544 of the laws of 2006, is amended to read as follows:

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

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

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

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

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

2. For the purposes of this section:

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

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

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

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

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

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

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

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

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

PROVIDED, HOWEVER, BLOOD LEAD ANALYSIS DATA COLLECTED FROM PHYSICIAN OFFICE LABORATORIES BY THE COMMISSIONER OF HEALTH AND MENTAL HYGIENE OF THE CITY OF NEW YORK PURSUANT TO THE HEALTH CODE OF THE CITY OF NEW YORK SHALL BE PROVIDED TO THE DEPARTMENT IN A FORMAT PRESCRIBED BY THE COMMISSIONER.

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

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

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

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

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

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

(b) In addition to the immunization administration information required by this section, the operation of any immunization registry established under chapter five hundred twenty-one of the laws of nine-

teen hundred ninety-four, section [11.04] 11.07 of title twenty-four of volume eight of the compilation of the rules of the city of New York and administered by a local health district collecting information from health care providers about vaccinations previously administered to a vaccinee prior to the effective date of this section shall provide the commissioner access to such information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S 8. Intentionally omitted.

S 9. Intentionally omitted.

S 10. Intentionally omitted.

S 11. Intentionally omitted.

S 12. Intentionally omitted.

S 13. Subdivisions 3, 4, 5 and 7 of section 217-a of the elder law, as added by section 23 of part B of chapter 58 of the laws of 2004, are amended to read as follows:

3. The commissioner of health, the superintendent of insurance and the director of the office for the aging shall appoint a state program coordinator to implement, administer and supervise the long term care insurance education and outreach program, and coordinate the development of the educational and informational materials. The state program coordinator shall be [a full time] AN employee of the office for the aging who shall be selected from among individuals with expertise and experience in the fields of long term care insurance, and with other qualifications determined by the commissioner of health, the superintendent of insurance and the director of the office for the aging to be appropriate for the position. The state program coordinator shall, WITHIN AMOUNTS AVAILABLE, personally or through authorized representatives, be responsible for training staff persons of the program, including staff persons of the long term care insurance resource centers, and shall provide for the collection and dissemination of timely and accurate long term care insurance information to said staff persons.

4. The long term care insurance education and outreach program shall [at a minimum], WITHIN AMOUNTS AVAILABLE, consist of the following elements which shall be provided by the office for the aging:

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

(b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or presentations;

(c) establishment of a toll-free telephone hotline and electronic services to provide information; and

(d) establishment of long term care insurance resource centers within each area agency on aging.

5. Long term care insurance resource centers shall, [at a minimum] WITHIN AMOUNTS AVAILABLE, provide the general public with the following items or services:

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

(b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or presentations; and

(c) counseling, information, referral services, and direct assistance in choosing and obtaining long term care insurance. Direct assistance shall, WITHIN AMOUNTS AVAILABLE, include but not be limited to assistance with the following:

(i) planning for the financing of long term care;

(ii) understanding policy options, benefits and appeal rights;

(iii) obtaining the coverage needed and the appropriate benefits; and

(iv) avoiding or reporting illegal billing, fraudulent practices or scams.

Each long term care insurance resource center shall be responsible, WITHIN AMOUNTS AVAILABLE, for providing a sufficient number of staff positions (including volunteers) necessary to provide and carry out the services of the long term care insurance education and outreach program, provided that at least one position shall be filled by an individual who is employed full time and paid by the area agency on aging. The long term care insurance resource center shall be responsible for ensuring that its staff persons have no conflict of interest in providing the services described in subdivision four of this section.

7. The department of health shall produce, POST ON ITS WEBSITE, make available to others for reproduction, or contract with others to develop such materials [mentioned in] REQUIRED BY this section [as the coordinator deems appropriate]. The material produced pursuant to this section shall be culturally and linguistically appropriate for the communities served by the long term care insurance resource centers. These materials shall be made available to the public free of charge.

S 14. This act shall take effect immediately.

PART B

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

(C) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, FOR CERTIFIED HOME HEALTH AGENCIES AND FOR PROVIDERS OF LONG TERM HOME HEALTH CARE PROGRAMS THE ASSESSMENT SHALL BE 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.

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

4. [For periods prior to January first, two thousand five, the] THE commissioner is authorized to contract with the article forty-three insurance law plans, or such other administrators as the commissioner shall designate, to receive and distribute home care provider assessment funds and personal care services provider assessment funds assessed pursuant to section three hundred sixty-seven-i of the social services law. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commission-

er shall conduct annual audits of the receipt and distribution of the assessment funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis two hundred thousand dollars for all assessments established pursuant to this section and the personal care services provider assessment established pursuant to section three hundred sixty-seven-i of the social services law, shall be paid from the assessment funds.

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

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

(B) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, THE ASSESSMENT SHALL BE 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.

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

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

(B) NOTWITHSTANDING ANY CONTRARY PROVISIONS OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW OR REGULATION, THE ASSESSMENT SHALL BE 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.

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

(b) For purposes of this section, "proposed or final regulations of the Centers for Medicare and Medicaid Services" are regulations subject to a moratorium in effect until July 1, 2009 pursuant to P.L. 110-252,

as amended by P.L. 111-5, specifically: (i) interim final regulation dealing with case management and targeted case management published December 4, 2007 (CMS-2237-IFC); (ii) final rule implementing changes to Medicaid provider tax provisions published February 22, 2008 (CMS-2275-F); (iii) final rule dealing with public provider cost limits published May 29, 2007 (CMS-2258-FC); (iv) proposed rule dealing with Medicaid graduate medical education published May 23, 2007 (CMS-2279-P); (v) proposed rule dealing with the Medicaid rehabilitation services option published August 13, 2007 (CMS-2261-P); and (vi) final rule concerning school-based services published December 28, 2007 (CMS-2287-F) and a regulation subject to a moratorium in effect until June 30, 2009 pursuant to P.L. 111-5, specifically: final regulation concerning outpatient hospital facility services published November 7, 2008 (73 Federal Register 66187).

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. Intentionally omitted.

S 9. Intentionally omitted.

S 10. Subdivision 2 of section 93 of part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 fiscal year, is amended to read as follows:

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

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

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

S 12. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 65 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, AND 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 [and], 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, 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, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 13. Paragraph (b) of subdivision 1 of section 211 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 66 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning April 1, 2000, the department of health is authorized to pay public general hospitals, other than those operated by the state of New York or the state university of New York, as defined in subdivision 10 of section 2801 of the public health law, located in a city with a population of over 1 million, additional initial payments for inpatient hospital services of $120 million during each state fiscal year until March 31, 2003, and up to $120 million during the state fiscal year beginning April 1, 2005 through March 31, 2006 and during the state fiscal year beginning April 1, 2006 through March 31, 2007 and during the state fiscal year beginning April 1, 2007 through March 31, 2008 and during the state fiscal year beginning April 1, 2008 through March 31, 2009, AND 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, 2010 THROUGH MARCH 31, 2011 AND UP TO ONE HUNDRED TWENTY MILLION DOLLARS 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, 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 DATA, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

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

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

S 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [2009] 2011, and

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

S 15. Subdivisions 2 and 4 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 69 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011;

4. Section one of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011.

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

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

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

(iii) commencing April first, nineteen hundred ninety-seven through March thirty-first, nineteen hundred ninety-nine and commencing July

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

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

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

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

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

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

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

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

S 21. Subdivision 1 of section 46 of chapter 639 of the laws of 1996 amending the public health law and other laws relating to welfare reform, as amended by section 75 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation to the contrary, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through June 30, 1996 and on or after July 1, 1996 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2005 and on and after April 1, 2005 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009,

AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011, shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

S 22. Section 4 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 76 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 4. Notwithstanding any inconsistent provision of law, except subdivision 15 of section 2807 of the public health law and section 364-j-2 of the social services law and section 32-g of part F of chapter 412 of the laws of 1999, rates of payment for diagnostic and treatment centers established in accordance with paragraphs (b) and (h) of subdivision 2 of section 2807 of the public health law for the period ending September 30, 1995 shall continue in effect through September 30, 2000 and for the periods October 1, 2000 through September 30, 2003 and October 1, 2003 through September 30, 2007 and October 1, 2007 through September 30, 2009, AND ON AND AFTER OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2011, and further provided that rates in effect on March 31, 2003 as established in accordance with paragraph (e) of subdivision 2 of section 2807 of the public health law shall continue in effect for the period April 1, 2003 through September 30, 2007 and October 1, 2007 through September 30, 2009, AND ON AND AFTER OCTOBER 1, 2009 THROUGH SEPTEMBER 30, 2011, provided however that, subject to the approval of the director of the budget, such rates may be adjusted to include expenditures in those components of rates not subject to the ceilings of the corresponding rate methodology.

S 23. Subdivision 5 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 77 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

5. Section three of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009, AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011;

S 24. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates of residential health care facilities, as amended by section 78 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 194. 1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

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

S 25. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 fiscal year, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, AS AMENDED, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

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

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

S 27. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 80 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide reduction percentage

respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

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

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 reduction amount.

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

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 facility specific reduction amounts respectively.

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

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

same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law.

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

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

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

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 AND THE 2010 TARGET PERIOD SHALL MEAN JANUARY 1, 2010 THROUGH NOVEMBER 30, 2010 AND THE 2011 TARGET PERIOD SHALL MEAN JANUARY 1, 2011 THROUGH NOVEMBER 30, 2011.

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

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, [and] prior to February 1, 2007, [and] prior to February 1, 2008 [and], prior to February 1, 2009, PRIOR TO FEBRUARY 1, 2010 AND PRIOR TO FEBRUARY 1, 2011 for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

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

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

(i) one and one-tenth percentage points for CHHAs located within the downstate region;
(ii) six-tenths of one percentage point for CHHAs located within the upstate region;
(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and
(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.
(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:
(i) one and one-tenth percentage points for CHHAs located within the downstate region;
(ii) six-tenths of one percentage point for CHHAs located within the upstate region;
(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and
(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.
(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:
(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;
(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;
(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPs located within the downstate region; and
(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPs located within the upstate region.
5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.
(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid

revenue percentage to determine the amount of the shortfall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

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

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

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

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

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

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

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008 [and], 2009, 2010 AND 2011 for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

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

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

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

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

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

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

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

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

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

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

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

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

ble regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph (a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

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

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

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

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

10. On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider specific state share reduction amount in accordance with the methodology provided in paragraph (a) of subdivision 2, paragraph (a) of subdivision 5, paragraph (a) of subdivision 6 and paragraph (a) of subdivision 7 of this section. The provider specific state share reduction amount calculated in accordance with this subdivision shall be compared to the 1996 provider specific state share reduction amount calculated in accordance with paragraph (a) of subdivision 7 of this section. Any amount in excess of the amount determined in accordance with paragraph (a) of subdivision 7 of this section shall be due to the state from each CHHA and LTHHCP and may be recouped in accordance with paragraph (a) of subdivision 8 of this section. If the amount is less than the amount determined in accordance with paragraph (a) of subdivision 7 of this section, the difference shall be refunded to the CHHA and LTHHCP by the state no later than July 15, 1997. CHHAs and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

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

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

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

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

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

S 32. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 86 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011;

S 33. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 87 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, AND ON AND AFTER APRIL 1, 2009 THROUGH MARCH 31, 2011.

S 34. Intentionally omitted.

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

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

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

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

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

S 37. Intentionally omitted.

S 38. Subdivision 1 of section 20 of chapter 451 of the laws of 2007 amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [2009] 2011;

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

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

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

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

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

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

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

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

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

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

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

S 2. This act shall take effect immediately and shall be deemed to apply to claims for reimbursement payments whether submitted before, on or after the effective date of this act[, and shall expire and be deemed repealed July 1, 2009].

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

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

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

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

S 46-a. Section 365-a of the social services law is amended by adding a new subdivision 8 to read as follows:

8. WHEN A NON-GOVERNMENTAL ENTITY IS AUTHORIZED BY THE DEPARTMENT PURSUANT TO CONTRACT OR SUBCONTRACT TO MAKE PRIOR AUTHORIZATION OR PRIOR APPROVAL DETERMINATIONS THAT MAY BE REQUIRED FOR ANY ITEM OF MEDICAL ASSISTANCE, A RECIPIENT MAY CHALLENGE ANY ACTION TAKEN OR FAILURE TO ACT IN CONNECTION WITH A PRIOR AUTHORIZATION OR PRIOR APPROVAL DETERMINATION AS IF SUCH DETERMINATION WERE MADE BY A GOVERNMENT ENTITY, AND SHALL BE ENTITLED TO THE SAME MEDICAL ASSISTANCE BENEFITS AND STANDARDS AND TO THE SAME NOTICE AND PROCEDURAL DUE PROCESS RIGHTS, INCLUDING A RIGHT TO A FAIR HEARING AND AID CONTINUING PURSUANT TO SECTION TWENTY-TWO OF THIS CHAPTER, AS IF THE PRIOR AUTHORIZATION OR PRIOR APPROVAL DETERMINATION WERE MADE BY A GOVERNMENT ENTITY.

S 47. Section 11 of part C of chapter 58 of the laws of 2008 amending the social services law and the public health law relating to adjustments of rates, as amended by section 1 of part I of chapter 2 of the laws of 2009, is amended to read as follows:

S 11. 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, but subject to subparagraph (iii) of paragraph [(b)] (A) of subdivision 33 of section 2807-c of the public health law, in determining rates of payments by state governmental agen-

cies effective for services provided on and after April 1, 2008, 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 and long term home health care programs, other than for services provided to home care patients diagnosed with AIDS as determined by applicable regulations, and personal care services provided pursuant to paragraph (e) of subdivision two of section 365-a of the social services law, the commissioner of health shall apply a trend factor projection equal to sixty-five percent of the otherwise applicable trend factor projection attributable to the period January 1, 2008 through December 31, 2008 in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that for rates of payment effective for services provided on and after January 1, 2009, the final trend factor projections attributable to the 2008 calendar year period shall be further adjusted such that any increase to the average trend factor projections for the period April 1, 2008 through December 31, 2008 shall be reduced, on an annualized basis, by one and three tenths percentage points AND PROVIDED FURTHER, HOWEVER, THAT ON AND AFTER APRIL 1, 2009, SUCH TREND FACTOR PROJECTIONS, INCLUDING SERVICES PROVIDED TO HOME CARE PATIENTS DIAGNOSED WITH AIDS AS DETERMINED BY APPLICABLE REGULATIONS, SHALL BE FURTHER REDUCED TO ZERO, and provided further, however, no retroactive adjustment to such 2008 trend factor projection shall be made for the period April 1, 2008 through December 31, 2008 pursuant to subparagraph 3 of paragraph (c) of subdivision 10 of section 2807-c of the public health law AND PROVIDED FURTHER, HOWEVER, THAT FOR RATES OF PAYMENT FOR ASSISTED LIVING PROGRAM SERVICES PROVIDED ON AND AFTER APRIL 1, 2009, TREND FACTOR PROJECTIONS ATTRIBUTABLE TO THE 2008 CALENDAR YEAR SHALL BE REDUCED TO ZERO, AND FURTHER PROVIDED, HOWEVER, THAT FOR RATES OF PAYMENT FOR PERSONAL CARE SERVICES PROVIDED ON AND AFTER APRIL 1, 2009, IN THOSE SOCIAL SERVICES DISTRICTS, INCLUDING NEW YORK CITY, WHOSE RATES OF PAYMENT FOR SUCH SERVICES ARE ISSUED BY SUCH SOCIAL SERVICES DISTRICTS PURSUANT TO A RATE-SETTING EXEMPTION ISSUED BY THE COMMISSIONER OF HEALTH TO SUCH SOCIAL SERVICES DISTRICTS IN ACCORDANCE WITH APPLICABLE REGULATIONS, TREND FACTOR PROJECTIONS ATTRIBUTABLE TO THE 2008 CALENDAR YEAR SHALL BE REDUCED TO ZERO.

S 48. 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, section 5 of part F of chapter 497 of the laws of 2008 and any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after [January] APRIL 1, 2009, 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 367-i of the social services law, the commissioner of health shall apply zero trend factor projections attributable to the 2009 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 2009 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 [January] APRIL 1, 2009, trend factor projections attributable to the 2009 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 49. Paragraph (a) of subdivision 2 of section 2807-d of the public health law is amended by adding a new subparagraph (vi) 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.

S 50. Paragraphs (b), (c), (d) and (e) of subdivision 2 of section 2807-j of the public health law, as amended by section 41 of part B of chapter 58 of the laws of 2005, are amended to read as follows:

(b) The total percentage allowance for each payor, other than governmental agencies, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, and other than payments for a patient that has no third-party coverage in whole or in part for services provided by a designated provider of services, shall be:

(i) the sum of (A) eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be eight and ninety-five hundredths percent, AND FURTHER PROVIDED THAT FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE PERCENTAGE SHALL BE NINE AND SIXTY-THREE HUNDREDTHS PERCENT, plus (B) twenty-four percent, provided, however, that for services provided on and after July first, two thousand three, the percentage shall be twenty-five and ninety-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the percentage shall be twenty-six and twenty-six hundredths percent, AND FURTHER PROVIDED THAT FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOU-

SAND NINE, THE PERCENTAGE SHALL BE TWENTY-EIGHT AND TWENTY-SEVEN HUNDREDTHS PERCENT, and plus (C) for a specified third-party payor as defined in subdivision one-a of section twenty-eight hundred seven-s of this article the percentage allowance applicable for a general hospital for inpatient hospital services pursuant to subdivision two of section twenty-eight hundred seven-s of this article;

(ii) unless (A) an election in accordance with paragraph (a) of subdivision five of this section to pay the allowance directly to the commissioner or the commissioner's designee is in effect for a third-party payor, and in addition (B) for a specified third-party payor an election to pay the assessment in accordance with section twenty-eight hundred seven-t of this article is in effect.

(c) If an election in accordance with subdivision five of this section is in effect for a third-party payor and in addition in accordance with section twenty-eight hundred seven-t of this article for a specified third-party payor, the total percentage allowance factor shall be reduced to eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance factor shall be reduced to eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance factor shall be reduced to eight and ninety-five hundredths percent, AND FURTHER PROVIDED THAT FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE TOTAL PERCENTAGE ALLOWANCE FACTOR SHALL BE REDUCED TO NINE AND SIXTY-THREE HUNDREDTHS PERCENT.

(d) The total percentage allowance for payments by governmental agencies, as determined in accordance with paragraphs (a) and (a-1) of subdivision one of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six, or health maintenance organizations for services provided to subscribers eligible for medical assistance pursuant to title eleven of article five of the social services law, or approved organizations for services provided to subscribers eligible for the family health plus program pursuant to title eleven-D of article five of the social services law, shall be five and ninety-eight-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be six and forty-seven hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be six and fifty-four hundredths percent, AND FURTHER PROVIDED THAT FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE TOTAL PERCENTAGE ALLOWANCE SHALL BE SEVEN AND FOUR HUNDREDTHS PERCENT.

(e) The total percentage allowance for payments for services provided by designated providers of services for which there is no third-party coverage in whole or in part shall be eight and eighteen-hundredths percent, provided, however, that for services provided on and after July first, two thousand three the total percentage allowance shall be eight and eighty-five hundredths percent, and further provided that for services provided on and after January first, two thousand six, the total percentage allowance shall be eight and ninety-five hundredths percent, AND FURTHER PROVIDED THAT FOR SERVICES PROVIDED ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE TOTAL PERCENTAGE ALLOWANCE SHALL BE NINE AND SIXTY-THREE HUNDREDTHS PERCENT. This paragraph shall not apply to patient deductibles and coinsurance amounts.

S 51. Clause (A) of subparagraph (i) of paragraph (b) of subdivision 1 of section 2807-1 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:

(A) an amount not to exceed six million dollars on an annualized basis for the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine; up to six million dollars for the period January first, two thousand through December thirty-first, two thousand; up to five million dollars for the period January first, two thousand one through December thirty-first, two thousand one; up to four million dollars for the period January first, two thousand two through December thirty-first, two thousand two; up to two million six hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three; up to one million three hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four; up to six hundred seventy thousand dollars for the period January first, two thousand five through June thirtieth, two thousand five; up to one million three hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven; and up to one million three hundred thousand dollars annually for the period April first, two thousand seven through March thirty-first, two thousand [eleven] NINE, shall be allocated to individual subsidy programs; and

S 52. Paragraph (e) of subdivision 2 of section 4 of section 1 of chapter 703 of the laws of 1988, relating to enacting the expanded health care coverage act of nineteen hundred eighty-eight and amending the insurance law and other laws relating to expanded health care and catastrophic health care coverage, as amended by section 20 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(e) Applications for enrollment in the individual subsidy program will not be accepted on and after January first, two thousand one; provided, however, individuals and families who are otherwise eligible to receive benefits under such program and are enrolled prior to January first, two thousand one, may remain enrolled in such program until March thirty-first, two thousand [eleven] NINE.

S 53. Subdivision 1 of section 368-a of the social services law is amended by adding a new paragraph (z) to read as follows:

(Z) ONE HUNDRED PERCENT OF THE AMOUNT EXPENDED FOR HEALTH CARE SERVICES DESCRIBED IN SECTIONS THREE HUNDRED SIXTY-EIGHT-D AND THREE HUNDRED SIXTY-EIGHT-E OF THIS TITLE, AFTER FIRST DEDUCTING THEREFROM ANY FEDERAL FUNDS PROPERLY RECEIVED OR TO BE RECEIVED ON ACCOUNT THEREOF.

S 54. Section 368-d of the social services law, as amended by chapter 82 of the laws of 1995, is amended to read as follows:

S 368-d. Reimbursement to public school districts and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law.

1. The department OF HEALTH shall review claims for expenditures made by or on behalf of local public school districts, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, for medical care, services and supplies which are furnished to children with handicapping conditions or such children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accord-

ance with the department's approved medical assistance fee schedules by payment to such local public school district, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, which furnished the care, services or supplies either directly or by contract[, of the amount of any federal funds properly received or to be received on account of such expenditures].

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

3. [The department's liability for payment for expenditures by or on behalf of local public school districts, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, for services furnished to children under this section shall be limited solely to payment of the federal funds received, or to be received, on account of such expenditures. In the event of any subsequent disallowances or recoupment of such funds by a federal governmental agency, upon notification by the commissioner, the comptroller shall withhold or cause to be withheld the amount of such disallowance or recoupment from moneys otherwise due the local public school district, and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law, as state aid pursuant to any provision of the education law, and the comptroller shall transfer such amount to the credit of the department of social services medical assistance program local assistance account] THE PROVISIONS OF THIS SECTION SHALL BE OF NO FORCE AND 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 SECTION.

S 55. Section 368-e of the social services law, as added by chapter 558 of the laws of 1989, subdivision 1 as amended by chapter 631 of the laws of 1997, is amended to read as follows:

S 368-e. Reimbursement to counties for pre-school children with handicapping conditions. 1. The department OF HEALTH shall review claims for expenditures made by counties and the city of New York for medical care, services and supplies which are furnished to preschool children with handicapping conditions or such preschool children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such county or city which furnished the care, services or supplies either directly or by contract[, of the amount of any federal funds properly received or to be received on account of such expenditures]. Notwithstanding any provisions of law, rule or regulation to the contrary, any clinic or diagnostic and treatment center licensed under article twenty-eight of the public health law, which as determined by the state education department, in conjunction with the department of health, has a less than arms length relationship with the provider approved under section forty-four hundred ten of the education law shall, subject to the approval of the department and based on standards developed by the department, be authorized to directly submit such claims for medical assistance, services or supplies so furnished for any period beginning on or after July first, nineteen hundred ninety-seven.

The actual full cost of the individualized education program (IEP) related services incurred by the clinic shall be reported on the New York State Consolidated Fiscal Report in the education law section forty-four hundred ten program cost center in which the student is placed and the associated medical assistance revenue shall be reported in the same manner.

2. Claims for payment under this section shall be made in such form and manner, at such times, and for such periods as the department may require.

[3. The department's liability for payment for expenditures by or on behalf of such county or the city of New York for services furnished to preschool children under this section shall be limited solely to payment of the federal funds received, or to be received, on account of such expenditures. In the event of any subsequent disallowances or recoupment of such funds by a federal governmental agency, the commissioner shall withhold such amount from any moneys otherwise due the county or city of New York under this chapter] THE PROVISIONS OF THIS SECTION SHALL BE OF NO FORCE AND 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 SECTION.

S 56. Subdivision 1 of section 368-e of the social services law, as amended by chapter 474 of the laws of 1996, is amended to read as follows:

1. The department OF HEALTH shall review claims for expenditures made by counties and the city of New York for medical care, services and supplies which are furnished to preschool children with handicapping conditions or such preschool children suspected of having handicapping conditions, as such children are defined in the education law. If approved by the department, payment for such medical care, services and supplies which would otherwise qualify for reimbursement under this title and which are furnished in accordance with this title and the regulations of the department to such children, shall be made in accordance with the department's approved medical assistance fee schedules by payment to such county or city which furnished the care, services or supplies either directly or by contract[, of the amount of any federal funds properly received or to be received on account of such expenditures]. Notwithstanding any provisions of law, rule or regulation to the contrary, any clinic or diagnostic and treatment center licensed under article twenty-eight of the public health law, or articles sixteen and thirty-one of the mental hygiene law, which submitted a claim for such reimbursement payments on or before June thirtieth, nineteen hundred ninety-five, shall, subject to the approval of the department and based on standards developed by the department, continue to be authorized to directly submit such claims for medical assistance, services or supplies so furnished for any period thereafter until March thirty-first, nineteen hundred ninety-seven or such later date as the commissioner shall authorize pursuant to regulation.

S 57. Section 5 of part G of chapter 56 of the laws of 2000, amending the public health law and other laws relating to the sale and possession of hypodermic syringes and needles, as amended by section 28 of part C of chapter 56 of the laws of 2007, is REPEALED.

S 57-a. Section 5 of part G of chapter 56 of the laws of 2000, amending the public health law, and other laws relating to the sale and possession of hypodermic syringes and needles, as amended by section 9 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

S 5. This act shall take effect January 1, 2001 [and shall remain in full force and effect until September 1, 2011 when upon such date the provisions of this act shall be deemed repealed]; provided, however, that effective immediately the commissioner of health is authorized to promulgate any rules and regulations necessary for the timely implementation of this act on such effective date.

S 58. Section 88 of chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, as amended by section 22-a of part C of chapter 58 of the laws of 2007, is amended to read as follows:

S 88. Notwithstanding any provision of law to the contrary, all operating demonstrations, as such term is defined in paragraph [(d)] (C) of subdivision 1 of section 4403-f of the public health law as added by section eighty-two of this act, due to expire prior to January 1, 2001 shall be deemed to expire on December 31, [2009] 2011.

S 59. This act shall take effect immediately; provided however that sections fifty-three through fifty-six of this act shall take effect July 1, 2009 and shall apply to services provided on and after such date; provided, however, that the amendments to section 2807-c of the public health law made by sections sixteen, seventeen, eighteen, and nineteen of this act shall not affect the expiration of such provisions and shall be deemed to expire therewith; provided that the amendments to section 2807-j of the public health law made by section fifty of this act shall not affect the expiration of such section and shall be deemed to expire therewith; and provided that the amendments to subdivision 1 of section 368-e of the social services law made by section fifty-five of this act shall be subject to the expiration and reversion of such subdivision pursuant to chapter 631 of the laws of 1997, as amended, when upon such date the provisions of section fifty-six of this act shall take effect.

PART C

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

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

S 1-b. Subparagraph (ii) of paragraph (a) of subdivision 33 of section 2807-c of the public health law, as added by section 12 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(ii) for the period April first, two thousand nine through March thirty-first, two thousand ten, such rates shall be revised pursuant to a

chapter of the laws of two thousand nine and as reflecting the findings and recommendations of the commissioner as issued pursuant to the provisions of paragraph (b) of this subdivision, provided, however, that such revisions shall reflect an aggregate reduction in such rates of no less than one hundred fifty-four million five hundred thousand dollars, PROVIDED FURTHER, HOWEVER, THAT, NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, AS DETERMINED BY THE COMMISSIONER, TO THE EXTENT THAT A CHAPTER OF THE LAWS OF TWO THOUSAND NINE IS NOT ENACTED RESULTING IN SUCH AN AGGREGATE ANNUAL REDUCTION OF NO LESS THAN ONE HUNDRED FIFTY-FOUR MILLION FIVE HUNDRED THOUSAND DOLLARS IN SUCH RATES, THE COMMISSIONER SHALL IMPLEMENT A UNIFORM REDUCTION OF SUCH RATES IN ACCORDANCE WITH THE METHODOLOGY DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH TO THE EXTENT NECESSARY, AS DETERMINED BY THE COMMISSIONER, TO ACHIEVE SUCH AN AGGREGATE REDUCTION IN SUCH RATES FOR THE STATE FISCAL YEAR BEGINNING APRIL FIRST, TWO THOUSAND NINE AND EACH STATE FISCAL YEAR THEREAFTER; and

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

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

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

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

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

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

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

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

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

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

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

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

(IX) RATES FOR NON-PUBLIC, NOT FOR PROFIT GENERAL HOSPITALS WHICH HAVE NOT, AS OF THE EFFECTIVE DATE OF THIS SUBDIVISION, PUBLISHED AN ANCILLARY CHARGES SCHEDULE AS PROVIDED IN PARAGRAPH (J) OF SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED THREE OF THIS ARTICLE SHALL HAVE THEIR INLIER PAYMENTS INCREASED BY AN AMOUNT EQUAL TO THE AVERAGE OF COST OUTLIER PAYMENTS FOR COMPARABLE HOSPITALS OR BY A METHODOLOGY THAT USES A STATEWIDE OR REGIONAL RATIO OF COST TO CHARGES APPLIED TO STATEWIDE OR REGIONAL COMPARABLE CHARGES FOR THOSE CASES DETERMINED BY THE COMMISSIONER;

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

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

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

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

(E) THE PROVISIONS OF THIS SUBDIVISION SHALL NOT APPLY TO THOSE GENERAL HOSPITALS OR DISTINCT UNITS OF GENERAL HOSPITALS WHOSE INPATIENT REIMBURSEMENT DOES NOT, AS OF NOVEMBER THIRTIETH, TWO THOUSAND NINE, REFLECT CASE BASED PAYMENT PER DIAGNOSIS-RELATED GROUP OR WHOSE INPATIENT REIMBURSEMENT IS, FOR PERIODS ON AND AFTER JULY FIRST, TWO THOUSAND NINE, GOVERNED BY THE PROVISIONS OF PARAGRAPHS (E-1) OR (E-2) OF SUBDIVISION FOUR OF THIS SECTION.

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

(G) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER MAY, FOR RATE PERIODS ON AND AFTER DECEMBER FIRST, TWO THOUSAND NINE AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, MAKE ADDITIONAL

ADJUSTMENTS TO THE INPATIENT RATES OF PAYMENT OF ELIGIBLE GENERAL HOSPITALS, TO FACILITATE IMPROVEMENTS IN HOSPITAL OPERATIONS AND FINANCES, IN ACCORDANCE WITH THE FOLLOWING:

(I) GENERAL HOSPITALS ELIGIBLE FOR DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH SHALL BE THOSE NON PUBLIC HOSPITALS WITH MEDICAID DISCHARGES EQUAL TO OR GREATER THAN SEVENTEEN AND ONE-HALF PERCENT FOR TWO THOUSAND SEVEN.

(II) FUNDS DISTRIBUTED PURSUANT TO THIS PARAGRAPH SHALL BE ALLOCATED TO ELIGIBLE HOSPITALS PURSUANT TO A FORMULA SUCH THAT, TO THE EXTENT OF FUNDS AVAILABLE, NO HOSPITAL'S REDUCTION IN MEDICAID INPATIENT REVENUE AS A RESULT OF THE APPLICATION OF THE PROVISIONS OF PARAGRAPHS (A) AND (B) OF THIS SUBDIVISION EXCEEDS A PERCENTAGE REDUCTION AS DETERMINED BY THE COMMISSIONER.

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

(A) FOR THE PERIOD DECEMBER FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN, UP TO SEVENTY-FIVE MILLION DOLLARS;

(B) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, UP TO THIRTY-THREE MILLION FIVE HUNDRED THOUSAND DOLLARS;

(C) FOR THE PERIOD APRIL FIRST, TWO THOUSAND ELEVEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWELVE, UP TO FIFTY MILLION DOLLARS;

(D) FOR THE PERIOD APRIL FIRST, TWO THOUSAND TWELVE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, UP TO TWENTY-FIVE MILLION DOLLARS.

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

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

(H) INPATIENT RATE ADJUSTMENTS MADE PURSUANT TO PARAGRAPHS (A) THROUGH (F) OF THIS SUBDIVISION AFTER APPLICATION OF ADJUSTMENTS AUTHORIZED PURSUANT TO SUBDIVISION THIRTY-THREE OF THIS SECTION SHALL RESULT IN A NET STATEWIDE DECREASE IN AGGREGATE MEDICAID PAYMENTS OF NO LESS THAN SEVENTY-FIVE MILLION DOLLARS FOR THE PERIOD DECEMBER FIRST, TWO THOUSAND NINE THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TEN, AND NO LESS THAN TWO HUNDRED TWENTY-FIVE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND TEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN AND EACH STATE FISCAL YEAR THEREAFTER, PROVIDED, HOWEVER, THAT SUCH REDUCTIONS SHALL BE IN ADDITION TO THE REDUCTIONS REQUIRED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION THIRTY-THREE OF THIS SECTION.

S 3. Notwithstanding any contrary provision of law, if the commissioner of health determines that federal financial participation will not be available with regard to the provisions of subparagraph (ii) of para-

graph (g) of subdivision 35 of section 2807-c of the public health law, such commissioner may deem such provision null and void and instead may allocate funds pursuant to such paragraph (g) proportionally, based on each eligible facility's relative share of Medicaid inpatient discharges in the year two years prior to the distribution year.

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

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

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

(A) eighteen million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; thirty-seven million four hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; fifty-two million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; twenty-six million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven[;], forty-nine million dollars for the period July first, two thousand seven through March thirty-first, two thousand eight[;], AND forty-nine million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine[; forty-nine million dollars for the period April first, two thousand nine through March thirty-first, two thousand ten; and forty-nine million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven].

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

(x) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special

revenue funds - other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of the non-public general hospital rates increases for recruitment and retention of health care workers from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

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

(viii) [fifty-three] FORTY-EIGHT million [one] SEVEN hundred [fifty] TWENTY-ONE thousand dollars for the period January first, two thousand nine through [December thirty-first] NOVEMBER THIRTIETH, two thousand nine[;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) [sixteen million] FOURTEEN MILLION SEVEN HUNDRED THOUSAND dollars for the period January first, two thousand nine through [December thirty-first] NOVEMBER THIRTIETH, two thousand nine[;

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

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

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

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

(ii) two million [five hundred thousand] TWO HUNDRED NINETY-TWO THOUSAND dollars for the period January first, two thousand nine through [December thirty-first] NOVEMBER THIRTIETH, two thousand nine[;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(n) Funds shall be accumulated and transferred from the health care reform act (HCRA) resources fund as follows: for the period April first, two thousand seven through March thirty-first, two thousand eight, and on an annual basis for the periods April first, two thousand eight through [March thirty-first] NOVEMBER THIRTIETH, two thousand [eleven] NINE, funds within amounts appropriated shall be transferred and deposited and credited to the credit of the state special revenue funds - other, HCRA transfer fund, medical assistance account, for purposes of

funding the state share of rate adjustments made to public and voluntary hospitals in accordance with paragraphs (i) and (j) of subdivision one of section twenty-eight hundred seven-c of this article.

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

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

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

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

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

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

(v) three million [five hundred] TWO HUNDRED EIGHT thousand dollars for the period January first, two thousand nine through [December thirty-first] NOVEMBER THIRTIETH, two thousand nine[;

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

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

(viii) provided, however, in the event federal financial participation is not available with regard to rate adjustments pursuant to subdivision thirty-two of section twenty-eight hundred seven-c of this article, allocations pursuant to this paragraph shall, on an annualized basis be increased to seven million dollars for the period January first, two thousand five through March thirty-first, two thousand eleven].

S 11. Paragraph (1) of subdivision 4 of section 2807-c of the public health law, as added by section 15 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

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

hundred fifty, or seven hundred fifty-one, shall be made on a per diem basis in accordance with the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(I) FOR PHYSICAL MEDICAL REHABILITATION SERVICES AND FOR CHEMICAL DEPENDENCY REHABILITATION SERVICES, THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND FIVE OPERATING COSTS FOR EACH RESPECTIVE CATEGORY OF SERVICES AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO JULY FIRST, TWO THOUSAND NINE AND AS ADJUSTED FOR INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTE, PROVIDED, HOWEVER, THAT SUCH TWO THOUSAND FIVE REPORTED OPERATING COSTS, BUT NOT INCLUDING REPORTED DIRECT MEDICAL EDUCATION COST, SHALL, FOR RATE-SETTING PURPOSES, BE HELD TO A CEILING OF ONE HUNDRED TEN PERCENT OF THE AVERAGE OF SUCH REPORTED COSTS IN THE REGION IN WHICH THE FACILITY IS LOCATED,

AS DETERMINED PURSUANT TO CLAUSE (E) OF SUBPARAGRAPH (III) OF PARAGRAPH (1) OF THIS SUBDIVISION.

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

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

(IV) FOR FACILITIES DESIGNATED BY THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES AS EXEMPT ACUTE CARE CHILDREN'S HOSPITALS AS OF DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, FOR WHICH A DISCRETE INSTITUTIONAL COST REPORT WAS FILED FOR THE TWO THOUSAND SEVEN CALENDAR YEAR, AND WHICH HAS REPORTED MEDICAID DISCHARGES GREATER THAN FIFTY PERCENT OF TOTAL DISCHARGES IN SUCH COST REPORT, SHALL BE DETERMINED IN ACCORDANCE WITH THE FOLLOWING:

(A) THE OPERATING COST COMPONENT OF SUCH RATES SHALL REFLECT THE USE OF TWO THOUSAND SEVEN OPERATING COSTS AS REPORTED BY EACH FACILITY TO THE DEPARTMENT PRIOR TO JULY FIRST, TWO THOUSAND NINE AND AS ADJUSTED FOR THE INFLATION PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TEN OF THIS SECTION, AS OTHERWISE MODIFIED BY ANY APPLICABLE STATUTES, AND AS FURTHER ADJUSTED AS THE COMMISSIONER DEEMS APPROPRIATE, INCLUDING TRANSITION ADJUSTMENTS. SUCH RATES SHALL BE DETERMINED ON A PER CASE BASIS OR PER DIEM BASIS, AS SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER.

(B) THE OPERATING COMPONENT OF OUTPATIENT SPECIALTY RATES OF HOSPITALS SUBJECT TO THIS SUBPARAGRAPH SHALL REFLECT THE USE OF TWO THOUSAND SEVEN OPERATING COSTS AS REPORTED TO THE DEPARTMENT PRIOR TO DECEMBER FIRST, TWO THOUSAND EIGHT, AND SHALL INCLUDE SUCH ADJUSTMENTS AS THE COMMISSIONER DEEMS APPROPRIATE.

(C) THE BASE PERIOD REPORTED OPERATING COSTS USED TO ESTABLISH INPATIENT AND OUTPATIENT RATES DETERMINED PURSUANT TO THIS SUBPARAGRAPH SHALL BE UPDATED NO LESS FREQUENTLY THAN EVERY TWO YEARS AND EACH SUCH HOSPITAL SHALL SUBMIT SUCH ADDITIONAL DATA AS THE COMMISSIONER MAY REQUIRE TO ASSIST IN THE DEVELOPMENT OF AMBULATORY PATIENT GROUPS (APGS) RATES FOR SUCH HOSPITALS' OUTPATIENT SPECIALTY SERVICES.

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

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

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

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

(IX) THE OPERATING COST COMPONENT OF INPATIENT MEDICAID RATES SUBJECT TO SUBPARAGRAPHS (I), (II) AND (III) OF THIS PARAGRAPH SHALL, WITH REGARD TO ALTERNATIVE LEVEL OF CARE (ALC) DAYS OF CARE BE SUBJECT TO COMPUTATION PURSUANT TO PARAGRAPH (H) OF THIS SUBDIVISION.

S 13-a. Paragraph (s-8) of subdivision 11 of section 2807-c of the public health law, as amended by section 57 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(s-8) To the extent funds are available and otherwise notwithstanding any inconsistent provision of law to the contrary, for rate periods on and after April first, two thousand seven through [March thirty-first] NOVEMBER THIRTIETH, two thousand nine, the commissioner shall increase rates of payment for patients eligible for payments made by state governmental agencies by an amount not to exceed sixty million dollars annually in the aggregate. Such amount shall be allocated among those voluntary non-profit general hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have medicaid inpatient discharges percentages equal to or greater than thirty-five percent. This percentage shall be computed based upon data reported to the department in each hospital's two thousand four institutional cost report, as submitted to the department on or before January first, two thousand seven. The rate adjustments calculated in accordance with this paragraph shall be allocated proportionally based on each eligible hospital's total reported medicaid inpatient discharges in two thousand four, to the total reported medicaid inpatient discharges for all such eligible hospitals in two thousand four, provided, however, that such rate adjustments shall be subject to reconciliation to ensure that each hospital receives in the aggregate its proportionate share of the full allocation to the extent allowable under federal law. Such payments may be added to rates of payment or made as aggregate payments to eligible hospitals, provided, however, that subject to the availability of federal financial participation and solely for the period April first, two thousand seven through March thirty-first, two thousand eight, six million dollars in the aggregate of this sixty million dollars shall be allocated to voluntary non-profit hospitals which continue to provide inpatient services as of April first, two thousand seven through March thirty-first, two thousand eight and which have Medicaid inpatient discharge percentages of less than thirty-five percent and which had previously qualified for distributions pursuant to paragraph (s-7) of this subdivision. The rate adjustment calculated in accordance with this paragraph shall be allocated proportionally based on the amount of money the hospital had received in two thousand six.

S 13-b. The commissioner is hereby authorized to seek through a federal waiver, or through the extension of a federal waiver, enhanced federal financial participation in excess of that authorized by the American Recovery and Reinvestment Act, in order to support state reform activ-

ities, including reimbursement reform, enacted by the legislature to promote patient centered care and improve access to and quality of primary and ambulatory care.

S 13-c. Subdivision 4-c of section 2807-p of the public health law, as amended by section 28-a of part B of chapter 58 of the laws of 2008, is amended to read as follows:

4-c. Notwithstanding any provision of law to the contrary, the commissioner shall make additional payments for uncompensated care to voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, in the amount of seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven, seven million five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight, seven million five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine, [seven] FIFTEEN million five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten, seven million five hundred thousand dollars, and for the period January first, two thousand eleven through March thirty-first, two thousand eleven, in the amount of one million eight hundred seventy-five thousand dollars, provided, however, that for periods on and after January first, two thousand eight, such additional payments shall be distributed to voluntary, non-profit diagnostic and treatment centers and to public diagnostic and treatment centers in accordance with paragraph (g) of subdivision four of this section. In the event that federal financial participation is available for rate adjustments pursuant to this section, the commissioner shall make such payments as additional adjustments to rates of payment for voluntary non-profit diagnostic and treatment centers that are eligible for distributions under subdivision four-a of this section in the following amounts: for the period June first, two thousand six through December thirty-first, two thousand six, fifteen million dollars in the aggregate, and for the period January first, two thousand seven through June thirtieth, two thousand seven, seven million five hundred thousand dollars in the aggregate. The amounts allocated pursuant to this paragraph shall be aggregated with and distributed pursuant to the same methodology applicable to the amounts allocated to such diagnostic and treatment centers for such periods pursuant to subdivision four of this section if federal financial participation is not available, or pursuant to subdivision four-a of this section if federal financial participation is available. Notwithstanding section three hundred sixty-eight-a of the social services law, there shall be no local share in a medical assistance payment adjustment under this subdivision.

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

(a)(i) for the period December first, two thousand eight through [December thirty-first] NOVEMBER THIRTIETH, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental

hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period [January] 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;

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

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

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

(b)(i) for the period March first, two thousand nine through December [thirty-first] FIRST, 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 first, two thousand ten 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;

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

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

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

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

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

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

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

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate

increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, SUCH AMOUNTS MAY BE ADJUSTED TO REFLECT PROJECTED DECREASES IN FEE-FOR-SERVICE MEDICAID UTILIZATION AND CHANGES IN CASE-MIX WITH REGARD TO SUCH SERVICES FROM THE TWO THOUSAND SEVEN CALENDAR YEAR TO THE APPLICABLE RATE YEAR, AND PROVIDED FURTHER, HOWEVER, THAT FUNDS MADE AVAILABLE AS A RESULT OF ANY SUCH DECREASES MAY BE UTILIZED BY THE COMMISSIONER TO INCREASE CAPITATION RATES PAID TO MEDICAID MANAGED CARE PLANS AND FAMILY HEALTH PLUS PLANS TO COVER INCREASED PAYMENTS TO HEALTH CARE PROVIDERS FOR AMBULATORY CARE SERVICES AND TO INCREASE SUCH OTHER AMBULATORY CARE PAYMENT RATES AS THE COMMISSIONER DETERMINES NECESSARY TO FACILITATE ACCESS TO QUALITY AMBULATORY CARE SERVICES.

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

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY UTILIZE EXISTING PAYMENT METHODOLOGIES OR MAY PROMULGATE REGULATIONS ESTABLISHING ALTERNATIVE PAYMENT METHODOLOGIES FOR ONE OR MORE OF THE SERVICES SPECIFIED IN CLAUSES (C) AND (D) OF THIS SUBPARAGRAPH, EFFECTIVE FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND NINE:

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

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

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

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

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

S 17. Notwithstanding any contrary provision of law, except section 43.02 of the mental hygiene law, subject to availability of federal financial participation, and within amounts appropriated therefore,

commencing on or after October 1, 2009 the commissioners of mental health and health are jointly authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology, for clinic services rendered by providers pursuant to their licensure under article 31 of the mental hygiene law.

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

S 19. Intentionally omitted.

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

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

S 22. Notwithstanding any contrary provision of law, subject to federal financial participation under Title XIX of the Social Security Act, and within amounts appropriated therefore, commencing on or after October 1, 2009 the commissioners of health, and alcoholism and substance abuse services are authorized to implement and enhance funding of the

Ambulatory Patient Group (APG) reimbursement methodology for clinic services rendered pursuant to providers' operating certificates under article 32 of the mental hygiene law.

S 23. The commissioners of alcoholism and substance abuse services, and health, subject to the approval of the state director of the budget, are jointly authorized to implement and enhance funding of the Ambulatory Patient Group (APG) reimbursement methodology for determining rates of payment for outpatient clinic services rendered pursuant to providers' operating certificates under article 32 of the mental hygiene law. The commissioner of alcoholism and substance abuse services, subject to the approval of the commissioner of health and the director of the budget, shall promulgate regulations pursuant to article 32 of the mental hygiene law which shall reflect utilization of the Ambulatory Patient Group (APG) methodology, as described in subdivision 2-a of section 2807 of the public health law, in which patients are grouped based on their diagnosis, the intensity of the services provided and the procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and discounting mechanisms.

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

S 24. Section 2 of the social services law is amended by adding a new subdivision 38 to read as follows:

38. WHEN USED IN THIS CHAPTER, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS, UNLESS OTHERWISE EXPRESSLY STATED OR UNLESS THE CONTEXT OR SUBJECT MATTER REQUIRES A DIFFERENT INTERPRETATION:

(A) "MEDICAID" OR "MEDICAL ASSISTANCE" MEANS TITLE ELEVEN OF ARTICLE FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER.

(B) "FAMILY HEALTH PLUS" MEANS TITLE ELEVEN-D OF ARTICLE FIVE OF THIS CHAPTER AND THE PROGRAM THEREUNDER.

(C) "CHILD HEALTH PLUS" MEANS TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW AND THE PROGRAM THEREUNDER.

(D) "MEDICAID MANAGED CARE" MEANS MEDICAID PROVIDED UNDER SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS CHAPTER.

(E) "MEDICAID FEE-FOR-SERVICE" MEANS MEDICAID PROVIDED OTHER THAN UNDER MEDICAID MANAGED CARE.

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

S 364-M. STATEWIDE PATIENT CENTERED MEDICAL HOME PROGRAM. 1. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO CERTIFY CERTAIN CLINICIANS AND CLINICS AS HEALTH CARE HOMES IN ORDER TO IMPROVE HEALTH OUTCOMES AND EFFICIENCY THROUGH PATIENT CARE CONTINUITY AND COORDINATION OF HEALTH SERVICES. THESE PROVIDERS WILL BE ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAID FEE-FOR-SERVICE; ENROLLEES ELIGIBLE FOR MEDICAID MANAGED CARE; ENROLLEES ELIGIBLE FOR AND ENROLLED IN FAMILY HEALTH PLUS ORGANIZATIONS PURSUANT TO TITLE ELEVEN-D OF THIS ARTICLE ("FAMILY HEALTH PLUS"); AND ENROLLEES ELIGIBLE FOR AND ENROLLED IN CHILD HEALTH PLUS. AS USED IN THIS SECTION "CLINIC" MEANS A GENERAL HOSPITAL PROVIDING OUTPATIENT CARE OR A DIAGNOSTIC AND TREATMENT CENTER, LICENSED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW.

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

3. TO MAINTAIN THEIR CERTIFICATION, PATIENT CENTERED MEDICAL HOMES MUST: (A) RENEW THEIR CERTIFICATION AT A FREQUENCY DETERMINED BY THE COMMISSIONER OF HEALTH; AND (B) PROVIDE DATA TO THE DEPARTMENT OF HEALTH AND TO HEALTH PLANS IN WHICH THE PATIENT IS ENROLLED TO PERMIT THE COMMISSIONER OF HEALTH TO EVALUATE THE IMPACT OF PATIENT CENTERED MEDICAL HOMES ON QUALITY, OUTCOMES AND COST.

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

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

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

5. BY DECEMBER THIRTY-FIRST, TWO THOUSAND TWELVE, THE COMMISSIONER OF HEALTH SHALL REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE IMPACT OF THE STATEWIDE PATIENT CENTERED MEDICAL HOME PROGRAM ON QUALITY, COST AND OUTCOMES FOR ENROLLEES IN MEDICAID FEE-FOR-SERVICE, MEDICAID MANAGED CARE, FAMILY HEALTH PLUS AND CHILD HEALTH PLUS.

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

RURAL HEALTH CARE ACCESS

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

TITLE 2

ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM

SECTION 2959. ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM.

S 2959. ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM. 1. THE COMMISSIONER IS AUTHORIZED TO ESTABLISH AN ADIRONDACK MEDICAL HOME MULTIPAYOR DEMONSTRATION PROGRAM AND MAY CERTIFY CERTAIN CLINICIANS AND CLINICS IN THE UPPER NORTHEASTERN REGION OF NEW YORK AS MEDICAL HOMES ELIGIBLE FOR ENHANCED PAYMENTS FOR SERVICES PROVIDED TO: RECIPIENTS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW ("MEDICAID FEE-FOR-SERVICE"); ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUCH TITLE AND ENROLLED IN APPROVED MANAGED CARE ORGANIZATIONS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF SUCH TITLE ("MEDICAID MANAGED CARE"); ENROLLEES ELIGIBLE FOR FAMILY HEALTH PLUS AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW ("FAMILY HEALTH PLUS"); ENROLLEES ELIGIBLE FOR THE CHILD HEALTH INSURANCE PROGRAM AND ENROLLED IN APPROVED ORGANIZATIONS PURSUANT TO TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THIS CHAPTER ("CHILD HEALTH PLUS PROGRAM"); ENROLLEES AND SUBSCRIBERS OF COMMERCIAL MANAGED CARE PLANS OPERATING IN ACCORDANCE

WITH THE PROVISIONS OF ARTICLE FORTY-FOUR OF THIS CHAPTER OR BY HEALTH MAINTENANCE ORGANIZATIONS ORGANIZED AND OPERATING IN ACCORDANCE WITH ARTICLE FORTY-THREE OF THE INSURANCE LAW; ENROLLEES AND SUBSCRIBERS OF OTHER COMMERCIAL INSURANCE PRODUCTS; AND EMPLOYEES OF EMPLOYER-SPONSORED SELF-INSURED PLANS. THE PURPOSE OF THIS DEMONSTRATION PROGRAM IS TO IMPROVE HEALTH CARE OUTCOMES AND EFFICIENCY THROUGH PATIENT CARE CONTINUITY AND COORDINATION OF HEALTH SERVICES.

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

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

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

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

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

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

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

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

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

(S) SMOKING CESSATION COUNSELING SERVICES FOR 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 YEARS OF AGE, DURING A MEDICAL VISIT WHEN PROVIDED BY A GENERAL HOSPITAL OUTPATIENT DEPARTMENT OR A FREE-STANDING CLINIC, OR BY A PHYSICIAN, REGISTERED PHYSICIAN'S ASSISTANT, REGISTERED NURSE PRACTITIONER OR LICENSED MIDWIFE IN OFFICE-BASED SETTINGS; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO SMOKING CESSATION COUNSELING SERVICES SHALL NOT TAKE EFFECT UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH SERVICES.

(T) CARDIAC REHABILITATION SERVICES WHEN ORDERED BY THE ATTENDING PHYSICIAN AND PROVIDED IN A HOSPITAL-BASED OR FREE-STANDING CLINIC IN AN AREA SET ASIDE FOR CARDIAC REHABILITATION, OR IN A PHYSICIAN'S OFFICE; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO CARDIAC REHABILITATION SERVICES SHALL NOT TAKE EFFECT UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH SERVICES.

(U) SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT IN HOSPITAL EMERGENCY DEPARTMENTS OF INDIVIDUALS AT RISK FOR SUBSTANCE ABUSE INCLUDING REFERRAL TO THE APPROPRIATE LEVEL OF INTERVENTION AND TREATMENT IN A COMMUNITY SETTING; PROVIDED, HOWEVER, THAT THE PROVISIONS OF THIS PARAGRAPH RELATING TO SCREENING, BRIEF INTERVENTION, 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 28. Intentionally omitted.

S 28-a. Notwithstanding any contrary provision of section 14 of part B of chapter 1 of the laws of 2002 or any other contrary provision of law, distributions made pursuant to section 14 of part B of chapter 1 of the laws of 2002, shall be based on each eligible hospital's proportionate share of the sum of all Medicaid outpatient visits for all eligible hospitals in the base year two years prior to the rate year.

S 29. Intentionally omitted.

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

S 364-f. [Physician] PRIMARY CARE case management programs. 1. The department is authorized to establish [physician] PRIMARY CARE case management [demonstration] programs, under the medical assistance program, in accordance with applicable federal law and regulations. PRIMARY CARE CASE MANAGEMENT PROGRAMS SHALL ONLY BE AUTHORIZED IN AREAS OF THE STATE WHERE COMPREHENSIVE HEALTH SERVICES PLANS, AS DEFINED IN SECTION FORTY-FOUR HUNDRED ONE OF THE PUBLIC HEALTH LAW, ARE NOT YET

AVAILABLE. Subject to the approval of the director of the budget, the commissioner is authorized to apply for the appropriate waivers under federal law and regulation, and may waive any of the provisions of sections three hundred sixty-five-a, three hundred sixty-six, three hundred sixty-seven-b [and], three hundred sixty-eight-a AND THREE HUNDRED SIXTY-FOUR-J of this chapter or any regulation of the department when such action would be necessary to assist in promoting the objectives of this section.

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

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

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

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

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

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

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

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

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

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

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

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

3. (a) [Physician] PRIMARY CARE case management programs may be conducted only in accordance with [plans submitted by social services districts and approved] GUIDELINES ESTABLISHED by the commissioner[, after consultation with the commissioner of health, and only to the

extent and period for which such plans have been approved by the commissioner. The commissioner shall not authorize the implementation of such plans in more than ten social services districts. For the purpose of implementing and administering the physician case management programs, social services districts may]. FOR THE PURPOSE OF IMPLEMENTING AND ADMINISTERING THE PRIMARY CARE CASE MANAGEMENT PROGRAMS, THE COMMISSIONER MAY contract with private not-for-profit and public agencies AS DEFINED IN GUIDELINES ESTABLISHED BY THE COMMISSIONER for the management AND ADMINISTRATION of [these plans provided, however, that such contracts shall require prior approval by the commissioner] THE PRIMARY CARE CASE MANAGEMENT PROGRAM.

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

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

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

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

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

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

[(vii)] (IV) provide for adequate safeguards to protect recipients from being misled concerning the program and from being coerced into participating in the [physician] PRIMARY CARE case management program[;].

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

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

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

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

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

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

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

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

S 31. The public health law is amended by adding a new section 2821 to read as follows:

S 2821. STATE ELECTRONIC HEALTH RECORDS (EHR) LOAN PROGRAM. 1. DEFINITIONS. AS USED IN THIS SECTION, THE FOLLOWING WORDS AND PHRASES SHALL HAVE THE FOLLOWING MEANINGS UNLESS A DIFFERENT MEANING IS PLAINLY REQUIRED BY THE CONTEXT:

(A) "AUTHORITY" SHALL MEAN THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK CREATED BY TITLE FOUR OF ARTICLE EIGHT OF THE PUBLIC AUTHORITIES LAW WHICH HAS SUCCEEDED TO THE POWERS, FUNCTIONS AND DUTIES OF THE MEDICAL CARE FACILITIES FINANCE AGENCY PURSUANT TO CHAPTER EIGHTY-THREE OF THE LAWS OF NINETEEN HUNDRED NINETY-FIVE.

(B) "ELIGIBLE HEALTH CARE PROVIDER" SHALL MEAN ANY HEALTH CARE PROVIDER ORGANIZED UNDER THE LAWS OF THIS STATE ELIGIBLE TO RECEIVE FEDERAL FUNDS, WHICH HAS BEEN APPROVED FOR PARTICIPATION IN THIS PROGRAM BY THE COMMISSIONER.

(C) "EHR LOAN FUND" SHALL MEAN THE CERTIFIED ELECTRONIC HEALTH RECORDS TECHNOLOGY LOAN FUND AUTHORIZED TO BE ESTABLISHED BY THE AUTHORITY PURSUANT TO THIS SECTION.

2. THE AUTHORITY SHALL ESTABLISH THE EHR LOAN FUND. FUNDS SHALL BE TRANSFERRED OR APPROPRIATED TO THE AUTHORITY FOR DEPOSIT IN THE EHR LOAN FUND AS AUTHORIZED PURSUANT TO ANY PROVISION OF LAW. FUNDS IN THE EHR LOAN FUND SHALL BE HELD BY THE AUTHORITY PURSUANT TO THIS SECTION AS CUSTODIAN, ADMINISTERED BY THE AUTHORITY PURSUANT TO AN AGREEMENT WITH THE COMMISSIONER AND INVESTED BY THE AUTHORITY IN ACCORDANCE WITH THE INVESTMENT GUIDELINES OF THE AUTHORITY. ALL INVESTMENT INCOME SHALL BE CREDITED TO, AND ANY REPAYMENTS OF LOANS AS HEREINAFTER PROVIDED SHALL BE DEPOSITED IN, THE EHR LOAN FUND, AND SPENT THEREFROM ONLY FOR THE PURPOSES SET FORTH IN THIS SECTION.

3. THE COMMISSIONER AND THE AUTHORITY SHALL ENTER INTO AN AGREEMENT, SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, FOR THE PURPOSE OF ADMINISTERING THE MONEYS IN THE EHR LOAN FUND IN A MANNER THAT WILL BENEFIT THE PUBLIC HEALTH BY ENCOURAGING IMPROVEMENTS IN THE HEALTH CARE DELIVERY SYSTEM THROUGH THE USE OF INFORMATION TECHNOLOGY IN THE STATE. SUCH AGREEMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING PROVISIONS:

(A) FOR THE RECEIPT, MANAGEMENT AND EXPENDITURE OF FUNDS HELD IN THE EHR LOAN FUND BY THE AUTHORITY;

(B) FOR THE DEVELOPMENT OF PROGRAM COMPONENTS, INCLUDING BUT NOT LIMITED TO PROVIDER ELIGIBILITY AND TERMS AND CONDITIONS OF LOANS, AND FOR THE DEVELOPMENT AND IMPLEMENTATION OF STRATEGIC PLANS FOR ELIGIBLE HEALTH CARE PROVIDERS, ADDRESSING THE DEVELOPMENT OF MEANINGFUL ELECTRONIC HEALTH RECORD IMPROVEMENTS, INCLUDING STRATEGIES FOR FACILITATING THE PURCHASE OF CERTIFIED ELECTRONIC HEALTH RECORDS TECHNOLOGY, ENHANCING THE UTILIZATION OF CERTIFIED ELECTRONIC HEALTH RECORDS TECHNOLOGY, TRAINING PERSONNEL IN THE USE OF SUCH TECHNOLOGY AND SUPPORTING THE SECURE EXCHANGE OF ELECTRONIC HEALTH INFORMATION TO AND FROM ELECTRONIC HEALTH RECORDS; AND

(C) OTHER REQUIREMENTS SET FORTH BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES WITH RESPECT TO THE STATE EHR LOAN FUND FOR THE EXPENDITURE BY THE AUTHORITY FROM THE EHR LOAN FUND TO REIMBURSE THE AUTHORITY AND THE DEPARTMENT FOR THE COST OF ADMINISTERING THE LOAN FUND.

4. ANY ELIGIBLE HEALTH CARE PROVIDER MAY APPLY FOR EHR LOAN FUNDS TO THE EXTENT SUCH FUNDS ARE DERIVED FROM DEPOSITS MADE PURSUANT TO LAW BY THE STATE. THE COMMISSIONER AND THE AUTHORITY SHALL CONSIDER THE EXTENT TO WHICH AN ELIGIBLE HEALTH CARE PROVIDER CAN PROVIDE MATCHING FUNDS THAT MAY BE REQUIRED BY LAW.

5. TO THE EXTENT FUNDS ARE AVAILABLE FROM AN ELIGIBLE HEALTH CARE PROVIDER, EXPENDITURES FROM THE EHR LOAN FUND SHALL BE REPAID TO THE EHR LOAN FUND FROM REPAYMENTS RECEIVED BY THE AUTHORITY, FROM AN ELIGIBLE HEALTH CARE PROVIDER PURSUANT TO THE TERMS OF ANY FINANCING AGREEMENT, MORTGAGE OR LOAN DOCUMENT PERMITTING THE RECOVERY FROM THE ELIGIBLE HEALTH CARE PROVIDER OF SUCH EXPENDITURES. THE AUTHORITY SHALL RECORD THE ACCOUNT FOR ALL SUCH PAYMENTS, WHICH SHALL BE DEPOSITED IN THE EHR LOAN FUND ACCOUNT.

6. LOANS FROM THE EHR LOAN FUND SHALL BE MADE PURSUANT TO AN AGREEMENT WITH THE ELIGIBLE HEALTH CARE PROVIDER SPECIFYING THE TERMS THEREOF, INCLUDING REPAYMENT TERMS. THE AUTHORITY SHALL RECORD AND ACCOUNT FOR ALL SUCH REPAYMENTS, WHICH SHALL BE DEPOSITED IN THE EHR LOAN FUND. THE AUTHORITY SHALL REPORT ANNUALLY TO THE DIRECTOR OF THE DIVISION OF BUDGET, THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, ON THE TRANSACTIONS IN THE EHR LOAN FUND, INCLUDING BUT NOT LIMITED TO DEPOSITS TO THE FUND, LOANS MADE FROM THE FUND, INVESTMENT INCOME, AND THE BALANCE ON HAND AS OF THE END OF EACH YEAR.

7. THE COMMISSIONER IS AUTHORIZED, WITH THE ASSISTANCE AND COOPERATION OF THE AUTHORITY, TO PROVIDE A PROGRAM OF TECHNICAL ASSISTANCE FOR ELIGIBLE HEALTH CARE PROVIDERS.

8. THE COMMISSIONER MAY PROMULGATE REGULATIONS, INCLUDING EMERGENCY REGULATIONS, TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

S 32. The commissioner is hereby authorized to submit such applications, strategic plans, reports to, and to comply with other requirements specified by, the federal secretary of health and human services in order to obtain federal funding for the certified EHR technology loan program.

S 33. Section 2818 of the public health law is amended by adding two new subdivisions 4 and 5 to read as follows:

4. NOTWITHSTANDING THE PROVISIONS OF SUBDIVISION ONE OF THIS SECTION, THE COMMISSIONER AND THE DIRECTOR OF THE DORMITORY AUTHORITY MAY AWARD, IN AN AMOUNT NOT TO EXCEED TWENTY-FIVE MILLION DOLLARS OF THE HEALTH CARE SYSTEM IMPROVEMENT CAPITAL GRANT PROGRAM ALLOCATED IN ANY GIVEN

FISCAL YEAR, GRANTS TO ELIGIBLE APPLICANTS WITHOUT THE PROCESS SET FORTH IN SUBDIVISION ONE OF THIS SECTION TO PROVIDE NECESSARY RESTRUCTURING SUPPORT TO HOSPITALS FOR TRANSITION TO A NEW REIMBURSEMENT METHODOLOGY.

(A) WITH RESPECT TO THE PROCESS FOR THE AWARDING OF SUCH FUNDS WITHOUT THE PROCESS SET FORTH IN SUBDIVISION ONE OF THIS SECTION, THE COMMISSIONER AND DIRECTOR OF THE DORMITORY AUTHORITY SHALL DETERMINE ELIGIBLE AWARDEES BASED SOLELY ON AN APPLICANT'S ABILITY TO MEET THE FOLLOWING CRITERIA:

(I) HAVE A LOSS OF OPERATIONS FOR EACH OF THE THREE CONSECUTIVE PRECEDING YEARS AS EVIDENCE BY AUDITED FINANCIAL STATEMENTS; AND

(II) HAVE A NEGATIVE FUND BALANCE OR NEGATIVE EQUITY POSITION IN EACH OF THE THREE PRECEDING YEARS AS EVIDENCE BY AUDITED FINANCIAL STATEMENTS; AND

(III) HAVE A CURRENT RATIO OF LESS THAN 1AGING FOR EACH OF THREE CONSECUTIVE PRECEDING DAYS; OR

(IV) BE DEEMED TO THE SATISFACTION OF THE COMMISSIONER TO BE A PROVIDER THAT FULFILLS AN UNMET HEALTH CARE NEED FOR THE COMMUNITY AS DETERMINED BY THE DEPARTMENT THROUGH CONSIDERATION OF THE VOLUME OF MEDICAID AND MEDICALLY INDIGENT PATIENTS SERVED; THE SERVICE VOLUME AND MIX, INCLUDING BUT NOT LIMITED TO MATERNITY, PEDIATRICS, TRAUMA, BEHAVIOR AND NEUROBEHAVIORAL, VENTILATOR, AND EMERGENCY ROOM VOLUME; AND, THE SIGNIFICANCE OF THE INSTITUTION IN ENSURING HEALTH CARE SERVICES ACCESS AS MEASURED BY MARKET SHARE WITHIN THE REGION; OR

(V) BE DEEMED TO THE SATISFACTION OF THE COMMISSIONER TO HAVE INCURRED OPERATING LOSSES RESULTING FROM THE IMPLEMENTATION OF REIMBURSEMENT RATE REFORMS AND OTHER REDUCTIONS ENACTED BY A CHAPTER OF THE LAWS OF TWO THOUSAND NINE, TO PROVIDE FOR THE CONTINUED FINANCIAL VIABILITY OF THE APPLICANT.

(B) PRIOR TO AN AWARD BEING GRANTED TO AN ELIGIBLE APPLICANT WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, THE COMMISSIONER AND THE DIRECTOR OF THE DORMITORY AUTHORITY SHALL NOTIFY THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE AND THE DIRECTOR OF THE BUDGET OF THE INTENT TO GRANT SUCH AN AWARD. SUCH NOTICE SHALL INCLUDE INFORMATION REGARDING HOW THE ELIGIBLE APPLICANT MEETS CRITERIA ESTABLISHED PURSUANT TO THIS SECTION.

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

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

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

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

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

(V) SECURING FINANCING FOR FACILITIES IN A MANNER THAT IMPROVES THE PRIMARY AND AMBULATORY CARE SYSTEM INCLUDING PROGRAMS UNDERTAKEN IN COLLABORATION WITH A LOCAL DEVELOPMENT CORPORATION INCORPORATED PURSUANT TO SECTIONS FOUR HUNDRED ONE AND ONE THOUSAND FOUR HUNDRED ELEVEN OF THE NOT-FOR-PROFIT CORPORATION LAW TO FOSTER THE DEVELOPMENT AND EXPANSION OF HIGH QUALITY, COST EFFECTIVE PRIMARY HEALTH CARE SERVICES AND RELATED AMBULATORY CARE AND ANCILLARY SERVICES BENEFITING MEDICALLY UNDERSERVED COMMUNITIES, PRINCIPALLY IN THE STATE, TO INCREASE ACCESS OF COMMUNITY RESIDENTS TO SUCH SERVICES, TO IMPROVE THE HEALTH STATUS OF SUCH RESIDENTS AND TO LESSEN THE BURDENS OF GOVERNMENT AND ACT IN THE PUBLIC INTEREST; AND

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

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

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

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

S 35. Subdivisions 5 and 7 of section 270 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended and a new subdivision 14 is added to read as follows:

5. "Non preferred drug" means a prescription drug that is [in a therapeutic class that is] included in the preferred drug program and is not one of the drugs on the preferred drug list [in that class] BECAUSE IT IS EITHER: (A) IN A THERAPEUTIC CLASS THAT IS INCLUDED IN THE PREFERRED DRUG PROGRAM AND IS NOT ONE OF THE DRUGS ON THE PREFERRED DRUG LIST IN THAT CLASS OR (B) MANUFACTURED BY A PHARMACEUTICAL MANUFACTURER WITH WHOM THE COMMISSIONER IS NEGOTIATING OR HAS NEGOTIATED A MANUFACTURER AGREEMENT AND IS NOT A PREFERRED DRUG UNDER A MANUFACTURER AGREEMENT.

7. "Preferred drug" means a prescription drug that is EITHER (A) in a therapeutic class that is included in the preferred drug program and is one of the drugs on the preferred drug list in that class OR (B) A PREFERRED DRUG UNDER A MANUFACTURER AGREEMENT.

14. "MANUFACTURER AGREEMENT" MEANS AN AGREEMENT BETWEEN THE COMMISSIONER AND A PHARMACEUTICAL MANUFACTURER UNDER PARAGRAPH (B) OF SUBDIVISION ELEVEN OF SECTION TWO HUNDRED SEVENTY-TWO OF THIS ARTICLE.

S 36. Subdivision 11 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:

11. (A) The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public

health [plan] PLANS FOR DRUGS WITHIN A THERAPEUTIC CLASS; such supplemental rebates shall be taken into consideration by the committee and the commissioner in determining the cost-effectiveness of drugs within a therapeutic class under the state public health plans.

(B) THE COMMISSIONER MAY DESIGNATE A PHARMACEUTICAL MANUFACTURER AS ONE WITH WHOM THE COMMISSIONER IS NEGOTIATING OR HAS NEGOTIATED A MANUFACTURER AGREEMENT, AND ALL OF THE DRUGS IT MANUFACTURES OR MARKETS SHALL BE INCLUDED IN THE PREFERRED DRUG PROGRAM. THE COMMISSIONER MAY NEGOTIATE DIRECTLY WITH A PHARMACEUTICAL MANUFACTURER FOR REBATES RELATING TO ANY OR ALL OF THE DRUGS IT MANUFACTURES OR MARKETS. A MANUFACTURER AGREEMENT SHALL DESIGNATE ANY OR ALL OF THE DRUGS MANUFACTURED OR MARKETED BY THE PHARMACEUTICAL MANUFACTURER AS BEING PREFERRED OR NON PREFERRED DRUGS. WHEN A PHARMACEUTICAL MANUFACTURER HAS BEEN DESIGNATED BY THE COMMISSIONER UNDER THIS PARAGRAPH BUT HAS NOT REACHED A MANUFACTURER AGREEMENT WITH THE PHARMACEUTICAL MANUFACTURER, THEN ALL OF THE DRUGS MANUFACTURED OR MARKETED BY THE PHARMACEUTICAL MANUFACTURER SHALL BE NON PREFERRED DRUGS. HOWEVER, NOTWITHSTANDING THIS PARAGRAPH, ANY DRUG THAT IS SELECTED TO BE ON THE PREFERRED DRUG LIST UNDER PARAGRAPH (B) OF SUBDIVISION TEN OF THIS SECTION ON GROUNDS THAT IT IS SIGNIFICANTLY MORE CLINICALLY EFFECTIVE AND SAFER THAN OTHER DRUGS IN ITS THERAPEUTIC CLASS SHALL BE A PREFERRED DRUG.

[Such supplemental] (C) SUPPLEMENTAL rebates UNDER THIS SUBDIVISION shall be in addition to those required by applicable federal law and subdivision seven of section three hundred sixty-seven-a of the social services law. In order to be considered in connection with the preferred drug program, such supplemental rebates shall apply to the drug products dispensed under the Medicaid program and the EPIC program. The commissioner is prohibited from approving alternative rebate demonstrations, value added programs or guaranteed savings from other program benefits as a substitution for supplemental rebates.

S 37. Subdivision 1 of section 273 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:

1. For the purposes of this article, a prescription drug shall be considered to be not on the preferred drug list if it is [in a therapeutic class that is included on the preferred drug list and is not one of the drugs on the preferred list in that class] A NON PREFERRED DRUG.

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

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

S 39. Subdivision 3 of section 369-cc of the social services law, as added by chapter 632 of the laws of 1992, is amended, and a new subdivision 4 is added to read as follows:

3. The prospective DUR program shall be based on the guidelines established by the DUR board not in conflict with education or social services laws and shall provide that prior to the prescription being filled or delivered, a review will be conducted by the pharmacist at the point of sale to screen for potential drug therapy problems resulting from:

(a) Therapeutic duplication;

(b) Drug-drug interactions;

(c) Incorrect dosage/duration of treatment;

(d) Drug-allergy interactions;

(e) Clinical abuse/misuse.

In conducting the prospective DUR, the pharmacist may not alter the prescribed outpatient drug therapy without the consent of the [physician] PRESCRIBER who prescribed that therapy.

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

(B) THE COMMISSIONER, THROUGH THE PROSPECTIVE DUR PROGRAM, MAY FROM TIME TO TIME LIMIT THE QUANTITY, FREQUENCY, AND DURATION OF DRUG THERAPY, USING GUIDELINES DEVELOPED BY THE DUR BOARD. THE DUR BOARD SHALL DEVELOP CLINICAL PRESCRIBING GUIDELINES RELATING TO QUANTITY, FREQUENCY, AND DURATION OF DRUG THERAPY FOR THE COMMISSIONER'S USE UNDER THIS PARAGRAPH. IN ESTABLISHING THESE GUIDELINES, THE BOARD SHALL CONSIDER CLINICAL EFFECTIVENESS, SAFETY, AND COST EFFECTIVENESS. PRIOR AUTHORIZATION UNDER THIS PARAGRAPH SHALL BE OBTAINED UNDER SECTION TWO HUNDRED SEVENTY-THREE OF THE PUBLIC HEALTH LAW. EXCEPTIONS TO ANY PRIOR AUTHORIZATION IMPOSED AS A RESULT OF THESE GUIDELINES SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, PROVISION FOR EMERGENCY CIRCUMSTANCES WHERE A MEDICAL CONDITION REQUIRES ALLEVIATION OF SEVERE PAIN OR WHICH THREATENS TO CAUSE DISABILITY OR TO TAKE A LIFE IF NOT PROMPTLY TREATED.

S 40. Intentionally omitted.

S 41. Intentionally omitted.

S 42. Intentionally omitted.

S 43. Intentionally omitted.

S 44. Intentionally omitted.

S 45. Intentionally omitted.

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

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

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE COMMISSIONER IS AUTHORIZED TO DENY REIMBURSEMENT FOR A GENERIC EQUIVALENT, INCLUDING A GENERIC EQUIVALENT THAT IS ON THE PREFERRED DRUG LIST OR THE CLINICAL DRUG REVIEW PROGRAM, WHEN THE NET COST OF THE BRAND NAME DRUG, AFTER CONSIDERATION OF ALL REBATES, IS LESS THAN THE COST OF THE GENERIC EQUIVALENT, UNLESS PRIOR AUTHORIZATION IS OBTAINED UNDER SECTION TWO HUNDRED SEVENTY-THREE OF THE PUBLIC HEALTH LAW;

S 46-a. Paragraph (a-2) of subdivision 4 of section 365-a of the social services law, as added by section 12 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(a-2) drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, and which are [non-preferred] NON PREFERRED drugs [in a therapeutic class subject to the preferred drug program] pursuant to section two hundred seventy-two of the public health law, or the clinical drug review program under section two hundred seventy-four of the public health law, unless prior authorization is granted or not required;

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

(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar and for each brand name prescription drug dispensed shall be three dollars; provided, however, that the co-payments charged for each brand name prescription drug on the preferred drug list established pursuant to section two hundred seventy-two of the public health law AND THE CO-PAYMENTS CHARGED FOR EACH BRAND NAME PRESCRIPTION DRUG REIMBURSED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A-1) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE shall be one dollar.

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

(ii) for prescription drugs categorized as brand-name prescription [drug] DRUGS by the prescription drug pricing service used by the department, three dollars and fifty cents per prescription, PROVIDED, HOWEVER, THAT FOR BRAND NAME PRESCRIPTION DRUGS REIMBURSED PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A-1) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE, THE DISPENSING FEE SHALL BE FOUR DOLLARS AND FIFTY CENTS PER PRESCRIPTION.

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

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

S 50. Intentionally omitted.

S 51. Intentionally omitted.

S 52. Intentionally omitted.

S 53. Intentionally omitted.
S 54. Intentionally omitted.
S 55. Intentionally omitted.
S 56. Intentionally omitted.
S 57. Intentionally omitted.
S 58. Clauses (ii) and (iii) of subparagraph 1 and subparagraphs 3 and 4 of paragraph (a) of subdivision 1 of section 366 of the social services law, clauses (ii) and (iii) of subparagraph 1 as amended by section 60 of part C of chapter 58 of the laws of 2008, subparagraph 3 as amended by chapter 309 of the laws of 1996, subparagraph 4 as amended by chapter 1080 of the laws of 1974, are amended to read as follows:

(ii) such person [may have resources up to the amount specified in subparagraph four of paragraph (a) of subdivision two of this section] SHALL NOT BE SUBJECT TO A RESOURCE TEST;

(iii) a person whose income [and resources are] IS within the [limits] LIMIT set forth in [clauses] CLAUSE (i) [and (ii)] of this subparagraph shall be deemed to have unmet needs for purposes of the eligibility requirements of the safety net program as it existed on the first day of November, nineteen hundred ninety-seven;

(3) is a child under the age of twenty-one years receiving care (A) away from his own home in accordance with title two of article six of this chapter; (B) during the initial thirty days of placement with the division for youth pursuant to section 353.3 of the family court act; (C) in an authorized agency when placed pursuant to section seven hundred fifty-six or 353.3 of the family court act; or (D) in residence at a division foster family home or a division contract home, and has not, according to the criteria promulgated by the department, sufficient income [and resources], including available support from his parents, to meet all costs of required medical care and services available under this title; or

(4) is receiving care, in the case of and in connection with the birth of an out of wedlock child, in accordance with title two of article six of this chapter, and has not, according to the criteria promulgated by the department, sufficient income [and resources], including available support from responsible relatives, to meet all costs of required medical care and services available under this title; or

S 59. Subparagraphs 5, 6 and 8 of paragraph (a) of subdivision 1 of section 366 of the social services law, subparagraph 5 as amended by section 55 of part B of chapter 436 of the laws of 1997, subparagraph 6 as amended by chapter 710 of the laws of 1988 and subparagraph 8 as amended by section 60 of part C of chapter 58 of the laws of 2008, are amended and a new subparagraph 5-a is added to read as follows:

(5) although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has [not, according to the criteria and standards established by this article or by action of the department, sufficient] income and resources, including available support from responsible relatives, [to meet all the costs of medical care and services available under this title,] THAT DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION, and is (i) [under the age of twenty-one years, or] sixty-five years of age or older, or certified blind or certified disabled or (ii) [a spouse of a cash public assistance recipient living with him or her and essential or necessary to his or her welfare and whose needs are taken into account in determining the amount of his or her cash payment or (iii)] for reasons other than income or resources[: (A)], is eligible for federal supplemental security income benefits and/or additional state

payments[, or (B) would meet the eligibility requirements of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six]; or

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

(6) is a resident of a home for adults operated by a social services district or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, OR IN THE CASE OF A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER, CERTIFIED BLIND, OR CERTIFIED DISABLED, SUFFICIENT INCOME and resources, including available support from responsible relatives, to meet all the costs of required medical care and services available under this title; or

(8) is a member of a family which contains a dependent child living with a caretaker relative, which has net available income not in excess of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, to be increased annually by the same percentage as the percentage increase in the federal consumer price index[, and which has net available resources not in excess of the amount specified in subparagraph four of paragraph (a) of subdivision two of this section]; for purposes of this subparagraph, the net available income [and resources] of a family shall be determined using the methodology of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven, except that no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; for purposes of this subparagraph, the term dependent child means a person under twenty-one years of age who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health; or

S 59-a. Subparagraph 10 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 1 of part E of chapter 57 of the laws of 2000, is amended to read as follows:

(10) is a child who is under twenty-one years of age, who is not living with a caretaker relative, who has net available income not in excess of the income standards of the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven[, and who has net available resources not in excess of one thousand dollars]; for purposes of this subparagraph, the child's net available income [and resources] shall be determined using the methodology of the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, except that [(i) there shall be disre-

garded an additional amount of resources equal to the difference between the applicable resource standard of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven and one thousand dollars and (ii)] no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; or

S 59-b. Paragraph (i) of subdivision 1 of section 369-ee of the social services law is REPEALED.

S 59-c. The opening paragraph of paragraph (b) of subdivision 2 of section 369-ee of the social services law, as amended by section 45-d of part C of chapter 58 of the laws of 2008, is amended to read as follows:

Subject to the provisions of paragraph (d) of this subdivision, in order to establish [income] eligibility under this subdivision, WHICH SHALL BE DETERMINED WITHOUT REGARD TO RESOURCES, an individual shall provide such documentation as is necessary and sufficient to initially, and annually thereafter, determine an applicant's eligibility for coverage under this title. Such documentation shall include, but not be limited to the following, if needed to verify eligibility:

S 59-d. Paragraph (c) of subdivision 2 of section 369-ee of the social services law is REPEALED.

S 60. Subdivision 1 and paragraph (a) of subdivision 2 of section 366-a of the social services law, subdivision 1 as amended by chapter 532 of the laws of 1972 and paragraph (a) of subdivision 2 as added by section 51 of part A of chapter 1 of the laws of 2002, are amended to read as follows:

1. Any person requesting medical assistance may make application therefor in person, through another in his behalf or by mail to the social services official of the county, city or town, or to the service officer of the city or town in which the applicant resides or is found. In addition, in the case of a person who is sixty-five years of age or older and is a patient in a state hospital for tuberculosis or for the mentally disabled, applications may be made to the department or to a social services official designated as the agent of the department. Notwithstanding any provision of law to the contrary, [in accordance with department regulations, when an application is made by mail,] a personal interview [shall be conducted] with the applicant or with the person who made application [in] ON his OR HER behalf [when the applicant cannot be interviewed due to his physical or mental condition] SHALL NOT BE REQUIRED AS PART OF A DETERMINATION OF INITIAL OR CONTINUING ELIGIBILITY PURSUANT TO THIS TITLE.

(a) Upon receipt of such application, the appropriate social services official, or the department of health or its agent when the applicant is a patient in a state hospital for the mentally disabled, shall verify the eligibility of such applicant. In accordance with the regulations of the department of health, it shall be the responsibility of the applicant to provide information and documentation necessary for the determination of initial and ongoing eligibility for medical assistance. If an applicant or recipient is unable to provide necessary documentation, the public welfare official shall promptly cause an investigation to be made. Where an investigation is necessary, sources of information other than public records will be consulted only with permission of the applicant or recipient. In the event that such permission is not granted by the applicant or recipient, or necessary documentation cannot be obtained, the social services official or the department of health or its agent may suspend or deny medical assistance until such time as it

may be satisfied as to the applicant's or recipient's eligibility therefor. [To the extent practicable, any interview conducted as a result of an application for medical assistance shall be conducted in the home of the person interviewed or in the institution in which such person is receiving medical assistance.]

S 61. Paragraph (a) of subdivision 5 of section 369-ee of the social services law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

(a) [Personal interviews, pursuant to section three hundred sixty-six-a of this chapter, may be required upon initial application only and may be conducted in community settings.] A PERSONAL INTERVIEW WITH THE APPLICANT OR WITH THE PERSON WHO MADE APPLICATION ON HIS OR HER BEHALF SHALL NOT BE REQUIRED AS PART OF A DETERMINATION OF INITIAL OR CONTINUING ELIGIBILITY PURSUANT TO THIS TITLE. Recertification of eligibility shall take place on no more than an annual basis [and shall not require a personal interview]. Nothing herein shall abridge the participant's obligation to report changes in residency, financial circumstances or household composition.

S 62. Section 23-a of part B of chapter 436 of the laws of 1997, constituting the welfare reform act of 1997, is amended to read as follows:

S 23-a. Notwithstanding any contrary provision thereof, section 266 of chapter 83 of the laws of 1995 shall apply to applicants for or recipients of public assistance and care[, including medical assistance]; provided, however, that [with respect to medical assistance, such section shall apply only to persons who are subject to the photograph identification requirements established by the commissioner of health for] SUCH SECTION SHALL NOT APPLY TO the medical assistance program.

S 63. Subparagraph 8 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(8) is a member of a family which contains a dependent child living with a caretaker relative, which has: (I) SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOME NOT IN EXCESS OF ONE HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, net available income not in excess of one hundred thirty percent of the highest amount that ordinarily would have been paid to a person without any income or resources under the family assistance program as it existed on the first day of November, nineteen hundred ninety-seven, to be increased annually by the same percentage as the percentage increase in the federal consumer price index, and which has net available resources not in excess of the amount specified in subparagraph four of paragraph (a) of subdivision two of this section; for purposes of this subparagraph, the net available income and resources of a family shall be determined using the methodology of the family assistance program as it exists on the first day of November, nineteen hundred ninety-seven, except that no part of the methodology of the family assistance program will be used which is more restrictive than the methodology of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six; for purposes of this subparagraph, the term dependent child means a person under twenty-one years of age who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by

reason of the unemployment of the parent, as defined by the department of health; or

S 64. Paragraph (a) of subdivision 1 of section 366 of the social services law is amended by adding a new subparagraph 8-a to read as follows:

(8-A) IS AN INDIVIDUAL WHO IS AT LEAST NINETEEN BUT UNDER TWENTY-ONE YEARS OF AGE AND IS A MEMBER OF A HOUSEHOLD WHICH HAS GROSS INCOME NOT IN EXCESS OF ONE HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A HOUSEHOLD OF THE SAME SIZE; OR

S 65. Paragraph (p) of subdivision 4 of section 366 of the social services law, as added by chapter 651 of the laws of 1990, subparagraph 2 as amended by section 97 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

(p) (1) Children who are at least one year of age but younger than [six] NINETEEN years of age who are not otherwise eligible for medical assistance and whose families have: (I) SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOMES NOT IN EXCESS OF ONE HUNDRED SIXTY PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, NET incomes equal to or less than one hundred thirty-three percent of the federal income official poverty line (as defined and annually revised by the federal office of management and budget) for a family of the same size as the families that include the children shall be eligible for medical assistance and shall remain eligible therefor as provided in subparagraph three of this paragraph.

(2) For purposes of determining eligibility for medical assistance under this paragraph, family income shall be determined by use of the same methodology used to determine eligibility for the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six provided, however, that costs incurred for medical or remedial care shall not be considered and resources available to such families shall not be considered nor required to be applied toward the payment or part payment of the cost of medical care, services and supplies available under this paragraph.

(3) An eligible child who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains [six] NINETEEN years of age, and who, but for attaining such age, would remain eligible for medical assistance under this paragraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

S 65-a. Subparagraph 1 of paragraph (m) of subdivision 4 of section 366 of the social services law, as added by chapter 584 of the laws of 1989, is amended to read as follows:

(1) Pregnant women and infants younger than one year of age who are not otherwise eligible for medical assistance and whose families have NET incomes equal to or less than one hundred percent of the [comparable] federal [income official] poverty line (as defined and annually revised by the [federal office of management and budget] UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) for families of the same size SHALL BE ELIGIBLE FOR MEDICAL ASSISTANCE AS PROVIDED IN SUBPARAGRAPH THREE OF THIS PARAGRAPH. SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, FINANCIAL ELIGIBILITY PURSUANT TO

THIS PARAGRAPH MAY BE DETERMINED USING AN EQUIVALENT METHODOLOGY BASED ON THE FAMILY'S GROSS INCOME.

S 65-b. Subparagraph 1 of paragraph (n) of subdivision 4 of section 366 of the social services law, as amended by section 2 of part D of chapter 57 of the laws of 2000, is amended to read as follows:

(1) Infants younger than one year who are not otherwise eligible for medical assistance and whose families have: (I) SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOMES NOT IN EXCESS OF TWO HUNDRED THIRTY PERCENT OF THE FEDERAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, NET incomes equal to or less than two hundred percent of the federal [income official] poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size as the families that include the infants, shall be eligible for medical assistance as provided in subparagraph three of this paragraph. For purposes of this paragraph, family income shall be determined by use of the same methodology used to determine eligibility for the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six.

S 65-c. Subparagraph 1 of paragraph (o) of subdivision 4 of section 366 of the social services law, as amended by section 3 of part D of chapter 57 of the laws of 2000, is amended to read as follows:

(1) Pregnant women who are not otherwise eligible for medical assistance [are eligible for services provided under the prenatal care assistance program established pursuant to title two of article twenty-five of the public health law if the income of the family that includes the pregnant woman does not exceed] AND WHOSE FAMILIES HAVE: (I) SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, GROSS INCOMES NOT IN EXCESS OF TWO HUNDRED THIRTY PERCENT OF THE FEDERAL POVERTY LINE (AS DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE AS THE FAMILIES THAT INCLUDE THE CHILDREN OR (II) IN THE ABSENCE OF SUCH APPROVAL, NET INCOMES EQUAL TO OR LESS THAN two hundred percent of the [comparable] federal [income official] poverty line (as defined and annually revised by the United States department of health and human services) for families of the same size, SHALL BE ELIGIBLE FOR COVERAGE OF PRENATAL CARE SERVICES AS PROVIDED IN SUBPARAGRAPH THREE OF THIS PARAGRAPH.

S 65-d. Paragraph (a) of subdivision 2 of section 2529 of the public health law, as amended by chapter 59 of the laws of 1993, is amended to read as follows:

2. (a) Any inconsistent provision of law notwithstanding, a pregnant woman shall be presumed to be an eligible service recipient beginning on the date that a qualified provider determines, on the basis of preliminary information, that the pregnant woman's NET household income does not exceed the applicable income level of eligibility. SUBJECT TO THE APPROVAL OF THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, FINANCIAL ELIGIBILITY PURSUANT TO THIS SUBDIVISION MAY BE DETERMINED USING AN EQUIVALENT METHODOLOGY BASED ON THE FAMILY'S GROSS INCOME.

S 66. Paragraph (q) of subdivision 4 of section 366 of the social services law is REPEALED.

S 67. Subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by chapter 419 of the laws of 2000, is amended to read as follows:

(v) (A) in the case of a parent or stepparent of a child under the age of twenty-one who lives with such child, has gross family income equal to or less than the applicable percent of the federal income official poverty line (as defined and updated by the United States Department of Health and Human Services) for a family of the same size; for purposes of this clause, the applicable percent effective as of:

(I) January first, two thousand one, is one hundred twenty percent; and

(II) October first, two thousand one, is one hundred thirty-three percent; and

(III) October first, two thousand two, is one hundred fifty percent; [or] AND

(IV) APRIL FIRST, TWO THOUSAND TEN, IS ONE HUNDRED SIXTY PERCENT; OR

(B) in the case of an individual WHO IS AT LEAST TWENTY-ONE YEARS OF AGE AND who is not a parent or stepparent living with his or her child under the age of twenty-one, has gross family income equal to or less than one hundred percent of the federal income official poverty line (as defined and updated by the United States Department of Health and Human Services) for a family of the same size[.]; OR

(C) IN THE CASE OF AN INDIVIDUAL WHO IS AT LEAST NINETEEN BUT UNDER TWENTY-ONE YEARS OF AGE AND WHO IS NOT A PARENT OR STEPPARENT LIVING WITH HIS OR HER CHILD UNDER THE AGE OF TWENTY-ONE, HAS GROSS FAMILY INCOME EQUAL TO OR LESS THAN ONE HUNDRED SIXTY PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE; OR

(D) IS NOT DESCRIBED IN CLAUSE (A), (B) OR (C) OF THIS SUBPARAGRAPH AND HAS GROSS FAMILY INCOME EQUAL TO OR LESS THAN TWO HUNDRED PERCENT OF THE FEDERAL INCOME OFFICIAL POVERTY LINE (AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES) FOR A FAMILY OF THE SAME SIZE; PROVIDED, HOWEVER, THAT ELIGIBILITY UNDER THIS CLAUSE IS SUBJECT TO SOURCES OF FEDERAL AND NON-FEDERAL FUNDING FOR SUCH PURPOSE DESCRIBED IN SECTION SIXTY-SEVEN-A OF THE CHAPTER OF THE LAWS OF TWO THOUSAND NINE THAT ADDED THIS CLAUSE OR AS MAY BE AVAILABLE UNDER THE WAIVER AGREEMENT ENTERED INTO WITH THE FEDERAL GOVERNMENT UNDER SECTION ELEVEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, AS JOINTLY DETERMINED BY THE COMMISSIONER AND THE DIRECTOR OF THE DIVISION OF THE BUDGET. IN NO CASE SHALL STATE FUNDS BE UTILIZED TO SUPPORT THE NON-FEDERAL SHARE OF EXPENDITURES PURSUANT TO THIS SUBPARAGRAPH, PROVIDED HOWEVER THAT THE COMMISSIONER MAY DEMONSTRATE TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES THE EXISTENCE OF NON-FEDERALLY PARTICIPATING STATE EXPENDITURES AS NECESSARY TO SECURE FEDERAL FUNDING UNDER AN ELEVEN HUNDRED FIFTEEN WAIVER FOR THE PURPOSES HEREIN. ELIGIBILITY UNDER THIS CLAUSE MAY BE PROVIDED TO RESIDENTS OF ALL COUNTIES OR, AT THE JOINT DISCRETION OF THE COMMISSIONER AND THE DIRECTOR OF THE DIVISION OF THE BUDGET, A SUBSET OF COUNTIES OF THE STATE.

S 67-a. Notwithstanding any contrary provision of law, the commissioner of health is authorized to enter into an agreement with the United States department of health and human services establishing a waiver agreement pursuant to section 1115 of the federal social security act which may include the redirection of such Medicaid payments described below, or a portion thereof, and the utilization of such funds to fund services to uninsured persons and/or expand coverage under the family health plus program to families with gross income equal to or less than 200 percent of the federal poverty level, as provided in clause (D) of subparagraph (v) of paragraph (a) of subdivision two of

section 369-ee of the social services law. Such waiver may include the following:

1. Notwithstanding any inconsistent provisions of sections 211, 212, 213 and 214 of chapter 474 of the laws of 1996, as amended, sections 13, 14, 18 and 21 of part B of chapter 1 of the laws of 2002, as amended, and sections 12, 14, 15 and 22 of part A of chapter 1 of the laws of 2002, as amended, or any other contrary provision of law, and subject to the availability of federal financial participation and the receipt of all necessary federal approvals, Medicaid payments authorized pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, but not including any payments to general hospitals operated by the state of New York or the university of the state of New York, sections 13 and 14 of part B of chapter 1 of the laws of 2002, and sections 12 and 14 of part A of chapter 1 of the laws of 2002, shall be in accord with the provisions of this section.

2. Social services districts which voluntarily elect to participate in such program to fund services to uninsured persons and/or expand family health plus coverage may have the non-federal share of the payment amounts described in subdivision one of this section, or a portion thereof, redirected by the commissioner of health to support the non-federal share of payments associated with such program to fund services to uninsured persons and/or expand family health plus coverage. Such elections may be revoked effective 6 months after such local social services district provides notice of revocation. Such elections by each social services district shall be subject to the approval of the commissioner of health and with the consent of the public hospitals which are located within each such social services district and which are otherwise eligible to receive such redirected payments.

3. The non-federal share payment obligations of social services districts that voluntarily elect to participate in such program to fund services to uninsured persons and/or expand family health plus coverage shall be established at 50 percent of the amount of final reconciled Medicaid payments authorized pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, as amended, for the social services district for the year two years prior to the social services district's election to participate and shall not be subject to further adjustment. Further non-federal share payment obligations of social services districts that voluntarily elect to participate in such program to fund services to uninsured persons and/or expand family health plus coverage shall be established as follows: (a) 50 percent of the amount actually expended in state fiscal year 2007-2008 for Medicaid payments authorized pursuant to section 12 of part A of chapter 1 of the laws of 2002 and pursuant to section 13 of part B of chapter 1 of the laws of 2002, and, (b) 50 percent of the amount actually expended in state fiscal year 2004-2005 for Medicaid payments authorized pursuant to section 14 of part A of chapter 1 of the laws of 2002, and pursuant to section 14 of part B of chapter 1 of the laws of 2002.

4. For electing social services districts, the portion of each such payment obligation to be utilized for such program to fund services to uninsured persons and/or expand family health plus coverage shall be determined by the commissioner of health.

5. Payments to public general hospitals, other than those operated by the state of New York or the state university of New York, pursuant to section 211 and paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, sections 13 and 14 of part B of chapter 1 of

the laws of 2002 and sections 12 and 14 of part A of chapter 1 of the laws of 2002, located in electing social services districts, shall be reduced to an amount that can be supported by the non-federal share payment obligations of such social services districts as reduced by the portion of such payment obligations to be utilized for such program to fund services to uninsured persons and/or expand family health plus coverage as described above.

S 67-b. Notwithstanding any contrary provision of law, the commissioner of health is authorized to enter into a waiver agreement with the United States department of health and human services pursuant to section 1115 of the federal social security act to utilize federal funds available to the state under its federal disproportionate share hospital allotment pursuant to section 1923(f) of the federal social security act, that are projected to be in excess of the amounts necessary to fully fund existing state authorized disproportionate share hospital programs, to provide funding to fund services to the uninsured and/or expand coverage under the family health plus program as provided in clause (D) of subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law.

S 68. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by section 28 of part E of chapter 63 of the laws of 2005, is amended to read as follows:

(iii) does not have equivalent health care coverage under insurance or equivalent mechanisms, as defined by the commissioner in consultation with the superintendent of insurance[, and is not a federal, state, county, municipal or school district employee that is eligible for health care coverage through his or her employer];

S 69. Subdivision 24 of section 206 of the public health law, as added by section 39 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

24. Notwithstanding any inconsistent provision of law to the contrary, the commissioner is authorized to receive applications and to determine initial and continuing eligibility for enrollment under the child health plus program established under title I-A of article twenty-five of this chapter, the medical assistance program established under title eleven of article five of the social services law, and the family health plus program established under title eleven-D of such article. The commissioner may exercise such authority with respect to all residents, or a subset of residents, of one or more local social services districts. The commissioner is authorized to enter into one or more contracts, which contracts shall be procured on a competitive basis pursuant to a request for proposal process, for the purpose of exercising his or her authority under this subdivision. STATE EMPLOYEES SHALL SUPERVISE AND PROVIDE OVERSIGHT AND QUALITY ASSURANCE MONITORING OF CONTRACT STAFF ACTIVITIES. PROVIDED FURTHER, THE DEPARTMENT SHALL ENDEAVOR TO USE STATE EMPLOYEES IN EXERCISING THE COMMISSIONER'S AUTHORITY UNDER THIS SUBDIVISION.

S 70. Intentionally omitted.

S 71. Intentionally omitted.

S 72. Intentionally omitted.

S 72-a. Subdivision 9 of section 2510 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D) FOR PERIODS ON OR AFTER JULY FIRST, TWO THOUSAND NINE, AMOUNTS AS FOLLOWS:

(I) NO PAYMENTS ARE REQUIRED FOR ELIGIBLE CHILDREN WHOSE FAMILY GROSS HOUSEHOLD INCOME IS LESS THAN ONE HUNDRED SIXTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL AND FOR ELIGIBLE CHILDREN WHO ARE AMERICAN INDIANS

OR ALASKAN NATIVES, AS DEFINED BY THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WHOSE FAMILY GROSS HOUSEHOLD INCOME IS LESS THAN TWO HUNDRED FIFTY-ONE PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL; AND

(II) NINE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN ONE HUNDRED SIXTY PERCENT AND TWO HUNDRED TWENTY-TWO PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN TWENTY-SEVEN DOLLARS PER MONTH PER FAMILY; AND

(III) FIFTEEN DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN TWO HUNDRED TWENTY-THREE PERCENT AND TWO HUNDRED FIFTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN FORTY-FIVE DOLLARS PER MONTH PER FAMILY; AND

(IV) THIRTY DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN TWO HUNDRED FIFTY-ONE PERCENT AND THREE HUNDRED PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN NINETY DOLLARS PER MONTH PER FAMILY;

(V) FORTY-FIVE DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN THREE HUNDRED ONE PERCENT AND THREE HUNDRED FIFTY PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN ONE HUNDRED THIRTY-FIVE DOLLARS PER MONTH PER FAMILY; AND

(VI) SIXTY DOLLARS PER MONTH FOR EACH ELIGIBLE CHILD WHOSE FAMILY GROSS HOUSEHOLD INCOME IS BETWEEN THREE HUNDRED FIFTY-ONE PERCENT AND FOUR HUNDRED PERCENT OF THE NON-FARM FEDERAL POVERTY LEVEL, BUT NO MORE THAN ONE HUNDRED EIGHTY DOLLARS PER MONTH PER FAMILY.

S 73. Intentionally omitted.

S 74. Intentionally omitted.

S 75. Intentionally omitted.

S 76. Intentionally omitted.

S 77. Intentionally omitted.

S 78. Subdivision 8 of section 2511 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D)(I) EFFECTIVE APRIL FIRST, TWO THOUSAND NINE, PAYMENT FOR MARKETING AND FACILITATED ENROLLMENT ACTIVITIES SET FORTH IN SUBDIVISION NINE OF THIS SECTION AND INCLUDED IN SUBSIDY PAYMENTS MADE TO APPROVED ORGANIZATIONS PROVIDING SUCH SERVICES PURSUANT TO A CONTRACT WITH THE STATE SHALL BE LIMITED TO AN AMOUNT DETERMINED ANNUALLY BY THE COMMISSIONER.

(II) SUCH SUBSIDY PAYMENTS SHALL BE ADJUSTED BY THE COMMISSIONER TO REMOVE ANY COSTS OF APPROVED ORGANIZATIONS IN EXCESS OF THE AMOUNT DETERMINED IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH BASED ON COST REPORTS SUBMITTED TO THE DEPARTMENT BY APPROVED ORGANIZATIONS.

S 79. Intentionally omitted.

S 80. Intentionally omitted.

S 81. Intentionally omitted.

S 82. Intentionally omitted.

S 83. Intentionally omitted.

S 84. Intentionally omitted.

S 85. Intentionally omitted.

S 86. Section 2801-a of the public health law is amended by adding a new subdivision 16 to read as follows:

16. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF HOSPITALS THE FOLLOWING APPLICATION FEE:

(I) FOR GENERAL HOSPITALS: $3,000

(II) FOR NURSING HOMES: $3,000

(III) FOR SAFETY NET DIAGNOSTIC AND TREATMENT CENTERS AS DEFINED IN PARAGRAPH (C) OF THIS SUBDIVISION: $1,000

(IV) FOR ALL OTHER DIAGNOSTIC AND TREATMENT CENTERS: $2,000

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A HOSPITAL SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE.

(C) THE COMMISSIONER MAY DESIGNATE A DIAGNOSTIC AND TREATMENT CENTER OR PROPOSED DIAGNOSTIC AND TREATMENT CENTER AS A "SAFETY NET DIAGNOSTIC AND TREATMENT CENTER" IF IT IS OPERATED OR PROPOSES TO BE OPERATED BY A NOT-FOR-PROFIT CORPORATION OR LOCAL HEALTH DEPARTMENT; PARTICIPATES OR INTENDS TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM; DEMONSTRATES OR PROJECTS THAT A SIGNIFICANT PERCENTAGE OF ITS VISITS, AS DETERMINED BY THE COMMISSIONER, WERE BY UNINSURED INDIVIDUALS; AND PRINCIPALLY PROVIDES PRIMARY CARE SERVICES AS DEFINED BY THE COMMISSIONER.

(D) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION FOR ESTABLISHMENT OF A HOSPITAL APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE CAPITAL COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. THE COST OF SUCH FEES AND CHARGES SHALL NOT BE SUBJECT TO REIMBURSEMENT CEILING OR OTHER PENALTIES USED BY THE COMMISSIONER FOR THE PURPOSE OF ESTABLISHING REIMBURSEMENT RATES PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 87. Subdivision 7 of section 2802 of the public health law, as amended by section 1 of part C of chapter 1 of the laws of 2002, is amended to read as follows:

7. (A) The commissioner shall charge to applicants for construction of hospitals the following fees and charges for administrative services so as to recover departmental costs in performing these functions. Each applicant for construction of a hospital shall pay to the department an application fee of [one thousand two hundred fifty dollars] TWO THOUSAND DOLLARS, PROVIDED, HOWEVER, THAT DIAGNOSTIC AND TREATMENT CENTERS DESIGNATED BY THE COMMISSIONER AS SAFETY NET DIAGNOSTIC AND TREATMENT CENTERS, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL PAY A FEE OF ONE THOUSAND TWO HUNDRED FIFTY DOLLARS.

(B) At such time as the commissioner's written approval OF THE CONSTRUCTION is granted, each applicant shall pay [an] THE FOLLOWING additional fee [of forty-five hundredths of one percent of the total capital value of the application, provided that only those applications requiring review by the State Hospital Review and Planning Council shall be subject to such fee.]:

(I) FOR HOSPITAL, NURSING HOME AND DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS THAT REQUIRE APPROVAL BY THE COUNCIL, THE ADDITIONAL FEE SHALL BE FIFTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION, PROVIDED HOWEVER THAT APPLICATIONS FOR CONSTRUCTION OF A SAFETY NET DIAGNOSTIC AND TREATMENT CENTER, AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL BE SUBJECT TO A FEE OF FORTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION; AND

(II) FOR HOSPITAL, NURSING HOME AND DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS THAT DO NOT REQUIRE APPROVAL BY THE COUNCIL, THE ADDITIONAL FEE SHALL BE THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION, PROVIDED HOWEVER THAT SAFETY NET DIAGNOSTIC AND TREATMENT CENTER APPLICATIONS, AS DEFINED IN PARAGRAPH (C) OF SUBDIVI-

SION SIXTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE, SHALL BE SUBJECT TO A FEE OF TWENTY-FIVE HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(C) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH REDUCED FEES FOR APPLICATIONS SUBJECT TO LIMITED REVIEW, AS DESCRIBED IN REGULATION, THAT DO NOT REQUIRE REVIEW BY THE COUNCIL.

(D) The fees and charges paid by an applicant pursuant to this subdivision for any application for construction of a hospital approved in accordance with this section shall be deemed allowable capital costs in the determination of reimbursement rates established pursuant to this article. The cost of such fees and charges shall not be subject to reimbursement ceiling or other penalties used by the commissioner for the purpose of establishing reimbursement rates pursuant to this article. All fees pursuant to this section shall be payable to the department of health for deposit into the special revenue funds - other, miscellaneous special revenue fund - 339, certificate of need account.

S 88. Section 3605 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE LICENSURE OF HOME CARE SERVICES AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 89. Section 3606 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF CERTIFIED HOME HEALTH AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS.

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A CERTIFIED HOME HEALTH AGENCY SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION THIRTY-SIX HUNDRED SIX-A OF THIS ARTICLE.

(C) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 90. Section 3606-a of the public health law is amended by adding a new subdivision 9 to read as follows:

9. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR CONSTRUCTION OF CERTIFIED HOME HEALTH AGENCIES AN APPLICATION FEE OF TWO THOUSAND DOLLARS. EACH SUCH APPLICANT SHALL, AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF THE CONSTRUCTION IS GRANTED, PAY AN ADDITIONAL FEE OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(B) THE FEES AND CHARGES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 91. Section 3610 of the public health law is amended by adding a new subdivision 6 to read as follows:

6. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE AUTHORIZATION OR CONSTRUCTION OF LONG TERM HOME HEALTH CARE PROGRAMS AN APPLICATION FEE OF TWO THOUSAND DOLLARS. EACH SUCH APPLICANT SHALL, AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF A CONSTRUCTION APPLICATION IS GRANTED, PAY AN ADDITIONAL FEE OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(B) THE FEES PAID BY AN APPLICANT PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 92. Section 3611-a of the public health law, as added by chapter 959 of the laws of 1984, is amended to read as follows:

S 3611-a. Change in the operator or owner. 1. Any change in the person who, or ANY TRANSFER, ASSIGNMENT, OR OTHER DISPOSITION OF AN INTEREST OR VOTING RIGHTS OF TEN PERCENT OR MORE, OR ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION WHICH RESULTS IN THE OWNERSHIP OR CONTROL OF AN INTEREST OR VOTING RIGHTS OF TEN PERCENT OR MORE, IN A LIMITED LIABILITY COMPANY OR A partnership which is the operator of a licensed home care services agency or a certified home health agency shall be approved by the public health council in accordance with the provisions of subdivision four of section [three thousand six] THIRTY-SIX hundred five of this [chapter] ARTICLE relative to licensure or subdivision two of section [three thousand six] THIRTY-SIX hundred six of this [chapter] ARTICLE relative to certificate of approval, EXCEPT THAT:

(A) PUBLIC HEALTH COUNCIL APPROVAL SHALL BE REQUIRED ONLY WITH RESPECT TO THE PERSON, OR THE MEMBER OR PARTNER THAT IS ACQUIRING THE INTEREST OR VOTING RIGHTS; AND

(B) WITH RESPECT TO CERTIFIED HOME HEALTH AGENCIES, SUCH CHANGE SHALL NOT BE SUBJECT TO THE PUBLIC NEED ASSESSMENT DESCRIBED IN PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION THIRTY-SIX HUNDRED SIX OF THIS ARTICLE.

(C) NO PRIOR APPROVAL OF THE PUBLIC HEALTH COUNCIL SHALL BE REQUIRED WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION OF:

(I) AN INTEREST OR VOTING RIGHTS TO ANY PERSON PREVIOUSLY APPROVED BY THE PUBLIC HEALTH COUNCIL FOR THAT OPERATOR; OR

(II) AN INTEREST OR VOTING RIGHTS OF LESS THAN TEN PERCENT IN THE OPERATOR. HOWEVER, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST NINETY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNER OR MEMBER COMPLETES AND FILES WITH THE PUBLIC HEALTH COUNCIL NOTICE ON FORMS TO BE DEVELOPED BY THE PUBLIC HEALTH COUNCIL, WHICH SHALL DISCLOSE SUCH INFORMATION AS MAY REASONABLY BE NECESSARY FOR THE PUBLIC HEALTH COUNCIL TO DETERMINE WHETHER IT SHOULD BAR THE TRANSACTION. SUCH TRANSACTION WILL BE FINAL AS OF THE INTENDED EFFECTIVE DATE UNLESS, PRIOR THERETO, THE PUBLIC HEALTH COUNCIL SHALL STATE SPECIFIC REASONS FOR BARRING SUCH TRANSACTIONS UNDER THIS PARAGRAPH AND SHALL NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

2. Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a licensed home care services agency or a certified home health agency, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of more than ten percent of the stock or voting rights thereunder of such corporation by any person shall be subject to approval by the public health council in accordance with the provisions

of subdivision four of section [three thousand six] THIRTY-SIX hundred five of this [chapter] ARTICLE relative to licensure or subdivision two of section [three thousand six] THIRTY-SIX hundred six of this [chapter] ARTICLE relative to certificate of approval , EXCEPT THAT:

(A) PUBLIC HEALTH COUNCIL APPROVAL SHALL BE REQUIRED ONLY WITH RESPECT TO THE PERSON OR ENTITY ACQUIRING SUCH STOCK OR VOTING RIGHTS; AND

(B) WITH RESPECT TO CERTIFIED HOME HEALTH AGENCIES, SUCH CHANGE SHALL NOT BE SUBJECT TO THE PUBLIC NEED ASSESSMENT DESCRIBED IN PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION THIRTY-SIX HUNDRED SIX OF THIS ARTICLE. In the absence of such approval, the license or certificate of approval shall be subject to revocation or suspension.

(C) NO PRIOR APPROVAL OF THE PUBLIC HEALTH COUNCIL SHALL BE REQUIRED WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION OF AN INTEREST OR VOTING RIGHTS TO ANY PERSON PREVIOUSLY APPROVED BY THE PUBLIC HEALTH COUNCIL FOR THAT OPERATOR. HOWEVER, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNER OR MEMBER COMPLETES AND FILES WITH THE PUBLIC HEALTH COUNCIL NOTICE ON FORMS TO BE DEVELOPED BY THE PUBLIC HEALTH COUNCIL, WHICH SHALL DISCLOSE SUCH INFORMATION AS MAY REASONABLY BE NECESSARY FOR THE PUBLIC HEALTH COUNCIL TO DETERMINE WHETHER IT SHOULD BAR THE TRANSACTION. SUCH TRANSACTION WILL BE FINAL AS OF THE INTENDED EFFECTIVE DATE UNLESS, PRIOR THERETO, THE PUBLIC HEALTH COUNCIL SHALL STATE SPECIFIC REASONS FOR BARRING SUCH TRANSACTIONS UNDER THIS PARAGRAPH AND SHALL NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

3. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR A CHANGE IN OPERATOR OR OWNER OF A LICENSED HOME CARE SERVICES AGENCY OR A CERTIFIED HOME HEALTH AGENCY AN APPLICATION FEE IN THE AMOUNT OF TWO THOUSAND DOLLARS.

(B) THE FEES PAID BY CERTIFIED HOME HEALTH AGENCIES PURSUANT TO THIS SUBDIVISION FOR ANY APPLICATION APPROVED IN ACCORDANCE WITH THIS SECTION SHALL BE DEEMED ALLOWABLE COSTS IN THE DETERMINATION OF REIMBURSEMENT RATES ESTABLISHED PURSUANT TO THIS ARTICLE. ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 93. Section 4004 of the public health law is amended by adding a new subdivision 5 to read as follows:

5. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR THE ESTABLISHMENT OF A HOSPICE AN APPLICATION FEE IN THE AMOUNT OF TWO THOUSAND DOLLARS.

(B) AN APPLICANT FOR BOTH ESTABLISHMENT AND CONSTRUCTION OF A HOSPICE SHALL NOT BE SUBJECT TO THIS SUBDIVISION AND SHALL BE SUBJECT TO FEES AND CHARGES AS SET FORTH IN SECTION FOUR THOUSAND SIX OF THIS ARTICLE.

(C) ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUNDS - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 94. Section 4006 of the public health law is amended by adding a new subdivision 9 to read as follows:

9. (A) THE COMMISSIONER SHALL CHARGE TO APPLICANTS FOR CONSTRUCTION OF A HOSPICE AN APPLICATION FEE OF TWO THOUSAND DOLLARS.

(B) AT SUCH TIME AS THE COMMISSIONER'S WRITTEN APPROVAL OF THE CONSTRUCTION IS GRANTED, EACH SUCH APPLICANT SHALL PAY AN ADDITIONAL FEE OF THIRTY HUNDREDTHS OF ONE PERCENT OF THE TOTAL CAPITAL VALUE OF THE APPLICATION.

(C) ALL FEES PURSUANT TO THIS SECTION SHALL BE PAYABLE TO THE DEPARTMENT OF HEALTH FOR DEPOSIT INTO THE SPECIAL REVENUE FUND - OTHER, MISCELLANEOUS SPECIAL REVENUE FUND - 339, CERTIFICATE OF NEED ACCOUNT.

S 95. The opening paragraph of paragraph (s) of subdivision 1 of section 2807-m of the public health law, as amended by section 16 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

"Adjustment amount" means an amount determined for each teaching hospital FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE by:

S 96. Paragraph (b) of subdivision 2 of section 2807-m of the public health law, as amended by chapter 1 of the laws of 1999, is amended to read as follows:

(b) [Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH regional pool shall be distributed on a monthly basis to teaching general hospitals for costs associated with graduate medical education provided by such teaching general hospitals in accordance with the distribution methodology set forth in subdivision three of this section; provided however, teaching general hospitals with a resident count of zero as of July first of the year preceding the distribution period shall not be eligible for distributions pursuant to this section. General hospitals may elect to have their distribution paid through the consortium.

S 97. Paragraphs (a), (c), (e) and (f) and the opening paragraphs of paragraphs (b) and (d) of subdivision 3 of section 2807-m of the public health law, paragraph (a) and the opening paragraph of paragraph (b) as added by chapter 639 of the laws of 1996, paragraph (c) as amended by chapter 419 of the laws of 2000, the opening paragraph of paragraph (d) as amended by section 17 of part B of chapter 58 of the laws of 2008, paragraph (e) as amended by section 11 of part OO of chapter 57 of the laws of 2008 and paragraph (f) as amended by section 13 of part E of chapter 63 of the laws of 2005, are amended to read as follows:

(a) Distributions to teaching general hospitals shall be made from the regional pools described in subdivision two of this section for each period PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, less amounts set aside pursuant to subdivision five of this section. To be eligible to participate in distributions pursuant to this section, a teaching general hospital and consortium must be in compliance with graduate medical education reporting requirements set forth in subdivision four of this section.

[Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH teaching general hospital in a region shall have a proxy calculated for its graduate medical education costs as follows:

(c) [A] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, A distribution amount for each teaching general hospital shall be calculated from the applicable regional pool described in subdivision two of this section as adjusted pursuant to paragraph (d) of this subdivision based upon its percentage of the regional total of the graduate medical education proxies, except that for purposes of this paragraph the statewide amount used to compute such distribution amounts shall be four hundred ninety million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand two and two hundred forty-five million dollars for the period January first, two thousand three through June thirtieth, two thousand three, less amounts set aside each period pursuant to subdivision seven of this section.

[Each] FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, EACH teaching general hospital shall receive a distribution from the applica-

ble regional pool based on its distribution amount determined under paragraph (c) of this subdivision adjusted by a reduction amount that is determined as follows:

(e) Effective April first, two thousand four THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, the distribution amount calculated pursuant to paragraphs (c) and (d) of this subdivision for each non-public teaching general hospital shall be reduced by the amount calculated and included in rates pursuant to paragraph (d) of subdivision twenty-five of section twenty-eight hundred seven-c of this article.

(f) Effective January first, two thousand five THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT, each teaching general hospital shall receive a distribution from the applicable regional pool based on its distribution amount determined under paragraphs (c), (d) and (e) of this subdivision and reduced by its adjustment amount calculated pursuant to paragraph [(1)] (S) of subdivision one of this section and, for distributions for the period January first, two thousand five through December thirty-first, two thousand five, further reduced by its extra reduction amount calculated pursuant to paragraph [(m)] (T) of subdivision one of this section.

S 98. The opening paragraph of paragraph (b), paragraph (c), the opening paragraphs of paragraphs (d) and (e) and paragraphs (f) and (g) of subdivision 5-a of section 2807-m of the public health law, the opening paragraph of paragraph (b), paragraph (c), the opening paragraph of paragraph (e), and paragraphs (f) and (g) as added by section 75-c of part C of chapter 58 of the laws of 2008 and the opening paragraph of paragraph (d) as amended by section 15 of part OO of chapter 57 of the laws of 2008, are amended to read as follows:

Empire clinical research investigator program (ECRIP) and other graduate medical education reforms. [Thirty-one] THIRTY million FOUR HUNDRED THOUSAND dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and seven million [seven hundred fifty] SIX HUNDRED thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section to be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the state and shall be available for distribution as follows:

(c) Ambulatory care training. [Five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, [five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, and one million two hundred [fifty] TWENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to sponsoring institutions to be directed to support clinical training of medical students and residents in free-standing ambulatory care settings, including community health centers and private practices. Such funding shall be allocated regionally with two-thirds of the available funding going to New York city and one-third of the available funding going to the rest of the

state and shall be distributed to sponsoring institutions in each region pursuant to a request for application or request for proposal process with preference being given to sponsoring institutions which provide training in sites located in underserved rural or inner-city areas and those that include medical students in such training.

[Two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, [two] ONE million NINE HUNDRED SIXTY THOUSAND dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, and [five] FOUR hundred NINETY thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician loan repayment in accordance with subdivision ten of this section. Such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner as follows:

[Five] FOUR million NINE HUNDRED THOUSAND dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, [five] FOUR million NINE HUNDRED THOUSAND dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and one million two hundred [fifty] TWENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for purposes of physician practice support. Such funding shall be allocated regionally with one-third of available funds going to New York city and two-thirds of available funds going to the rest of the state and shall be distributed in a manner to be determined by the commissioner as follows:

(f) Study on physician workforce. [Six] FIVE hundred NINETY thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, and one hundred [fifty] FORTY-EIGHT thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund a study of physician workforce needs and solutions including, but not limited to, an analysis of residency programs and projected physician workforce and community needs. The commissioner shall enter into agreements with one or more organizations to conduct such study based on a request for proposal process.

(g) Diversity in medicine/post-baccalaureate program. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, [two] ONE million NINE HUNDRED SIXTY THOUSAND dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, and [five] FOUR hundred NINETY thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section

and shall be available for distributions to the Associated Medical Schools of New York to fund its diversity program including existing and new post-baccalaureate programs for minority and economically disadvantaged students and encourage participation from all medical schools in New York. The associated medical schools of New York shall report to the commissioner on an annual basis regarding the use of funds for such purpose in such form and manner as specified by the commissioner.

S 99. Subdivision 7 of section 2807-m of the public health law, as amended by section 75-d of part C of chapter 58 of the laws of 2008, is amended to read as follows:

7. Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, up to one million dollars for the period January first, two thousand through December thirty-first, two thousand, one million six hundred thousand dollars annually for the periods January first, two thousand one through December thirty-first, two thousand [ten,] EIGHT, ONE MILLION FIVE HUNDRED THOUSAND DOLLARS ANNUALLY FOR THE PERIODS JANUARY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN, and [four] THREE hundred SEVENTY-FIVE thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of expanding community-based training of medical students. In addition, one million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, and two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available for distributions to the New York state area health education center program for the purpose of post-secondary training of health care professionals who will achieve specific program outcomes within the New York state area health education center program. The New York state area health education center program shall report to the commissioner on an annual basis regarding the use of funds for each purpose in such form and manner as specified by the commissioner.

S 100. Paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 22 of part A of chapter 58 of the laws of 2007, subparagraphs (viii), (ix) and (xii) as amended by section 14 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(a) funds shall be accumulated in regional professional education pools established by the commissioner or the healthcare reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, for distribution in accordance with section twenty-eight hundred seven-m of this article, in the following amounts:

(i) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven,

(ii) ninety-two and forty-five-hundredths percent of the funds accumulated less seventy-six million dollars for the period January first,

nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight,

(iii) ninety-two and forty-five-hundredths percent of the funds accumulated less one hundred one million dollars for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine,

(iv) four hundred ninety-four million dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand three,

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

(vi) four hundred eighty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five,

(vii) four hundred ninety-four million dollars for the period January first, two thousand six through December thirty-first, two thousand six,

(viii) four hundred seventy million dollars [annually] for the period January first, two thousand seven through December thirty-first, two thousand [ten] SEVEN, [and]

(ix) [one hundred seventeen] FOUR HUNDRED FORTY-SIX MILLION SIX HUNDRED THOUSAND DOLLARS FOR THE PERIOD JANUARY FIRST, TWO THOUSAND EIGHT THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT,

(X) FORTY-SEVEN MILLION TWO HUNDRED TEN THOUSAND DOLLARS ON AN ANNUAL BASIS FOR THE PERIODS JANUARY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND TEN; AND

(XI) ELEVEN million [five] EIGHT hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

[(x)] (XII) provided, however, FOR PERIODS PRIOR TO JANUARY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph may be reduced by the commissioner in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the graduate medical education program established pursuant to section twenty-eight hundred seven-m of this article;

[(xi)] (XIII) provided further, however, FOR PERIODS PRIOR TO JULY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph shall be reduced by an amount equal to the total actual distribution reductions for all facilities pursuant to paragraph (e) of subdivision three of section twenty-eight hundred seven-m of this article; and

[(xii)] (XIV) provided further, however, FOR PERIODS PRIOR TO JULY FIRST, TWO THOUSAND NINE, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-m of this article.

S 101. Section 2807-k of the public health law is amended by adding a new subdivision 5-b to read as follows:

5-B. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER MAY FIRST, TWO THOUSAND NINE, FUNDS AS HEREINAFTER DESCRIBED SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED IN ACCORDANCE WITH THE FOLLOWING:

(A) FOR THE PERIOD MAY FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE PAYMENTS SHALL BE MADE AS FOLLOWS:

(I) NINETY PERCENT OF FUNDS AVAILABLE FOR THE TWO THOUSAND NINE CALENDAR YEAR PURSUANT TO PARAGRAPH (A-1) OF SUBDIVISION FOUR OF THIS SECTION SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED AS MEDICAID DISPROPORTIONATE SHARE (DSH) PAYMENTS TO THE SAME HOSPITALS AND IN THE SAME PROPORTIONAL AMOUNTS AS RECEIVED PURSUANT TO SUCH PARAGRAPH (A-1) IN TWO THOUSAND EIGHT;

(II) THREE HUNDRED SEVEN MILLION DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO FACILITIES DESIGNATED BY THE DEPARTMENT AS TEACHING HOSPITALS AS OF DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT IN ACCORDANCE WITH A SCHEDULE OF PAYMENTS TO BE SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER TO COMPENSATE SUCH FACILITIES FOR MEDICAID AND SELF-PAY LOSSES REPORTED IN EACH FACILITY'S TWO THOUSAND SEVEN ANNUAL COST REPORT;

(III) SIXTEEN MILLION DOLLARS SHALL BE PROPORTIONALLY DISTRIBUTED AS MEDICAID DSH PAYMENTS TO NON-TEACHING HOSPITALS BASED UPON THEIR PROPORTION OF UNINSURED LOSSES AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION FIVE-A OF THIS SECTION TO SUCH LOSSES OF ALL NON-TEACHING HOSPITALS ON A STATEWIDE BASIS;

(IV) TWENTY-FIVE MILLION DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO NON-MAJOR PUBLIC HOSPITALS HAVING MEDICAID DISCHARGES OF FORTY PERCENT OR GREATER AS ESTABLISHED BY THE COMMISSIONER FROM DATA REPORTED IN EACH HOSPITAL'S TWO THOUSAND SEVEN ANNUAL COST REPORT, IN ACCORDANCE WITH A SCHEDULE TO BE SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER, TO COMPENSATE SUCH FACILITIES FOR PROJECTED MEDICAID NET LOSSES, AS DETERMINED BY THE COMMISSIONER, STEMMING FROM MODIFICATIONS TO MEDICAID PAYMENTS MADE PURSUANT TO A CHAPTER OF THE LAWS OF TWO THOUSAND NINE.

(B) FOR ANNUAL PERIODS BEGINNING JANUARY FIRST, TWO THOUSAND TEN PAYMENTS SHALL BE MADE AS FOLLOWS:

(I) TWO HUNDRED SIXTY-NINE MILLION FIVE HUNDRED THOUSAND DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DSH PAYMENTS TO NON-MAJOR PUBLIC TEACHING HOSPITALS, AND SUCH DISTRIBUTIONS SHALL BE MADE ON A REGIONAL BASIS TO COVER, WITHIN AMOUNTS AVAILABLE FOR EACH REGION, EACH ELIGIBLE FACILITY'S PROPORTIONAL REGIONAL SHARE OF UNMET NEED FOR TWO THOUSAND SEVEN, PROVIDED, HOWEVER, THAT SUCH REGIONS AND REGIONAL ALLOCATIONS AND THE DEFINITION OF UNMET NEED SHALL BE SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER;

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

(III) SIXTEEN MILLION DOLLARS SHALL BE DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF SUBPARAGRAPH (III) OF PARAGRAPH (A) OF THIS SUBDIVISION;

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

(V) TWENTY-FOUR MILLION FIVE HUNDRED THOUSAND DOLLARS SHALL BE DISTRIBUTED AS NON-MEDICAID GRANTS TO NON-MAJOR PUBLIC ACADEMIC MEDICAL CENTERS PURSUANT TO A SCHEDULE TO BE SET FORTH IN REGULATIONS PROMULGATED BY THE COMMISSIONER, FOR FUNDING FOR THE FOLLOWING PURPOSES:

(A) QUALITY OF CARE STANDARDS LINKED TO THE ALL PATIENT REFINED (APR) DRGS;

(B) BEST PRACTICES AND EVIDENCE-BASED GUIDELINES WITH PARTICULAR FOCUS ON OBSTETRIC, PSYCHIATRIC AND OTHER HIGH RISK SPECIALTIES;

(C) INPATIENT PSYCHIATRIC CASE PAYMENT SYSTEM AND FINANCIAL INCENTIVES TO DIVERT ADMISSIONS AND IMPROVE LINKAGES TO OUTPATIENT PROGRAMS;

(D) MEDICAL HOME STANDARDS AND INTEGRATED DELIVERY SYSTEMS WITH A PARTICULAR FOCUS ON CHRONIC CARE PATIENTS SERVED IN ACADEMIC MEDICAL CENTERS AND COMMUNITY-BASED SETTINGS; AND

(E) REFORMS TO RESIDENCY TRAINING CURRICULUM FOCUSING ON CULTURAL COMPETENCY, QUALITY OF TRAINING PROGRAMS, AND PHYSICIAN SUPPLY IN NEEDED SPECIALTIES AND GEOGRAPHIC AREAS.

S 101-a. Paragraph (a-1) of subdivision four of section 2807-k of the public health law, as amended by section 1 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

(a-1) From funds in the pool for each year, twenty-seven million dollars shall be reserved on an annual basis for the periods January first, two thousand through December thirty-first, two thousand ten, for distribution in accordance with subdivision sixteen of this section, provided, however, that payments on and after January first, two thousand nine THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE shall be subject to the provisions of [subdivision] SUBDIVISIONS five-a AND FIVE-B of this section, AND SHALL BE SUBJECT TO THE PROVISIONS OF SUBDIVISION FIVE-B OF THIS SECTION FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN.

S 101-b. Notwithstanding any contrary provision of law, if the commissioner of health determines that federal financial participation will not be available with regard to the provisions of subparagraph (ii) of paragraph (a) of subdivision 5-b of section 2807-k of the public health law, such commissioner may deem such provision null and void and instead may allocate funds in accordance with the methodology set forth in subparagraph (i) of paragraph (b) of subdivision 5-b of section 2807-k of the public health law.

S 102. Paragraph (c) of subdivision 5-a of section 2807-k of the public health law, as added by section 28-b of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(c) For the purposes of distributions in accordance with paragraphs (a) and (b) of this subdivision, each facility's relative uncompensated care need amount shall be determined [by multiplying reported inpatient and outpatient units of service from the calendar year two years prior to the distribution year, but excluding referred ambulatory services units of service, for all uninsured patients by the applicable Medicaid rates, but not including prospective rate adjustments and rate add-ons, in effect for the calendar year two years prior to the distribution year for such services, provided, however, that for distributions on and after January first, two thousand ten, each facility's uncompensated need amount shall be reduced by the sum of all payment amounts collected from such patients. The total uncompensated care need for each facility subject to paragraph (a) or (b) of this subdivision shall then be adjusted by application of the nominal need scale set forth in subdivision five of this section.] IN ACCORDANCE WITH THE FOLLOWING:

(I) INPATIENT UNITS OF SERVICES FOR ALL UNINSURED PATIENTS FROM THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, BUT EXCLUDING REFERRED AMBULATORY UNITS OF SERVICES, SHALL BE MULTIPLIED BY THE APPLICABLE MEDICAID INPATIENT RATES IN EFFECT FOR SUCH PRIOR YEAR, BUT NOT INCLUDING PROSPECTIVE RATE ADJUSTMENTS AND RATE ADD-ONS, PROVIDED, HOWEVER, THAT FOR DISTRIBUTIONS ON AND AFTER JANUARY FIRST, TWO THOUSAND

TEN, THE UNCOMPENSATED AMOUNT FOR INPATIENT SERVICES SHALL UTILIZE THE INPATIENT RATES IN EFFECT AS OF JULY FIRST OF THE PRIOR YEAR;

(II) OUTPATIENT UNITS OF SERVICE FOR ALL UNINSURED PATIENTS FROM THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, INCLUDING EMERGENCY DEPARTMENT SERVICES AND AMBULATORY SURGERY SERVICES, BUT EXCLUDING REFERRED AMBULATORY SERVICES UNITS OF SERVICE, SHALL BE MULTIPLIED BY MEDICAID OUTPATIENT RATES THAT REFLECT THE EXCLUSIVE UTILIZATION OF THE AMBULATORY PATIENT GROUPS (APG) RATE-SETTING METHODOLOGY AS SET FORTH IN REGULATIONS PROMULGATED PURSUANT TO SUBDIVISION TWO-A OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE, AS IN EFFECT FOR THE DISTRIBUTION YEAR, PROVIDED FURTHER, HOWEVER, THAT FOR THOSE SERVICES FOR WHICH APG RATES ARE NOT AVAILABLE THE APPLICABLE MEDICAID OUTPATIENT RATE SHALL BE THE RATE IN EFFECT FOR THE CALENDAR YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR;

(III) THE UNCOMPENSATED CARE NEED FOR EACH FACILITY FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND TEN SHALL BE REDUCED BY THE SUM OF ALL PAYMENT AMOUNTS COLLECTED FROM SUCH PATIENTS; AND

(IV) THE TOTAL UNCOMPENSATED CARE NEED FOR EACH FACILITY SUBJECT TO THIS SUBDIVISION SHALL THEN BE ADJUSTED BY APPLICATION OF THE NOMINAL NEED SCALE SET FORTH IN SUBDIVISION FIVE OF THIS SECTION.

S 103. Section 2807-p of the public health law is amended by adding a new subdivision 10 to read as follows:

10. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, THE COMMISSIONER IS AUTHORIZED TO SEEK A WAIVER FROM THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, OR SUCH OTHER FEDERAL LAW PROVISION AS MAY BE DEEMED APPROPRIATE, SEEKING FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS MADE PURSUANT TO THIS SECTION, IN WHICH CASE THE STATE FUNDING MADE AVAILABLE PURSUANT TO THIS SECTION SHALL BE UTILIZED AS THE NON-FEDERAL SHARE OF SUCH PAYMENTS. TO THE EXTENT AS MAY BE REQUIRED, PAYMENTS MADE PURSUANT TO THIS SECTION AND IN ACCORDANCE WITH THIS SUBDIVISION, MAY BE DEEMED TO BE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS IN ACCORDANCE WITH THE PROVISIONS OF THE FEDERAL SOCIAL SECURITY ACT.

(B) IF FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS MADE PURSUANT TO THIS SECTION ARE MADE AVAILABLE IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBDIVISION, FREE-STANDING CLINICS LICENSED SOLELY PURSUANT TO ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW SHALL ALSO BE DEEMED ELIGIBLE FOR PARTICIPATION IN SUCH PAYMENTS TO THE SAME DEGREE AND IN ACCORDANCE WITH THE SAME DISTRIBUTION METHODOLOGY OTHERWISE PROVIDED IN THIS SECTION, PROVIDED, HOWEVER, THAT ONLY THOSE UNITS OF SERVICE PROVIDED BY SUCH FREE-STANDING CLINICS THAT CONSTITUTE MEDICAL SERVICES THAT ARE OTHERWISE ELIGIBLE FOR CONSIDERATION FOR MEDICAID PAYMENTS SHALL BE REFLECTED IN DISTRIBUTIONS MADE PURSUANT TO THIS SECTION, AND FURTHER PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, REQUIRE SUCH CLINICS, AS A CONDITION OF RECEIVING SUCH DISTRIBUTIONS, TO PROVIDE REPORTS AND DATA TO THE DEPARTMENT AS THE COMMISSIONER DEEMS NECESSARY TO ADEQUATELY IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION WITH REGARD TO SUCH CLINICS.

S 104. Intentionally omitted.

S 105. Intentionally omitted.

S 106. Intentionally omitted.

S 107. Intentionally omitted.

S 107-a. Intentionally omitted.

S 108. Intentionally omitted.

S 109. Intentionally omitted.

S 110. Subdivision 2 of section 241 of the elder law, as amended by section 13 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

2. "Provider pharmacy" shall mean a pharmacy registered in the state of New York pursuant to section sixty-eight hundred eight of the education law, A NON-RESIDENT ESTABLISHMENT REGISTERED PURSUANT TO SECTION SIXTY-EIGHT HUNDRED EIGHT-B OF THE EDUCATION LAW, or a pharmacy registered in a state bordering the state of New York when certified as necessary by the executive director pursuant to section two hundred fifty-three of this title, for which an agreement to provide pharmacy services for purposes of this program pursuant to section two hundred forty-nine of this title is in effect.

S 111. Subdivision 1 of section 249 of the elder law is amended to read as follows:

1. The state shall offer an opportunity to participate in this program to all provider pharmacies as defined in section two hundred forty-one of this title, PROVIDED, HOWEVER, THAT THE PARTICIPATION OF PHARMACIES REGISTERED IN THE STATE PURSUANT TO SECTION SIXTY-EIGHT HUNDRED EIGHT-B OF THE EDUCATION LAW SHALL BE LIMITED TO STATE ASSISTANCE PROVIDED UNDER THIS TITLE FOR PRESCRIPTION DRUGS COVERED BY A PROGRAM PARTICIPANT'S MEDICARE OR OTHER DRUG PLAN.

S 112. Paragraph (e) of subdivision 3 of section 242 of the elder law, as amended by section 3 of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(e) As a condition of continued eligibility for benefits under this title, if a program participant's income indicates that the participant could be eligible for an income-related subsidy under section 1860D-14 of the federal social security act BY EITHER APPLYING FOR SUCH SUBSIDY OR BY ENROLLING IN A MEDICARE SAVINGS PROGRAM AS A QUALIFIED MEDICARE BENEFICIARY (QMB), A SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB), OR A QUALIFYING INDIVIDUAL (QI), a program participant is required to provide, and to authorize the elderly pharmaceutical insurance coverage program to obtain, any information or documentation required to establish the participant's eligibility for such subsidy, AND TO AUTHORIZE THE ELDERLY PHARMACEUTICAL INSURANCE COVERAGE PROGRAM TO APPLY ON BEHALF OF THE PARTICIPANT FOR THE SUBSIDY OR THE MEDICARE SAVINGS PROGRAM. The elderly pharmaceutical insurance coverage program shall make a reasonable effort to notify the program participant of his or her need to provide any of the above required information. After a reasonable effort has been made to contact the participant, a participant shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the participant's coverage may be terminated.

S 113. Intentionally omitted.

S 114. Paragraph (b) of subdivision 1-a of section 2807-s of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

(b) "Specified third-party payors", for purposes of this section and sections twenty-eight hundred seven-j and twenty-eight hundred seven-t of this article, shall include corporations organized and operating in accordance with article forty-three of the insurance law, organizations operating in accordance with the provisions of article forty-four of this chapter, self-insured funds and administrators acting on behalf of self-insured funds, and commercial insurers [licensed to do business in this state and] authorized to write accident and health insurance and

whose policy provides coverage on an expense incurred basis. Specified third-party payors, for purposes of this section, shall not include governmental agencies or providers of coverage pursuant to the comprehensive motor vehicle insurance reparations act, the workers' compensation law, the volunteer firefighters' benefit law, or the volunteer ambulance workers' benefit law.

S 115. Intentionally omitted.

S 116. Paragraph (b) of subdivision 2 of section 367-a of the social services law, as amended by section 58 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(b) Any inconsistent provision of this chapter or other law notwithstanding, upon furnishing assistance under this title to any applicant or recipient of medical assistance, the local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or [third party reimbursement] REIMBURSEMENT FROM LIABLE THIRD PARTIES, INCLUDING BUT NOT LIMITED TO HEALTH INSURERS, SELF-INSURED PLANS, GROUP HEALTH PLANS, SERVICE BENEFIT PLANS, MANAGED CARE ORGANIZATIONS, PHARMACY BENEFIT MANAGERS, OR OTHER PARTIES THAT ARE, BY STATUTE, CONTRACT, OR AGREEMENT, LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE. For purposes of this section, the term medical support shall mean the right to support specified as support for the purpose of medical care by a court or administrative order. The right of subrogation does not attach to insurance benefits paid or provided under any health insurance policy prior to the receipt of written notice of the exercise of subrogation rights by the carrier issuing such insurance, nor shall such right of subrogation attach to any benefits which may be claimed by a social services official or the department, by agreement or other established procedure, directly from an insurance carrier. No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within three years from the date services for which benefits are provided under the policy or contract are rendered. LIABLE THIRD PARTIES SHALL NOT DENY A CLAIM MADE BY A SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT IN CONFORMANCE WITH THIS PARAGRAPH SOLELY ON THE BASIS OF THE DATE OF SUBMISSION OF THE CLAIM, THE TYPE OR FORMAT OF THE CLAIM FORM, OR A FAILURE TO PRESENT PROPER DOCUMENTATION AT THE POINT-OF-SALE THAT IS THE BASIS OF THE CLAIM. The local social services district or the department shall also notify the carrier when the exercise of subrogation rights has terminated because a person is no longer receiving assistance under this title. Such carrier shall establish mechanisms to maintain the confidentiality of all individually identifiable information or records. Such carrier shall limit the use of such information or record to the specific purpose for which such disclosure is made, and shall not further disclose such information or records.

S 117. Paragraph (a) of subdivision 11 of section 367-a of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(a) Any inconsistent provisions of this title or other law notwithstanding, no health insurer, [health maintenance organization] SELF-INSURED PLAN, MANAGED CARE ORGANIZATION, PHARMACY BENEFIT MANAGER, or other [entity providing medical benefits] PARTY THAT IS, BY STATUTE, CONTRACT, OR AGREEMENT, LEGALLY RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR SERVICE, employer or organization who has a plan,

including an employee retirement income security act or service benefit plan, providing care and other medical benefits for persons, whether by insurance or otherwise, shall exclude a person from eligibility, coverage or entitlement to medical benefits by reason of the eligibility of such person for medical assistance under this title, or by reason of the fact that such person would, except for such plan, be eligible for benefits under this title.

S 117-a. Subsections (a), (b), (d) and (e) of section 320 of the insurance law, subsection (e) as amended by chapter 601 of the laws of 2007, are amended and a new subsection (f) is added to read as follows:

(a) Every insurer [doing an insurance business in this state or any pension fund, retirement system or other organization required by law to make reports to, or which is subject to examination by, the insurance department, except any corporation subject to article forty-three of this chapter,] shall, upon request of the state department of social services or of a local social services district for any records, or any information contained in such records, pertaining to the coverage of any individual for such individual's medical costs under any individual or group policy or other obligation made by such organizations, or the medical benefits paid by or claims made to such organizations pursuant to such policy or other obligation in accordance with the limitations of subsection (c) hereof, make the requested records or information available upon a certification by the department of social services or the social services district that such individual is an applicant for or recipient of medical assistance, or is a person who is legally responsible for such an applicant or recipient, pursuant to the social services law.

(b) The superintendent and the commissioner of the state department of social services shall enter into a cooperative agreement setting forth mutually agreeable procedures for requesting and furnishing appropriate information, not inconsistent with any law pertaining to the confidentiality and privacy of records, which procedures shall include financial arrangements as may be necessary to reimburse [insurance corporations or other] insurers [doing or authorized to do an insurance business in this state or any pension fund, retirement system or other organization subject to the provisions of this section] for necessary costs incurred in furnishing requested information, and the time and manner such procedures are to become effective. Such procedures may be added to [the cooperative agreement which was entered into between the superintendent and the commissioner of social services pursuant to the provisions of section four thousand three hundred eleven of this chapter or the procedures may be added to] a new cooperative agreement which shall supersede the agreement currently in existence between the superintendent and the commissioner of social services.

(d) Not later than the date upon which the procedures agreed to pursuant to subsection (b) hereof become effective, the superintendent shall establish guidelines to assure that information relating to an individual certified to be an applicant for or recipient of medical assistance, furnished to any [insurance corporation,] insurer, [pension fund, retirement system or other organization subject to the provisions of this section] is used only for the purpose of identifying the records or information requested in such manner so as not to violate the confidentiality provisions of the social services law.

(e) (1) Every insurer [doing an insurance business in this state or any pension fund, retirement system or other organization required by law to make reports to, or which is subject to examination by, the

department] shall, upon request of an authorized representative of the state office of temporary and disability assistance, or a social services district child support enforcement unit established pursuant to section one hundred eleven-c of the social services law, enter into an agreement with the state office of temporary and disability assistance or a social services district to develop and operate a data match system, using automated data exchanges to the maximum extent feasible, in which each such insurer, pension fund, retirement system or other organization shall provide for each calendar quarter the name, record address, social security number or other taxpayer identification number, and other identifying information for each individual who maintains a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account at such institution and who owes past-due support, as identified by the state office of temporary and disability assistance or a social services district child support enforcement unit by name and social security number or other taxpayer identification number. Nothing herein shall be deemed to limit the authority of a local social services district support collection unit pursuant to section one hundred eleven-h of the social services law.

(2) No insurer[, pension fund, retirement system or other organization] which discloses information pursuant to paragraph one of this subsection, or discloses any financial record to the state office of temporary and disability assistance or a social services district child support enforcement unit for the purpose of enforcing a child support obligation of such person, shall be liable under any law to any person for such disclosure, or for any other action taken in good faith to comply with paragraph one of this subsection.

(F) "INSURER", AS USED IN THIS SECTION, MEANS:

(1) (I) AN INSURER REQUIRED TO BE LICENSED TO DO AN INSURANCE BUSINESS IN THIS STATE UNDER THIS CHAPTER, INCLUDING A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER;

(II) A PENSION FUND, RETIREMENT SYSTEM OR OTHER ORGANIZATION REQUIRED BY LAW TO MAKE REPORTS TO, OR WHICH IS SUBJECT TO EXAMINATION BY, THE SUPERINTENDENT;

(III) A HEALTH MAINTENANCE ORGANIZATION SUBJECT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR

(IV) A SELF-FUNDED PLAN OR ANY OTHER INSURER WITH RESPECT TO ANY MEDICAL CLAIM OR BENEFIT OF A RESIDENT OF THIS STATE; AND

(2) ANY PERSON OR OTHER ENTITY ACTING ON BEHALF OF AN INSURER AS DESCRIBED IN PARAGRAPH ONE OF THIS SUBSECTION WITH RESPECT TO ANY MEDICAL CLAIM OR BENEFIT OF A RESIDENT OF THIS STATE.

S 117-b. Subparagraph (C) of paragraph 3 of subsection (e) of section 3212 of the insurance law, as amended by chapter 822 of the laws of 1987, is amended to read as follows:

(C) No right of subrogation to insurance benefits available under any health insurance policy shall be enforceable unless written notice of the exercise of such subrogation right is received by the carrier within [two] THREE years from the date services for which benefits are provided under the policy or contract are rendered. AN INSURER SHALL NOT DENY A CLAIM MADE IN CONFORMANCE WITH PARAGRAPH (B) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THE SOCIAL SERVICES LAW SOLELY ON THE BASIS OF THE DATE OF SUBMISSION OF THE CLAIM, THE TYPE OR FORMAT OF THE CLAIM FORM, OR A FAILURE TO PRESENT PROPER DOCUMENTATION AT THE POINT-OF-SALE THAT IS THE BASIS OF THE CLAIM.

S 117-c. Section 4311 of the insurance law is REPEALED.

S 118. Intentionally omitted.
S 119. Intentionally omitted.
S 120. Subparagraphs (vi), (vii) and (viii) of paragraph (uu) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, are amended to read as follows:
(vi) [nine] SEVEN million [five] EIGHT hundred THIRTY-THREE thousand THREE HUNDRED THIRTY-THREE dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and [two million] THREE HUNDRED THIRTY-THREE THOUSAND THREE HUNDRED THIRTY-THREE dollars shall be available for telemedicine demonstration programs FOR THE PERIOD JANUARY FIRST, TWO THOUSAND NINE THROUGH MARCH FIRST, TWO THOUSAND NINE;
(vii) [nine] SEVEN million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten[, of which seven million five hundred thousand dollars] shall be available for disease management demonstration programs [and two million dollars shall be available for telemedicine demonstration programs]; and
(viii) [two] ONE million [three] EIGHT hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven[, of which one million eight hundred seventy-five thousand dollars] shall be available for disease management demonstration programs [and five hundred thousand dollars shall be available for telemedicine demonstration programs].
S 121. Section 3621 of the public health law is REPEALED.
S 122. Intentionally omitted.
S 123. Intentionally omitted.
S 123-a. Intentionally omitted.
S 123-b. Intentionally omitted.
S 124. Paragraph (kk) of subdivision 1 of section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, is amended to read as follows:
(kk) Funds shall be deposited by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to the credit of the state special revenue funds -- other, HCRA transfer fund, medical assistance account, or any successor fund or account, for purposes of funding the state share of [Medicaid] MEDICAL ASSISTANCE PROGRAM expenditures [for pharmacy services] from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:
(i) thirty-eight million eight hundred thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;
(ii) up to two hundred ninety-five million dollars for the period January first, two thousand three through December thirty-first, two thousand three;
(iii) up to four hundred seventy-two million dollars for the period January first, two thousand four through December thirty-first, two thousand four;
(iv) up to nine hundred million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
(v) up to eight hundred sixty-six million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

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

(vii) up to five hundred seventy-eight million nine hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; AND

(viii) [up to five hundred fifty-one million dollars for the period] WITHIN AMOUNTS APPROPRIATED ON AND AFTER January first, two thousand nine [through December thirty-first, two thousand nine;

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

(x) up to sixty-one million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven].

S 125. Paragraphs (a) and (b) of subdivision 2 of section 480-a of the tax law, as added by chapter 190 of the laws of 1990, are amended to read as follows:

(a) (I) Every retail dealer and every person owning or, if the owner is not the operator, then any person operating one or more vending machines through which cigarettes or tobacco products are sold in this state, who is required under section eleven hundred thirty-six of this chapter to file a return for the quarterly period ending on the last day of August, nineteen hundred ninety or for the quarterly period ending on the last day of August in any year thereafter, [shall] MUST file an application for registration under this section with [such] THAT quarterly return, in such form as shall be prescribed by the commissioner [of taxation and finance].

(II) Each retail dealer [shall] MUST pay an application fee with [such] THE quarterly return [of one hundred dollars] DESCRIBED BY SUBPARAGRAPH (I) OF THIS PARAGRAPH for each retail place of business in this state through which it sells cigarettes or tobacco products, WHICH IS BASED ON GROSS SALES OF THAT PLACE OF BUSINESS DURING THE PREVIOUS CALENDAR YEAR. THE APPLICATION FEE IS: ONE THOUSAND DOLLARS FOR EACH RETAIL PLACE OF BUSINESS WITH GROSS SALES TOTALING LESS THAN ONE MILLION DOLLARS; TWO THOUSAND FIVE HUNDRED DOLLARS FOR EACH RETAIL PLACE OF BUSINESS WITH GROSS SALES TOTALING AT LEAST ONE MILLION DOLLARS BUT LESS THAN TEN MILLION DOLLARS; AND FIVE THOUSAND DOLLARS FOR EACH RETAIL PLACE OF BUSINESS WITH GROSS SALES TOTALING AT LEAST TEN MILLION DOLLARS.

(III) Every person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state, regardless of whether located on the premises of the vending machine owner or, if the owner is not the operator, then the premises of the operator or the premises of any other person, [shall] MUST pay an application fee with [such] THE quarterly return [of twenty-five dollars] DESCRIBED BY SUBPARAGRAPH (I) OF THIS PARAGRAPH for each [such] vending machine, WHICH IS BASED ON GROSS SALES OF THAT VENDING MACHINE DURING THE PREVIOUS CALENDAR YEAR. THE APPLICATION FEE IS: TWO HUNDRED FIFTY DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING LESS THAN ONE HUNDRED THOUSAND DOLLARS; SIX HUNDRED TWENTY-FIVE DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING AT LEAST ONE HUNDRED THOUSAND DOLLARS BUT LESS THAN ONE MILLION DOLLARS; AND ONE THOUSAND TWO HUNDRED FIFTY DOLLARS FOR EACH VENDING MACHINE WITH GROSS SALES TOTALING AT LEAST ONE MILLION DOLLARS. The department [shall] WILL issue a registration certificate, as

prescribed by the commissioner [of taxation and finance], after receipt of a registration application and the appropriate registration fee, prior to the next succeeding January first.

(b) Every retail dealer and every person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state who commences business after the last day of August, nineteen hundred ninety, or who commences selling cigarettes or tobacco products at retail through a new or different place of business in this state after such date, or who commences selling cigarettes or tobacco products through new or different vending machines after such date, [shall] MUST file with the commissioner [of taxation and finance] an application for registration, in a form prescribed by him OR HER, at least thirty days prior to commencing [such] business or commencing [such] sales. Each [such] application [shall] MUST be accompanied by an application fee [of one hundred dollars] for each retail place of business [to be registered] and [twenty-five dollars for] each vending machine to be registered. THE AMOUNT OF THE APPLICATION FEE IS DETERMINED BY SUBPARAGRAPHS (II) AND (III) OF PARAGRAPH (A) OF THIS SUBDIVISION, EXCEPT THAT ANY RETAIL PLACE OF BUSINESS OR VENDING MACHINE WITH ZERO DOLLARS IN GROSS SALES DURING THE PREVIOUS CALENDAR YEAR IS SUBJECT TO THE LOWEST APPLICATION FEE REQUIRED BY SUCH SUBPARAGRAPHS. The department, within ten days after receipt of an application for registration under this paragraph and payment of the proper fee for application for registration, [shall] WILL issue a registration certificate, as prescribed by the commissioner, for each retail place of business or cigarette or tobacco products vending machine registered.

S 125-a. Subdivision 3 of section 480-a of the tax law, as amended by chapter 262 of the laws of 2000, is amended to read as follows:

3. In addition to any other penalty imposed by this chapter: (a) Any retail dealer who violates the provisions of this section [shall], after due notice and an opportunity for a hearing, for a first violation [be] IS liable for a civil fine not less than five [hundred] THOUSAND dollars but not to exceed [two] TWENTY-FIVE thousand dollars and for a second or subsequent violation within three years following a prior finding of violation [be] IS liable for a civil fine not less than [one] TEN thousand dollars but not to exceed [three thousand five hundred] THIRTY-FIVE THOUSAND dollars; or

(b) Any person who owns or, if the owner is not the operator, then any person who operates one or more vending machines through which cigarettes or tobacco products are sold in this state and who violates the provisions of this section [shall], after due notice and an opportunity for a hearing, for a first violation [be] IS liable for a civil fine not less than [seventy-five] SEVEN HUNDRED FIFTY dollars but not to exceed two [hundred] THOUSAND dollars and for a second or subsequent violation within three years following a prior finding of violation be liable for a civil fine not less than two [hundred] THOUSAND dollars but not to exceed six [hundred] THOUSAND dollars.

S 125-b. Section 482 of the tax law, as amended by section 3 of part RR-1 of chapter 57 of the laws of 2008, is amended to read as follows:

S 482. Deposit and disposition of revenue. (A) All taxes, fees, interest and penalties collected or received by the commissioner under this article and article twenty-A of this chapter shall be deposited and disposed of pursuant to the provisions of section one hundred seventy-one-a of this chapter. (B) From the taxes, interest and penalties collected or received by the commissioner under sections four hundred

seventy-one and four hundred seventy-one-a of this article, effective on and after March first, two thousand, forty-nine and fifty-five hundredths, and effective on and after February first, two thousand two, forty-three and seventy hundredths; and effective on and after May first, two thousand two, sixty-four and fifty-five hundredths; and effective on and after April first, two thousand three, sixty-one and twenty-two hundredths percent; and effective on and after June third, two thousand eight, seventy and sixty-three hundredths percent collected or received under [such] THOSE sections [shall] MUST be deposited to the credit of the tobacco control and insurance initiatives pool to be established and distributed by the commissioner of health in accordance with section twenty-eight hundred seven-v of the public health law. (C) FROM THE FEES COLLECTED OR RECEIVED BY THE COMMISSIONER UNDER SUBDIVISION TWO OF SECTION FOUR HUNDRED EIGHTY-A OF THIS ARTICLE, EFFECTIVE ON OR AFTER SEPTEMBER FIRST, TWO THOUSAND NINE, ANY MONIES COLLECTED OR RECEIVED UNDER THAT SECTION IN EXCESS OF THREE MILLION DOLLARS MUST BE DEPOSITED TO THE CREDIT OF THE TOBACCO CONTROL AND INSURANCE INITIATIVES POOL TO BE DISTRIBUTED BY THE COMMISSIONER OF HEALTH IN ACCORDANCE WITH SECTION TWENTY-EIGHT HUNDRED SEVEN-V OF THE PUBLIC HEALTH LAW.

S 125-c. Subdivisions (a) and (b) of section 92-dd of the state finance law, as added by section 89 of part B of chapter 58 of the laws of 2005, are amended to read as follows:

(a) On and after April first, two thousand five, such fund shall consist of the revenues heretofore and hereafter collected or required to be deposited pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, SUBDIVISIONS (B) AND (C) OF section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law.

(b) The pool administrator under contract with the commissioner of health pursuant to section twenty-eight hundred seven-y of the public health law shall continue to collect moneys required to be collected or deposited pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred seven-c, and sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of the public health law, and shall deposit such moneys in the HCRA resources fund. The comptroller shall deposit moneys collected or required to be deposited pursuant to SUBDIVISIONS (B) AND (C) OF section four hundred eighty-two of the tax law and required to be credited to the tobacco control and insurance initiatives pool, subparagraph (O) of paragraph four of subsection (j) of section four thousand three hundred one of the insurance law, section twenty-seven of part A of chapter one of the laws of two thousand two and all other moneys credited or transferred thereto from any other fund or source pursuant to law in the HCRA resources fund.

S 125-d. The commissioner of health shall establish a home health care reimbursement workgroup for the purposes of studying the home health care reimbursement system. The commissioner of health is authorized to appoint members to the workgroup, including representatives of certified home health agencies, licensed home care services agencies, long term home health care providers, hospice providers, consumers of home health

care services, local governments, labor organizations and other home health care stakeholders.

Such study shall include but not be limited to an analysis of:

(a) the impact of episodic payments on high-utilization and outlier thresholds, special needs populations, and dual eligible patients;

(b) the relationship between, or compatibility of, Medicare and Medicaid episodic payments;

(c) billing procedures related to cash flow of episodic payments;

(d) wage index factor adjustments; and

(e) subcontracting between certified home health agencies, long term home health care agencies, and AIDS home care programs with licensed home care services agencies.

The commissioner of health shall report to the temporary president of the senate, the speaker of the assembly, the chairs of the senate finance committee and assembly committee on ways and means, and the chairs of the senate and assembly health committees. Such report shall be submitted no later than December first, two thousand nine.

S 125-e. Section 364-j-2 of the social services law, as amended by section 44-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 364-j-2. Transitional supplemental payments. 1. As used in this section, "covered provider" shall mean a voluntary not-for-profit health care provider that is any of the following:

(a) a freestanding diagnostic and treatment center licensed under article twenty-eight of the public health law that qualifies for a distribution pursuant to section twenty-eight hundred seven-p of such article, or section seven of chapter four hundred thirty-three of the laws of nineteen hundred ninety-seven, or receives funding under section three hundred thirty-three of the federal public health services act for health care for the homeless; or

(b) a freestanding diagnostic and treatment center which operates an approved program under the prenatal care assistance program established pursuant to article twenty-five of the public health law; or

(c) a facility licensed under article twenty-eight of the public health law that is sponsored by a university or dental school which has been granted an operating certificate pursuant to article twenty-eight of the public health law to provide dental services; or

(d) a freestanding family planning clinic licensed under article twenty-eight of the public health law.

2. (a) Notwithstanding paragraphs (b) and (h) of subdivision two of section twenty-eight hundred seven of the public health law, the commissioner of health shall make supplemental payments of nine million eight hundred twenty-four thousand dollars ($9,824,000), to covered providers described in subdivision one of this section who are qualified providers as described in paragraph (a) of subdivision three of this section, based on adjustments to fee-for-service rates for the period February first through March thirty-first, two thousand two and nine million eight hundred twenty-four thousand dollars ($9,824,000) for the period October first through December thirty-first, two thousand two and four million nine hundred twelve thousand dollars ($4,912,000) for the period October first through December thirty-first, two thousand three and an additional amount of four million nine hundred twelve thousand dollars ($4,912,000) for the period October first through December thirty-first, two thousand three and nine million eight hundred twenty-four thousand dollars ($9,824,000) for the period April first through June thirtieth, two thousand five, and nine million eight hundred twenty-four thousand

dollars ($9,824,000) for the period October first through December thirty-first, two thousand six, and an additional nine million eight hundred twenty-four thousand dollars ($9,824,000) for the period October first through December thirty-first, two thousand six, and nine million eight hundred twenty-four thousand dollars ($9,824,000) for the period October first through December thirty-first, two thousand seven, as medical assistance payments for services provided pursuant to this title for persons eligible for federal financial participation under title XIX of the federal social security act to reflect additional costs associated with the transition to a managed care environment, and nine million eight hundred twenty-four thousand dollars ($9,824,000) for the period October first through December thirty-first, two thousand eight, AND SEVEN MILLION THREE HUNDRED EIGHTY-EIGHT THOUSAND DOLLARS ($7,388,000) FOR THE PERIOD OCTOBER FIRST THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE, as medical assistance payments for services provided pursuant to this title for persons eligible for federal financial participation under title XIX of the federal social security act to reflect additional costs associated with the operation of electronic health record systems that meet such standards as may be established by the commissioner of health. There shall be no local share in these payments. The director of the budget shall allocate the non-federal share of such payments from an appropriation for the miscellaneous special revenue fund - 339 community service provider assistance program account for the two thousand one--two thousand two state fiscal year for adjustments for the period February first through March thirty-first, two thousand two. Adjustments for the period October first, two thousand two through December thirty-first, two thousand two shall be within amounts appropriated for the two thousand two--two thousand three state fiscal year and adjustments for the period October first, two thousand three through December thirty-first, two thousand three shall be within amounts appropriated for the two thousand three--two thousand four state fiscal year and adjustments for the non-federal share of the additional amount of four million nine hundred twelve thousand dollars ($4,912,000) for such period shall be allocated by the director of the budget from an appropriation for maintenance undistributed general fund community projects fund - 007 account for the two thousand three--two thousand four state fiscal year. The director of the budget shall allocate the non-federal share of adjustments for the period April first, two thousand five through June thirtieth, two thousand five from an appropriation for the maintenance undistributed general fund community projects fund - 007 - cc account for the two thousand four--two thousand five state fiscal year. The director of the budget shall allocate the non-federal share of adjustments for the period October first, two thousand six through December thirty-first, two thousand six from an appropriation for the maintenance undistributed, general fund, community projects fund - 007-cc account for the two thousand five--two thousand six state fiscal year. The director of the budget shall allocate the non-federal share of the additional adjustments for the period October first, two thousand six through December thirty-first, two thousand six from such funds as may be made available from an appropriation for the maintenance undistributed, general fund, community projects fund - 007-cc account for the two thousand six--two thousand seven state fiscal year. The director of the budget shall allocate the non-federal share of the adjustments for the period October first, two thousand seven through December thirty-first, two thousand seven from an appropriation for the medical assistance program, general fund, local assistance account - 001 for the two thousand seven--two

thousand eight state fiscal year. The director of the budget shall allocate the non-federal share of the adjustments for the period October first, two thousand eight through December thirty-first, two thousand eight from an appropriation for the medical assistance program, general fund, local assistance account - 001 for the two thousand eight--two thousand nine state fiscal year. THE DIRECTOR OF THE BUDGET SHALL ALLOCATE THE NON-FEDERAL SHARE OF THE ADJUSTMENTS FOR THE PERIOD OCTOBER FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE FROM AN APPROPRIATION FOR THE MEDICAL ASSISTANCE PROGRAM, GENERAL FUND, LOCAL ASSISTANCE ACCOUNT - 001 FOR THE TWO THOUSAND NINE--TWO THOUSAND TEN STATE FISCAL YEAR. Such adjustments to fee for service rates shall not be subject to subsequent adjustment or reconciliation. Alternatively, such payments may be made as aggregate payments to eligible providers.

(a-1) Notwithstanding the provisions of paragraph (a) of this subdivision, for facilities licensed under article twenty-eight of the public health law that are sponsored by a university or dental school which has been granted an operating certificate pursuant to article twenty-eight of the public health law and which provides dental services as its principal mission, two hundred twenty-four thousand dollars ($224,000) in the aggregate for use pursuant to this section shall be allocated for distribution to such facilities pursuant to the methodology described in paragraph (b) of subdivision two and subparagraph (i) of paragraph (b) of subdivision four of section two thousand eight hundred seven-p of the public health law for services provided for the period February first, two thousand two through March thirty-first, two thousand two to persons eligible for federal financial participation under title XIX of the federal social security act, provided, however, that the amount paid pursuant to this paragraph for each such facility shall equal the facility's proportional share of the total nominal payment amounts calculated under this section of all such facilities multiplied by the total funds allocated for such payments. There shall be no local share in these payments. The director of the budget shall allocate the non-federal share of such payments from an appropriation for the miscellaneous special revenue fund - 339 community service provider assistance program account for the two thousand one--two thousand two state fiscal year. Such adjustments to fee for service rates shall not be subject to subsequent adjustment or reconciliation. Alternatively, such payments may be made as aggregate payments to eligible providers.

(a-2) (i) Notwithstanding the provisions of paragraph (a) of this subdivision, for facilities licensed under article twenty-eight of the public health law that are sponsored by a university or dental school which has been granted an operating certificate pursuant to article twenty-eight of the public health law and which provides dental services as its principal mission, two hundred twenty-four thousand dollars ($224,000) in the aggregate of the amount appropriated for the two thousand two--two thousand three state fiscal year for use pursuant to this section shall be allocated for the period October first through December thirty-first, two thousand two and one hundred twelve thousand dollars ($112,000) in the aggregate of the amount appropriated for the two thousand three--two thousand four state fiscal year, and an additional amount of one hundred twelve thousand dollars ($112,000) in the aggregate for use pursuant to this section shall be allocated for the period October first through December thirty-first, two thousand three and two hundred twenty-four thousand dollars ($224,000) in the aggregate of the amount appropriated for the two thousand four--two thousand five state

fiscal year shall be allocated for the period April first, two thousand five through June thirtieth, two thousand five, and two hundred twenty-four thousand dollars ($224,000) in the aggregate of the amount appropriated for the two thousand five--two thousand six state fiscal year shall be allocated for the period October first, two thousand six through December thirty-first, two thousand six, and an additional two hundred twenty-four thousand dollars ($224,000) in the aggregate of the amount appropriated for the two thousand six--two thousand seven state fiscal year shall be allocated for the period October first, two thousand six through December thirty-first, two thousand six, and two hundred twenty-four thousand dollars ($224,000) in the aggregate of the amount appropriated for the two thousand seven--two thousand eight state fiscal year shall be allocated for the period October first, two thousand seven through December thirty-first, two thousand seven, and two hundred twenty-four thousand DOLLARS ($224,000) in the aggregate of the amount appropriated for the two thousand eight--two thousand nine state fiscal year shall be allocated for the period October first, two thousand eight through December thirty-first, two thousand eight AND TWO HUNDRED TWENTY-FOUR THOUSAND DOLLARS ($224,000) IN THE AGGREGATE OF THE AMOUNT APPROPRIATED FOR THE TWO THOUSAND NINE--TWO THOUSAND TEN STATE FISCAL YEAR SHALL BE ALLOCATED FOR THE PERIOD OCTOBER FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE for distribution to such facilities pursuant to subparagraphs (ii) and (iii) of this paragraph. Adjustments for the non-federal share of the additional amount of one hundred twelve thousand dollars ($112,000) for the period October first, two thousand three through December thirty-first, two thousand three shall be allocated by the director of the budget from an appropriation for maintenance undistributed general fund community projects fund - 007 account for the two thousand three--two thousand four state fiscal year. The non-federal share of adjustments for the period April first, two thousand five through June thirtieth, two thousand five shall be allocated by the director of the budget from an appropriation for the maintenance undistributed general fund community projects fund - 007 account for the two thousand four--two thousand five state fiscal year. The non-federal share of adjustments for the period October first, two thousand six through December thirty-first, two thousand six shall be allocated by the director of the budget from an appropriation for the maintenance undistributed, general fund, community projects fund - 007-cc account for the two thousand five--two thousand six state fiscal year. The non-federal share of the additional adjustments for the period October first, two thousand six through December thirty-first, two thousand six shall, subject to the availability of funds, be allocated by the director of the budget from the medical assistance local assistance appropriation for the two thousand six--two thousand seven state fiscal year. The non-federal share of the adjustments for the period October first, two thousand seven through December thirty-first, two thousand seven shall be allocated by the director of the budget from an appropriation for the medical assistance program, general fund, local assistance account - 001 for the two thousand seven--two thousand eight state fiscal year. The non-federal share of the adjustments for the period October first, two thousand eight through December thirty-first, two thousand eight shall be allocated by the director of the budget from an appropriation for the medical assistance program, general fund, local assistance account - 001 for the two thousand eight--two thousand nine state fiscal year. THE NON-FEDERAL SHARE OF THE ADJUSTMENTS FOR THE PERIOD OCTOBER FIRST, TWO THOUSAND NINE

THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE SHALL BE ALLOCATED BY THE DIRECTOR OF THE BUDGET FROM AN APPROPRIATION FOR THE MEDICAL ASSISTANCE PROGRAM, GENERAL FUND, LOCAL ASSISTANCE ACCOUNT - 001 FOR THE TWO THOUSAND NINE--TWO THOUSAND TEN STATE FISCAL YEAR.

(ii) Forty percent shall be allocated for equal distribution to such facilities, reduced by the amount, if any, that a distribution exceeds forty percent of a facility's uncompensated care need as defined in paragraph (b) of subdivision two of section two thousand eight hundred seven-p of the public health law. Any funds allocated but not distributed in accordance with this subparagraph shall be added to those amounts distributed in accordance with subparagraph (iii) of this paragraph.

(iii) Sixty percent, plus any funds allocated and not distributed in accordance with subparagraph (ii) of this paragraph, shall be allocated for distribution to such facilities pursuant to the methodology described in paragraph (b) of subdivision two and subparagraph (i) of paragraph (b) of subdivision four of section two thousand eight hundred seven-p of the public health law, provided, however, that the amount paid pursuant to this allocation for each such facility shall equal the facility's proportional share of the total nominal payment amounts calculated under this section of all such facilities multiplied by the total funds allocated for such payments.

(iv) There shall be no local share in these payments.

(b) Notwithstanding the provisions of subdivision one of section three hundred sixty-eight-a of this title, there shall be paid to each social services district the full amount expended on behalf of the department of health for medical assistance furnished pursuant to the provisions of this section, after first deducting therefrom any federal funds properly received or to be received on account thereof.

3. (a) For periods prior to January first, two thousand eight, a covered provider described in subdivision one of this section shall be qualified to receive a supplemental payment only if its number of medicaid visits for patient care services in the base year described in subparagraph (ii) of paragraph (b) of this subdivision equals or exceeds twenty-five percent of its total number of visits for patient care services and its number of medicaid visits for patient care services for medicaid managed care enrollees equals or exceeds three percent of its total number of medicaid visits during the base year. For periods on and after January first, two thousand eight, a covered provider described in subdivision one of this section shall be qualified to receive a supplemental payment only if it has in place during such period an operational electronic health record system that meets such standards as may be established by the commissioner of health and its number of medicaid visits for patient care services in the base year described in subparagraph (ii) of paragraph (b) of this subdivision equals or exceeds twenty-five percent of its total number of visits for patient care services during the base year or its number of medicaid visits combined with its number of uninsured visits for patient care services in the base year described in subparagraph (ii) of paragraph (b) of this subdivision equals or exceeds thirty percent of its total number of visits for patient care services during the base year.

(b) (i) For periods prior to January first, two thousand eight, each qualified provider described in paragraph (a) of this subdivision shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated pursuant to this section, based upon the ratio of its visits from medical assistance recipients enrolled in

managed care during the base year to the total number of visits to all such qualified providers by medical assistance recipients enrolled in managed care during the base year. For periods on and after January first, two thousand eight, each qualified provider described in paragraph (a) of this subdivision shall receive a supplemental payment equal to such provider's proportional share of the total funds allocated pursuant to this section, based upon the ratio of its visits from medical assistance recipients during the base year to the total number of visits from medical assistance recipients to all such qualified providers during the base year.

(ii) For periods prior to January first, two thousand eight, for purposes of the calculation described in this subdivision, the base year will be two thousand, and the commissioner of health shall utilize data as reported on the 2000 AHCF-1 cost report initially submitted by covered providers to the department of health on or about August seventeenth, two thousand one. For periods on and after January first, two thousand eight, for purposes of the calculation described in this subdivision, the base year will be two years prior to the grant year, and the commissioner of health shall utilize data as reported on AHCF-1 cost report submitted by covered providers to the department of health for such base year.

4. Payments made pursuant to this section shall constitute additional reimbursement to qualified providers and shall not be used to reduce levels of other funding provided to qualified providers by governmental agencies.

5. (a) The commissioner of health shall make medical assistance payments to qualified providers from funds made available pursuant to the provisions of this section contingent upon the receipt of all federal approvals necessary and subject to the availability of federal financial participation under title XIX of the federal social security act for the transitional supplemental payments. In the event such federal approval is not received prior to March thirty-first, two thousand two, for adjustments for the period February first, two thousand two through March thirty-first, two thousand two and prior to October first, two thousand two for adjustments for the period October first, two thousand two through December thirty-first, two thousand two and prior to October first, two thousand three for adjustments for the period October first, two thousand three through December thirty-first, two thousand three, and prior to October first, two thousand five for adjustments for the period April first, two thousand five through June thirtieth, two thousand five, and prior to October first, two thousand six for adjustments for the period October first, two thousand six through December thirty-first, two thousand six, and prior to October first, two thousand seven for adjustments for the period October first, two thousand seven through December thirty-first, two thousand seven, and prior to October first, two thousand eight for adjustments for the period October first, two thousand eight through December thirty-first, two thousand eight, AND PRIOR TO OCTOBER FIRST, TWO THOUSAND NINE FOR ADJUSTMENTS FOR THE PERIOD OCTOBER FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE, the commissioner of health shall make medical assistance payments to qualified providers consisting of the state share amount available for purposes of this section and apportioned in accordance with subdivisions two and three of this section. In the event such federal approval is denied, such state share amount payments shall be deemed to be grants to such qualified providers and such qualified

providers shall not be eligible to receive any other payments pursuant to this section.

(b) The commissioner of health shall take all steps necessary and shall use best efforts to secure federal financial participation under title XIX of the social security act, for the purposes of this section, including the prompt submission of appropriate amendments to the title XIX state plan.

S 126. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 127. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of subdivisions 4, 7, 7-a and 7-b of section 2807 of the public health law and section 18 of chapter 2 of the laws of 1988, as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and shall, for purposes of implementing the provisions of this act, be deemed to have been without any force or effect from and after October 1, 2008 for such rates effective for the period January 1, 2008 through December 31, 2008.

S 128. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 129. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009; provided that:

(a) sections fifteen, sixteen and sixteen-a shall be deemed to be in effect on and after March 1, 2009;

(b) sections twenty-five, twenty-six-a, sixty-two and one hundred ten through one hundred twelve of this act shall take effect July 1, 2009;

(c) sections thirty-eight, thirty-nine, forty-six, forty-seven and forty-eight of this act shall take effect September 1, 2009;

(d) sections fifty-eight, fifty-nine, fifty-nine-a, fifty-nine-b, fifty-nine-c and fifty-nine-d of this act shall take effect October 1, 2009;

(e) sections sixty, sixty-one, sixty-three through sixty-seven, sixty-seven-a and sixty-seven-b of this act shall take effect April 1, 2010;

(f) section twenty-five of this act shall expire and be deemed repealed April 1, 2013;

(g) section twenty-six-a of this act shall expire and be deemed repealed April 1, 2014;

(h-1) section one hundred twenty-five of this act applies only to fees related to applications for registration for the 2010 calendar year and thereafter;

(h-2) sections one hundred twenty-five-a, one hundred twenty-five-b, and one hundred twenty-five-c of this act shall take effect September 1, 2009;

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

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

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

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

(m) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act;

(n) the amendments to section 364-f of the social services law made by section thirty of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(o) the amendments to paragraph (a-1) of subdivision 4 of section 365-a of the social services law made by section forty-six of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(p) the amendments to subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law made by section forty-seven of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(q) the amendments to subdivision 9 of section 367-a of the social services law made by sections forty-eight and forty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(q-1) the amendments made to subdivisions 5 and 7 of section 270 of the public health law by section thirty-five of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

(q-2) the amendments made to subdivision 11 of section 272 of the public health law by section thirty-six of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

(q-3) the amendments made to subdivision 1 of section 273 of the public health law by section thirty-seven of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

(q-4) the amendments made to paragraph (a-2) of subdivision 4 of section 365-a of the social services law by section forty-six-a of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

(r) section sixty-eight of this act shall take effect on the same date and in the same manner as the amendments made to subparagraph (iii) of paragraph (a) of subdivision 2 of section 369-ee of the social services law by section 28 of part E of chapter 63 of the laws of 2005, takes effect;

(s) the amendments to section 2807-s of the public health law made by sections one hundred and one hundred fourteen of this act shall not

affect the expiration of such section and shall be deemed to expire therewith;

(t) the amendments to paragraph (c) of subdivision 5-a of section 2807-k of the public health law made by section one hundred two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith; and

(u) section twenty-seven shall be deemed effective on and after January 1, 2010, provided, however, that with regard to smoking cessation counseling services provided to pregnant women pursuant to paragraph (s) of subdivision 2 of section 365-a of the social services law such section twenty-seven shall be deemed effective on and after March 1, 2009, and with regard to screening, brief intervention, referral and treatment provided pursuant to paragraph (u) of subdivision 2 of section 365-a of the social services law, such sections shall be deemed effective on and after April 1, 2009.

PART D

Section 1. The legislature finds that New York leads the nation in Medicaid spending on long-term care services and that Medicaid spending on home and personal care services are among the fastest growing areas of Medicaid expenditure despite the fact that the number of beneficiaries receiving these services has not increased. Current processes for assessing the service needs of elderly and disabled beneficiaries do not consistently result in appropriate placement and services and show wide variation across the state. Current reimbursement levels and methodologies do not ensure quality or efficiency, with providers in the same community serving comparable populations receiving markedly different Medicaid payments. It is the intent of this legislation to ensure that elderly and disabled beneficiaries have access to the right level of care in the most appropriate setting; to implement transparent and accurate reimbursement systems for nursing and home care services; and to reward quality and efficiency as well as to make targeted investments to improve long-term care services.

S 1-a. Short title. This act shall be known and may be cited as "The Long-Term Care Reform Act".

S 2. 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 3. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 3 of part I of chapter 2 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 4. Subdivision 17-a of section 2808 of the public health law, as amended by section 73 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

17-a. Notwithstanding any inconsistent provision of law or regulation to the contrary, for purposes of establishing rates of payment by governmental agencies for residential health care facilities for services provided on and after January first, nineteen hundred ninety-eight, the regional direct and indirect input price adjustment factors to be applied to any such facility's rate calculation shall be based upon the utilization of either nineteen hundred eighty-three, nineteen hundred eighty-seven or nineteen hundred ninety-three calendar year financial and statistical data and for periods beginning April first,

two thousand four through March thirty-first, two thousand nine based on either nineteen hundred eighty-three, nineteen hundred eighty-seven, nineteen hundred ninety-three or two thousand one calendar year financial and statistical data; provided, however, the state share amount for the utilization of two thousand one calendar year data shall be no more than twenty-two million dollars on a pro rata basis per calendar year. The determination of which calendar year's data to utilize shall be based upon a methodology that ensures that the particular year chosen by each facility results in a factor that yields no less reimbursement to the facility than would result from the use of any of the other three years' data. Such methodology shall utilize the nineteen hundred eighty-three and nineteen hundred eighty-seven regional direct and indirect input price adjustment factor corridor percentages in existence on January first, nineteen hundred ninety-seven as well as nineteen hundred ninety-three regional direct and indirect input price adjustment factor corridor percentage in existence on January first, two thousand four as well as a two thousand one regional direct and indirect input price adjustment factor corridor percentage calculated in the same manner as the nineteen hundred ninety-three direct and indirect input price adjustment factor corridor percentages in existence on January first, two thousand four; provided, however, for rate periods on and after April first, two thousand nine, the regional input price adjustment factors shall be based on the case mix predicted staffing for registered nurses, licensed practical nurses, nurses' aides, licensed therapists and therapist aides. For the rate period beginning April first, two thousand nine through [December thirty-first, two thousand nine] MARCH THIRTY-FIRST, TWO THOUSAND TEN, the regional direct and indirect input price adjustment factors to be applied to a facility's rate calculation shall be based upon the utilization of two thousand two calendar year financial and statistical data. Such methodology shall utilize two thousand two regional direct and indirect input price adjustment factor corridor percentages calculated in the same manner as the two thousand one regional direct and indirect input price adjustment factor corridor percentages in existence on December thirty-first, two thousand six except that every region shall receive a corridor to reflect the region's actual variation subject to a maximum statewide average variable corridor percentage of ten percent. [For the rate periods beginning January first, two thousand ten through December thirty-first, two thousand eleven, the regional direct and indirect input price adjustment factors to be applied to a facility's rate calculation shall be based upon the utilization of two thousand eight calendar year financial and statistical data. Such methodology shall utilize two thousand eight regional direct and indirect input price adjustment factor corridor percentages calculated in the same manner as the two thousand two regional direct and indirect input price adjustment factor corridor percentages, with every region receiving a corridor to reflect the region's actual variation subject to a maximum statewide average variable corridor percentage of ten percent. For the three year period beginning January first, two thousand twelve, the regional direct price and indirect input price adjustment factors and the regional direct and indirect input price adjustment factor corridor percentages shall be based upon the utilization of financial and statistical data from the base period used for the operating component of rates for the two thousand twelve rate period pursuant to paragraph (f) of subdivision two-b of this section.]

S 5. Section 2808 of the public health law is amended by adding a new subdivision 2-c to read as follows:

2-C. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE OPERATING COSTS OF RATES OF PAYMENT BY GOVERNMENTAL AGENCIES FOR INPATIENT SERVICES PROVIDED BY RESIDENTIAL HEALTH CARE FACILITIES ON AND AFTER APRIL FIRST, TWO THOUSAND TEN SHALL BE DETERMINED IN ACCORDANCE WITH THE FOLLOWING:

(I) THE DIRECT AND INDIRECT COMPONENTS OF THE OPERATING COST COMPONENT OF SUCH RATES WILL BE COMPUTED ON A REGIONAL BASIS, USING ALLOWABLE OPERATING COSTS, AS DETERMINED BY THE COMMISSIONER, FROM TWO THOUSAND SEVEN CERTIFIED COST REPORTS ON FILE WITH THE DEPARTMENT AS OF JANUARY FIRST, TWO THOUSAND NINE, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH APPLICABLE STATUTES.

(II) THE NON-COMPARABLE COMPONENT OF THE OPERATING COMPONENT OF SUCH RATES SHALL BE COMPUTED ON A FACILITY SPECIFIC BASIS, USING ALLOWABLE OPERATING COSTS, AS DETERMINED BY THE COMMISSIONER, FROM TWO THOUSAND SEVEN CERTIFIED COST REPORT SUBMITTED BY EACH FACILITY AND ON FILE WITH THE DEPARTMENT ON JANUARY FIRST, TWO THOUSAND NINE, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH APPLICABLE STATUTES.

(III) THE CAPITAL COMPONENT OF RATES COMPUTED PURSUANT TO THIS SECTION SHALL FULLY REFLECT THE COST OF LOCAL PROPERTY TAXES AND PAYMENTS MADE IN LIEU OF LOCAL PROPERTY TAXES, AS REPORTED IN EACH FACILITY'S COST REPORT SUBMITTED FOR THE YEAR TWO YEARS PRIOR TO THE RATE YEAR.

(IV) THE DIRECT COMPONENT OF THE OPERATING COMPONENT OF RATES SHALL BE SUBJECT TO CASE MIX ADJUSTMENT THROUGH APPLICATION OF THE MINIMUM DATA SET (MDS) CLASSIFICATION EMPLOYED BY THE FEDERAL GOVERNMENT WITH REGARD TO PAYMENTS TO SKILLED NURSING FACILITIES PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT (MEDICARE) TO REFLECT PATIENT SERVICE INTENSITY, AS MAY BE ADJUSTED BY THE COMMISSIONER. SUCH ADJUSTMENTS SHALL BE MADE SEMI-ANNUALLY IN EACH CALENDAR YEAR, AND BOTH THE ADJUSTMENTS AND THE RELATED PATIENT CLASSIFICATIONS IN EACH FACILITY SHALL BE SUBJECT TO AUDIT REVIEW IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE COMMISSIONER.

(V) NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION OR ANY OTHER CONTRARY PROVISION OF LAW, RULE OR REGULATION, RATES OF PAYMENT SHALL, EXCEPT FOR THE ESTABLISHMENT OF ANY REGIONAL PRICES, BE CALCULATED UTILIZING THE NUMBER OF PATIENTS REPORTED IN EACH PATIENT CLASSIFICATION GROUP AND ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW.

(VI) NOTWITHSTANDING SUBPARAGRAPH (I) OF THIS PARAGRAPH, THE OPERATING COST COMPONENT OF THE RATES, EFFECTIVE APRIL FIRST, TWO THOUSAND TEN FOR THE FOLLOWING CATEGORIES OF FACILITIES, AS ESTABLISHED PURSUANT TO APPLICABLE REGULATIONS, SHALL REFLECT THE RATES IN EFFECT FOR SUCH FACILITIES ON MARCH THIRTY-FIRST, TWO THOUSAND TEN, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH APPLICABLE STATUTES: (A) AIDS FACILITIES OR DISCRETE AIDS UNITS WITHIN FACILITIES, (B) DISCRETE UNITS FOR RESIDENTS RECEIVING CARE IN A LONG-TERM INPATIENT REHABILITATION PROGRAM FOR TRAUMATIC BRAIN INJURED PERSONS, (C) DISCRETE UNITS PROVIDING SPECIALIZED PROGRAMS FOR RESIDENTS REQUIRING BEHAVIORAL INTERVENTIONS, (D) DISCRETE UNITS FOR LONG-TERM VENTILATOR DEPENDENT RESIDENTS, AND (E) FACILITIES OR DISCRETE UNITS WITHIN FACILITIES THAT PROVIDE EXTENSIVE NURSING, MEDICAL, PSYCHOLOGICAL AND COUNSELING SUPPORT SERVICES SOLELY TO CHILDREN. SUCH RATE SHALL REMAIN IN EFFECT UNTIL THE DEPARTMENT, IN CONSULTATION WITH REPRESENTATIVES OF THE NURSING HOME INDUSTRY, AS SELECTED BY

THE COMMISSIONER, DEVELOPS A REGIONAL PRICING OR ALTERNATIVE METHODOLOGY FOR DETERMINING SUCH RATES.

(VII) THE OPERATING COMPONENT OF RATES OF PAYMENT, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH, SHALL, BY NO LATER THAN THE TWO THOUSAND THIRTEEN RATE PERIOD, BE BASED ON ALLOWABLE COSTS, AS REPORTED ON ANNUAL FACILITY COST REPORTS SUBMITTED AS REQUIRED BY THE COMMISSIONER, FROM A BASE YEAR PERIOD NO EARLIER THAN THREE YEARS PRIOR TO THE INITIAL RATE YEAR. THEREAFTER, THE BASE YEAR UTILIZED FOR RATE-SETTING PURPOSES SHALL BE UPDATED TO BE CURRENT NO LESS FREQUENTLY THAN EVERY SIX YEARS; PROVIDED, HOWEVER, THAT FOR THE PURPOSES OF THIS PARAGRAPH, CURRENT SHALL MEAN THAT THE OPERATING COMPONENTS OF THE INITIAL RATE YEAR, UTILIZING SUCH UPDATED BASE YEAR, SHALL REFLECT ALLOWABLE COSTS AS REPORTED IN ANNUAL FACILITY COST REPORTS FOR PERIODS NO EARLIER THAN THREE YEARS PRIOR TO SUCH INITIAL RATE YEAR, AS ADJUSTED FOR INFLATION IN ACCORDANCE WITH SUBPARAGRAPH (I) OF THIS PARAGRAPH.

(B) THE OPERATING COMPONENT OF RATES MAY BE ADJUSTED TO REFLECT A PER DIEM ADD-ON, AS DETERMINED BY THE COMMISSIONER, FOR THE FOLLOWING PATIENTS: (I) EACH PATIENT WHOSE BODY MASS INDEX IS GREATER THAN THIRTY-FIVE; (II) EACH PATIENT WHO QUALIFIES UNDER THE RUG-III IMPAIRED COGNITION AND BEHAVIORAL PROBLEMS CATEGORIES, OR HAS BEEN DIAGNOSED WITH ALZHEIMER'S DISEASE OR DEMENTIA, AND IS CLASSIFIED IN THE REDUCED PHYSICIAN FUNCTIONS A, B, OR C, OR IN BEHAVIORAL PROBLEMS A OR B CATEGORIES, AND HAS AN ACTIVITIES OF DAILY LIVING INDEX SCORE OF LESS THAN TEN; AND (III) EACH PATIENT WHO QUALIFIES FOR EXTENDED CARE AS A RESULT OF TRAUMATIC BRAIN INJURY AS DEFINED BY APPLICABLE REGULATIONS.

(C) THE COMMISSIONER MAY PROMULGATE REGULATIONS TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

(D) (I) SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A QUALITY OF CARE INCENTIVE POOL OR POOLS FOR ELIGIBLE RESIDENTIAL HEALTH CARE FACILITIES AND INCREASE MEDICAID RATES OF PAYMENT FOR SUCH ELIGIBLE FACILITIES FROM THIS POOL OR POOLS. WITHIN AMOUNTS AVAILABLE, PAYMENTS WILL BE DETERMINED BY THE COMMISSIONER BY APPLYING CRITERIA, INCLUDING, BUT NOT LIMITED TO, THE QUALITY COMPONENTS OF THE MINIMUM DATA SET REQUIRED UNDER FEDERAL LAW, SURVEY INFORMATION, DIRECT CARE STAFFING, INCLUDING LABOR COSTS, AND OTHER FACILITY DATA.

(II) FACILITIES THAT FALL WITHIN ONE OR MORE OF THE CATEGORIES BELOW DURING A REVIEW PERIOD WILL BE EXCLUDED FROM AWARD ELIGIBILITY:

(A) ANY RESIDENTIAL HEALTH CARE FACILITY THAT IS CURRENTLY DESIGNATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS A "SPECIAL FOCUS FACILITY";

(B) ANY RESIDENTIAL HEALTH CARE FACILITY FOR WHICH THE DEPARTMENT HAS ISSUED A FINDING OF IMMEDIATE JEOPARDY DURING THE MOST RECENTLY COMPLETED FEDERAL FISCAL YEAR;

(C) ANY RESIDENTIAL HEALTH CARE FACILITY THAT HAS RECEIVED A CITATION FOR SUBSTANDARD QUALITY OF CARE IN THE AREAS OF QUALITY OF LIFE, QUALITY OF CARE, RESIDENT BEHAVIOR, AND/OR FACILITY PRACTICES DURING THE MOST RECENTLY COMPLETED FEDERAL FISCAL YEAR;

(D) ANY RESIDENTIAL HEALTH CARE FACILITY THAT IS PART OF A CONTINUING CARE RETIREMENT COMMUNITY;

(E) ANY RESIDENTIAL HEALTH CARE FACILITY THAT OPERATES AS A TRANSITIONAL CARE UNIT; AND

(F) ANY OTHER EXCLUSIONS AS DEEMED APPROPRIATE BY THE COMMISSIONER.

(III) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION TO THE CONTRARY, IN THE EVENT THAT THE TOTAL AMOUNT OF FUNDING ALLOCATED

FOR A PARTICULAR FISCAL YEAR IS NOT DISTRIBUTED, FUNDS SHALL BE RESERVED AND ACCUMULATED FROM YEAR TO YEAR SO THAT ANY FUNDS REMAINING AT THE END OF A PARTICULAR FISCAL YEAR WILL BE AVAILABLE FOR DISTRIBUTION DURING THE FOLLOWING FISCAL YEAR.

(E) SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION AND WITHIN AMOUNTS AVAILABLE, THE COMMISSIONER MAY MAKE TRANSITION ADJUSTMENTS TO RATES OF PAYMENT FOR RESIDENTIAL HEALTH CARE FACILITIES FOR STATE FISCAL YEARS BEGINNING APRIL FIRST, TWO THOUSAND TEN TO FACILITATE IMPROVEMENTS IN RESIDENTIAL HEALTH CARE FACILITY OPERATIONS AND FINANCES IN ACCORDANCE WITH THE FOLLOWING:

(I) RESIDENTIAL HEALTH CARE FACILITIES ELIGIBLE FOR DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH SHALL BE THOSE NON-PUBLIC FACILITIES AND STATE OPERATED PUBLIC RESIDENTIAL HEALTH CARE FACILITIES, WHICH HAVE AN AVERAGE ANNUAL MEDICAID UTILIZATION PERCENTAGE OF FIFTY PERCENT OR GREATER FOR THE TWO YEARS PRIOR TO THE RATE YEAR AND WHICH, AS DETERMINED BY THE COMMISSIONER, EXPERIENCE A REDUCTION IN THEIR MEDICAID REVENUE OF A PERCENTAGE AS DETERMINED BY THE COMMISSIONER AS A RESULT OF THE APPLICATION OF REGIONAL PRICING AS DESCRIBED IN THIS SUBDIVISION.

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

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

(IV) EACH RESIDENTIAL HEALTH CARE FACILITY RECEIVING FUNDS PURSUANT TO THIS PARAGRAPH SHALL, AS A CONDITION FOR ELIGIBILITY FOR SUCH FUNDS, ADOPT A RESOLUTION OF THE BOARD OF DIRECTORS OR SUBMIT A REPORT BY THE OWNER ACCEPTABLE TO THE COMMISSIONER SETTING FORTH ITS CURRENT FINANCIAL CONDITION AND A PLAN FOR REFORMING AND IMPROVING SUCH FINANCIAL CONDITION, INCLUDING ONGOING BOARD OR OWNER OVERSIGHT, AND SHALL, AFTER TWO YEARS, ISSUE A REPORT AS ADOPTED BY EACH SUCH BOARD OR ISSUE A FURTHER REPORT BY THE OWNER ACCEPTABLE TO THE COMMISSIONER SETTING FORTH WHAT PROGRESS HAS BEEN ACHIEVED REGARDING SUCH IMPROVEMENT, PROVIDED, HOWEVER, IF SUCH FURTHER REPORT IS NOT SUBMITTED TO THE COMMISSIONER, OR IF SUCH FURTHER REPORT FAILS TO SET FORTH ADEQUATE PROGRESS, AS DETERMINED BY THE COMMISSIONER, THE COMMISSIONER MAY DEEM SUCH FACILITY INELIGIBLE FOR FURTHER DISTRIBUTIONS PURSUANT TO THIS PARAGRAPH AND MAY REDISTRIBUTE SUCH FURTHER DISTRIBUTIONS TO OTHER ELIGIBLE FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF THIS PARAGRAPH. THE COMMISSIONER SHALL BE PROVIDED WITH COPIES OF ALL SUCH RESOLUTIONS AND REPORTS.

(F) SUCH RATES SHALL BE ADJUSTED TO REFLECT APPROPRIATE COST DIFFERENTIALS RELATED TO DIRECT CARE STAFFING. SUCH ADJUSTMENT MAY BE MADE TO THE DIRECT COMPONENT OF THE OPERATING COST COMPONENT OF SUCH RATE, THROUGH A QUALITY OF CARE INCENTIVE POOL PURSUANT TO PARAGRAPH (D) OF THIS SUBDIVISION OR USING SUCH OTHER MECHANISM AS DEEMED APPROPRIATE BY THE COMMISSIONER, AFTER CONSIDERATION OF ANY RECOMMENDATIONS AND DISCUSSIONS OF THE WORKGROUP ESTABLISHED BY SECTION FORTY-EIGHT OF PART C OF CHAPTER ONE HUNDRED NINE OF THE LAWS OF TWO THOUSAND SIX.

S 5-a. Subdivision 11 of section 2808 of the public health law, as amended by chapter 474 of the laws of 1996, is amended to read as follows:

11. Residential health care facility reimbursement rate promulgation. With regard to a residential health care facility, the provisions of [paragraph (a) of] subdivision seven of section twenty-eight hundred seven of this article relating to advance notification of rates shall not apply to prospective or retroactive adjustments to rates that are

based on rate appeals filed by such facility, audits, changes in patient conditions or acuity levels, the correction of errors or omissions of data or errors in the computations of such rates, the submission of cost report data from facilities without an established cost basis, the judicial annulment or invalidation of existing rates or changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of existing rates or as otherwise authorized by law. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW OR REGULATION, AS OF APRIL FIRST, TWO THOUSAND NINE, WITH REGARD TO ADMINISTRATIVE RATE APPEALS, THE DEPARTMENT WILL ONLY REVIEW SUCH APPEALS FOR (A) THE CORRECTION OF COMPUTATIONAL ERRORS OR OMISSIONS OF DATA BY THE DEPARTMENT IN DETERMINING THE OPERATING RATE BASED UPON THE INFORMATION PROVIDED TO THE DEPARTMENT PRIOR TO THE COMPUTATION OF THE RATE, (B) CAPITAL COST REIMBURSEMENT, OR (C) SUCH REASONS AS THE COMMISSIONER DETERMINES ARE APPROPRIATE. THE DEPARTMENT WILL NOT CONSIDER ANY REVISIONS MADE TO A FACILITY'S ANNUAL COST REPORT FOR OPERATING RATE ADJUSTMENT PURPOSE LATER THAN THE DUE DATE ESTABLISHED BY THE COMMISSIONER.

S 6. Section 48 of part C of chapter 109 of the laws of 2006, amending the social services law and other laws relating to Medicaid reimbursement rate settings, as amended by section 65-a of part A of chapter 58 of the laws of 2007, is amended to read as follows:

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

(a) [the appropriate reimbursement for capital costs for those facilities which have received reimbursement reflecting one hundred percent of capital depreciation] OPERATING COSTS THAT SHOULD BE CONSIDERED ALLOWABLE IN THE DEVELOPMENT OF REGIONAL PRICES;

(b) [potential mechanisms for reimbursement of costs incurred by facilities with regard to the employment of nursing staff provided by independent companies] IDENTIFICATION OF APPROPRIATE COST DIFFERENTIALS AMONG FACILITIES BASED ON FACTORS INCLUDING, BUT NOT LIMITED TO, SIZE, AFFILIATION, LOCATION, PUBLIC VERSUS NON-PUBLIC, FACILITY LAYOUT, CULTURE EXCHANGE INITIATIVES AND LABOR COSTS, INCLUDING THE MOST APPROPRIATE MECHANISM TO ADJUST RATES OF PAYMENT TO REFLECT APPROPRIATE COST DIFFERENTIALS RELATED TO DIRECT CARE STAFFING, INCLUDING ADJUSTMENTS TO THE DIRECT COMPONENT OF THE OPERATING COST COMPONENT OF SUCH RATE, ESTABLISHMENT OF A QUALITY CARE INCENTIVE POOL PURSUANT TO SUBDIVISION (2-C) OF SECTION 2808 OF THE PUBLIC HEALTH LAW OR OTHER MECHANISMS;

(c) [reimbursement of costs related to insurance;

(d) conversion from the RUG II patient classification system to the "minimum data set" (RUG-III) patient classification system;

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

(D) THE RELATIONSHIP BETWEEN FACILITY SPENDING ON VARIOUS COSTS AND QUALITY OF CARE AND PATIENT OUTCOMES;

(E) APPROPRIATE REGIONS TO BE UTILIZED;

(f) [corridors applicable to the statewide mean prices as utilized for rate-setting purposes;

(g)] the reasons underlying the existing proportion of Medicaid patients to non-Medicaid patients in New York facilities;

[(h)] (G) issues related to Medicare;

[(i)] (H) impact of planned rightsizing of the acute care system;

[(j)] (I) impact of planned rightsizing of nursing home system;
[(k)] (J) impact of using Medicaid only case mix; and
[(l)] (K) other issues as determined by the commissioner.

The members of the workgroup shall include department of health staff and representatives of statewide associations representing the residential health care facility industry in New York, organizations representing employees, [and associations with less than a statewide membership shall have the ability to present information to the workgroup and participate in the discussions on the issues outlined in this section] AND, BY MAY THIRTY-FIRST, TWO THOUSAND NINE, ADVOCATES FOR RESIDENTIAL HEALTH CARE FACILITY RESIDENTS AND REPRESENTATIVES OF REGIONAL ASSOCIATIONS REPRESENTING THE RESIDENTIAL HEALTH CARE FACILITY INDUSTRY IN NEW YORK. THE WORKGROUP SHALL WORK IN CONSULTATION WITH THE ASSEMBLY AND THE SENATE. The commissioner of health shall appoint the chair of the workgroup [An initial report setting forth the workgroup's conclusions and recommendations shall be submitted to the commissioner of health by no later than January 1, 2008 and a subsequent report shall be submitted to the commissioner of health no later than June 15, 2008. Thereafter such workgroup shall continue until January 1, 2009, or as determined by the commissioner of health.] AND DESIGNATE SUCH EMPLOYEES OF THE DEPARTMENT OF HEALTH AS ARE REASONABLY NECESSARY TO PROVIDE NECESSARY DATA AND SUPPORT SERVICES TO THE WORKGROUP. THE COMMISSIONER OF HEALTH SHALL SUBMIT AN INTERIM REPORT SUMMARIZING THE WORKGROUP'S DELIBERATIONS AND THE COMMISSIONER OF HEALTH'S RECOMMENDATIONS TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE MINORITY LEADERS OF THE SENATE AND THE ASSEMBLY BY DECEMBER FIFTEENTH, TWO THOUSAND NINE, AND A SUBSEQUENT REPORT SHALL BE SUBMITTED TO THESE INDIVIDUALS NO LATER THAN FEBRUARY FIFTEENTH, TWO THOUSAND TEN. THE WORKGROUP SHALL CONTINUE UNTIL DECEMBER THIRTY-FIRST, TWO THOUSAND TEN TO EVALUATE THE IMPLEMENTATION OF THE NEW SYSTEM.

S 6-a. Paragraph d of subdivision 20 of section 2808 of the public health law is relettered paragraph e and a new paragraph d is added to read as follows:

D. (I) CAPITAL COST REIMBURSEMENT FOR PROPRIETARY RESIDENTIAL HEALTH CARE FACILITIES. ANY PROPRIETARY FACILITY WHICH OTHERWISE WOULD BE ENTITLED TO RESIDUAL REIMBURSEMENT AS PROVIDED UNDER APPLICABLE REGULATION, MAY HAVE THE CAPITAL COST COMPONENT OF ITS RATE RECALCULATED BY THE DEPARTMENT TO TAKE INTO ACCOUNT ANY CAPITAL IMPROVEMENTS AND/OR RENOVATIONS MADE TO THE FACILITY'S EXISTING INFRASTRUCTURE FOR THE PURPOSE OF CONVERTING BEDS TO ALTERNATIVE LONG-TERM CARE USES OR PROTECTING THE HEALTH AND SAFETY OF PATIENTS, SUBJECT TO THE APPROVAL OF THE COMMISSIONER AND ALL APPLICABLE CERTIFICATE OF NEED REQUIREMENTS.

(II) THE DEPARTMENT SHALL EVALUATE THE ADEQUACY OF CURRENT CAPITAL COST REIMBURSEMENT FOR VOLUNTARY RESIDENTIAL HEALTH CARE FACILITIES.

S 7. Notwithstanding any contrary provision of law, if the commissioner of health determines that federal financial participation will not be available with regard to the provisions of subparagraph (ii) of paragraph (e) of subdivision 2-c of section twenty-eight hundred eight of the public health law, the commissioner may deem such provision null and void and instead may allocate funds pursuant to such subparagraph (ii) proportionally, based on each eligible facility's relative share of Medicaid days in the year two years prior to the distribution year.

S 8. Subdivision 21 of section 2808 of the public health law, as added by section 27 of part C of chapter 58 of the laws of 2004 and paragraphs (a), (b), (f), (g) and (h) as amended by chapter 746 of the laws of 2004, is amended to read as follows:

21. (a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the purposes specified in subdivision nineteen of this section, the commissioner shall adjust medical assistance rates of payment established pursuant to this article for services provided on and after October first, two thousand four through December thirty-first, two thousand four and annually thereafter for services provided on and after January first, two thousand five, to include a rate adjustment to assist qualifying facilities pursuant to this subdivision, PROVIDED, HOWEVER, THAT PUBLIC RESIDENTIAL HEALTH CARE FACILITIES SHALL NOT BE ELIGIBLE FOR RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE.

(b) Eligibility for such rate adjustments shall be determined on the basis of each residential health care facility's operating margin over the most recent three-year period for which financial data are available from the RHCF-4 cost report or the institutional cost report. For purposes of the adjustments made for the period October first, two thousand four through December thirty-first, two thousand four, financial information for the calendar years two thousand through two thousand two shall be utilized. For each subsequent rate year, the financial data for the three-year period ending two years prior to the applicable rate year shall be utilized for this purpose.

(c) Each facility's operating margin for the three-year period shall be calculated by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by the total operating revenues for the three-year period, with the result expressed as a percentage. For hospital-based residential health care facilities for which an operating margin cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall three-year operating margin, as reported in the institutional cost report, shall be utilized for this purpose. All facilities with negative operating margins calculated in this way over the three-year period shall be arrayed into quartiles based on the magnitude of the operating margin. Any facility with a positive operating margin for the most recent three-year period, a negative operating margin that places the facility in the quartile of facilities with the smallest negative operating margins, a positive total margin in the most recent year of the three year period, or an average Medicaid utilization percentage of fifty percent or less during the most recent year of the three-year period shall be disqualified from receiving an adjustment pursuant to this subdivision, PROVIDED, HOWEVER, THAT FOR RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, SUCH DISQUALIFICATION:

(I) SHALL NOT BE APPLIED SOLELY ON THE BASIS OF A FACILITY'S HAVING A POSITIVE TOTAL MARGIN IN THE MOST RECENT YEAR OF SUCH THREE-YEAR PERIOD;

(II) SHALL BE EXTENDED TO THOSE FACILITIES IN THE QUARTILE OF FACILITIES WITH THE SECOND SMALLEST NEGATIVE OPERATING MARGINS; AND

(III) SHALL ALSO BE EXTENDED TO THOSE FACILITIES WITH AN AVERAGE MEDICAID UTILIZATION PERCENTAGE OF LESS THAN SEVENTY PERCENT DURING THE MOST RECENT YEAR OF THE THREE-YEAR PERIOD.

(d) For each facility remaining after the exclusions made pursuant to paragraph (c) of this subdivision, the commissioner shall calculate the average annual operating loss for the three-year period by subtracting total operating expenses for the three-year period from total operating revenues for the three-year period, and dividing the result by three, PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, THE AMOUNT OF SUCH AVERAGE ANNUAL OPERATING LOSS SHALL BE REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH FACILITY

PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION TWO-B OF THIS SECTION. For this purpose, for hospital-based residential health care facilities for which the average annual operating loss cannot be calculated on the basis of the submitted cost reports, the sponsoring hospital's overall average annual operating loss for the three-year period shall be apportioned to the residential health care facility based on the proportion the residential health care facility's total revenues for the period bears to the total revenues reported by the sponsoring hospital, AND SUCH APPORTIONED AVERAGE ANNUAL OPERATING LOSS SHALL THEN BE REDUCED BY AN AMOUNT EQUAL TO THE AMOUNT RECEIVED BY SUCH FACILITY PURSUANT TO SUBPARAGRAPH (II) OF PARAGRAPH (A) OF SUBDIVISION TWO-B OF THIS SECTION.

(e) [Each] FOR PERIODS PRIOR TO APRIL FIRST, TWO THOUSAND NINE, EACH such facility's qualifying operating loss shall be determined by multiplying the facility's average annual operating loss for the three-year period as calculated pursuant to paragraph (d) of this subdivision by the applicable percentage shown in the tables below for the quartile within which the facility's negative operating margin for the three-year period is assigned.

i. For a facility located in a county with a total population of two hundred thousand or more as determined by the two thousand U.S. Census:

First Quartile (lowest operating margins): 30 percent
Second Quartile: 15 percent
Third Quartile: 7.5 percent

ii. For a facility located in a county with a total population of fewer than two hundred thousand as determined by the two thousand U.S. Census:

First Quartile (lowest operating margins): 35 percent
Second Quartile: 20 percent
Third Quartile: 12.5 percent

(f) The amount of any facility's financially disadvantaged residential health care facility distribution calculated in accordance with this subdivision shall be reduced by the facility's estimated rate year benefit of the two thousand one update to the regional input price adjustment factors authorized pursuant to FORMER subdivision seventeen of this section as amended by section 24 of part C of chapter 58 of the laws of 2004, OR AS AUTHORIZED BY SUBDIVISION SEVENTEEN-A OF THIS SECTION, AS ADDED BY SECTION 56 OF PART C OF CHAPTER 58 OF THE LAWS OF 2007, if any, PROVIDED, HOWEVER, THAT SUCH REDUCTION SHALL NOT BE APPLIED WITH REGARD TO RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE. After all other adjustments to a facility's financially disadvantaged residential health care facility distribution have been made in accordance with this subdivision, the amount of each facility's distribution shall be limited to no more than four hundred thousand dollars during the period October first, two thousand four through December thirty-first, two thousand four and [during any subsequent annual rate period], ON AN ANNUALIZED BASIS, FOR RATE PERIODS THROUGH MARCH THIRTY-FIRST, TWO THOUSAND NINE, AND NO MORE THAN ONE MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND NINE THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND NINE AND FOR EACH ANNUAL RATE PERIOD THEREAFTER.

(g) The adjustment made to each qualifying facility's medical assistance rate of payment determined pursuant to this article shall be calculated by dividing the facility's financially disadvantaged residential

health care facility distribution calculated in accordance with this subdivision by the facility's total medical assistance patient days reported in the cost report submitted two years prior to the rate year, provided however, that such rate adjustments for the period October first, two thousand four through December thirty-first, two thousand four shall be calculated based on twenty-five percent of each facility's reported total medical assistance patient days as reported in the applicable two thousand two cost report. Such amounts shall not be reconciled to reflect changes in medical assistance utilization between the year two years prior to the rate year and the rate year.

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged residential health care facility rate adjustments to eligible facilities for a rate period in accordance with this subdivision shall be thirty million dollars for the period October first, two thousand four through December thirty-first, two thousand four and thirty million dollars [for annual] ON AN ANNUALIZED BASIS FOR rate periods on and after January first, two thousand five THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND EIGHT AND THIRTY MILLION DOLLARS ON AN ANNUALIZED BASIS ON AND AFTER JANUARY FIRST, TWO THOUSAND NINE. The nonfederal share of such [total shall be fifteen million dollars which] RATE ADJUSTMENTS shall be paid by the state, with no local share, from allocations made pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this [chapter] ARTICLE. In the event the statewide total of the ANNUAL rate adjustments determined pursuant to paragraph (g) of this subdivision varies from [thirty million dollars] THE AMOUNTS SET FORTH IN THIS PARAGRAPH, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the total OF THE ANNUAL rate adjustments made pursuant to this subdivision is equal to [thirty million dollars] THE AMOUNTS SET FORTH IN THIS PARAGRAPH on a statewide basis.

(i) This subdivision shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate adjustments determined in accordance with this subdivision.

(J) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, RESIDENTIAL HEALTH CARE FACILITIES WHICH ARE OTHERWISE ELIGIBLE FOR RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION SHALL ALSO, AS A CONDITION FOR RECEIPT OF SUCH RATE ADJUSTMENTS, SUBMIT TO THE COMMISSIONER A WRITTEN RESTRUCTURING PLAN THAT IS ACCEPTABLE TO THE COMMISSIONER AND WHICH IS IN ACCORD WITH THE FOLLOWING:

(I) SUCH AN ACCEPTABLE PLAN SHALL BE SUBMITTED TO THE COMMISSIONER WITHIN SIXTY DAYS OF THE FACILITY'S RECEIPT OF RATE ADJUSTMENTS PURSUANT TO THIS SUBDIVISION FOR A RATE PERIOD SUBSEQUENT TO MARCH THIRTY-FIRST, TWO THOUSAND EIGHT, PROVIDED, HOWEVER, THAT FACILITIES WHICH ARE ALLOCATED FOUR HUNDRED THOUSAND DOLLARS OR LESS ON AN ANNUALIZED BASIS SHALL BE REQUIRED TO SUBMIT SUCH PLANS WITHIN ONE HUNDRED TWENTY DAYS, AND FURTHER PROVIDED THAT THESE PERIODS MAY BE EXTENDED BY THE COMMISSIONER BY NO MORE THAN THIRTY DAYS, FOR GOOD CAUSE SHOWN; AND

(II) SUCH PLAN SHALL PROVIDE A DETAILED DESCRIPTION OF THE STEPS THE FACILITY WILL TAKE TO IMPROVE OPERATIONAL EFFICIENCY AND ALIGN ITS EXPENDITURES WITH ITS REVENUES, AND SHALL INCLUDE A PROJECTED SCHEDULE OF QUANTIFIABLE BENCHMARKS TO BE ACHIEVED IN THE IMPLEMENTATION OF THE PLAN; AND

(III) SUCH PLAN SHALL REQUIRE PERIODIC REPORTS TO THE COMMISSIONER, IN ACCORDANCE WITH A SCHEDULE ACCEPTABLE TO THE COMMISSIONER, SETTING FORTH THE PROGRESS THE FACILITY HAS MADE IN IMPLEMENTING ITS PLAN; AND

(IV) SUCH PLAN MAY INCLUDE THE FACILITY'S RETENTION OF A QUALIFIED CHIEF RESTRUCTURING OFFICER TO ASSIST IN THE IMPLEMENTATION OF THE PLAN, PROVIDED, HOWEVER, THAT THIS REQUIREMENT MAY BE WAIVED BY THE COMMISSIONER, FOR GOOD CAUSE SHOWN, UPON WRITTEN APPLICATION BY THE FACILITY.

(K) IF A RESIDENTIAL HEALTH CARE FACILITY FAILS TO SUBMIT AN ACCEPTABLE RESTRUCTURING PLAN IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH (J) OF THIS SUBDIVISION, THE FACILITY SHALL, FROM THAT TIME FORWARD, BE PRECLUDED FROM RECEIPT OF ALL FURTHER RATE ADJUSTMENTS MADE PURSUANT TO THIS SUBDIVISION AND SHALL BE DEEMED INELIGIBLE FROM ANY FUTURE RE-APPLICATION FOR SUCH ADJUSTMENTS. FURTHER, IF THE COMMISSIONER DETERMINES THAT A FACILITY HAS FAILED TO MAKE SUBSTANTIAL PROGRESS IN IMPLEMENTING ITS PLAN OR IN ACHIEVING THE BENCHMARKS SET FORTH IN SUCH PLAN, THEN THE COMMISSIONER MAY, UPON THIRTY DAYS NOTICE TO THAT FACILITY, DISQUALIFY THE FACILITY FROM FURTHER PARTICIPATION IN THE RATE ADJUSTMENTS AUTHORIZED BY THIS SUBDIVISION AND THE COMMISSIONER MAY REQUIRE THE FACILITY TO REPAY SOME OR ALL OF THE PREVIOUS RATE ADJUSTMENTS.

S 9. Clause (A) of subparagraph (i) of paragraph (a) of subdivision 18 of section 2808 of the public health law, as amended by section 73-b of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(A) fifty-three million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eighty-three million three hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; one hundred fifteen million eight hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; fifty-seven million nine hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, fifty-seven million nine hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, and [sixty-four] FIFTY-NINE million [eight] FOUR hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine [and twenty-six million two hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten and each state fiscal year thereafter].

S 10. Clause (A) of subparagraph (i) of paragraph (b) of subdivision 18 of section 2808 of the public health law, as amended by section 73-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(A) seven million five hundred thousand dollars on an annualized basis for the period April first, two thousand two through December thirty-first, two thousand two; eleven million seven hundred thousand dollars on an annualized basis for the period January first, two thousand three through December thirty-first, two thousand three; sixteen million two hundred thousand dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand six; and eight million one hundred thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, eight million one hundred thousand dollars for the period July first, two thousand seven through March thirty-first, two thousand eight, [seven] SIX million [three] SIX hundred NINETY thousand dollars for the period April first, two thousand eight through March thirty-

first, two thousand nine [and one million nine hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten and each state fiscal year thereafter].

S 11. Subdivision 5 of section 2808 of the public health law is amended by adding a new paragraph (c) to read as follows:

(C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SUBDIVISION, ON AND AFTER APRIL FIRST, TWO THOUSAND NINE, NO NON-PUBLIC RESIDENTIAL HEALTH CARE FACILITY, WHETHER OPERATED AS FOR-PROFIT FACILITY OR AS A NOT-FOR-PROFIT FACILITY, MAY WITHDRAW EQUITY OR TRANSFER ASSETS WHICH IN THE AGGREGATE EXCEED THREE PERCENT OF SUCH FACILITY'S TOTAL MEDICAID REVENUE IN THE PRIOR CALENDAR YEAR, WITHOUT THE PRIOR WRITTEN APPROVAL OF THE COMMISSIONER. THE COMMISSIONER SHALL MAKE A DETERMINATION TO APPROVE OR DISAPPROVE A REQUEST FOR WITHDRAWAL OF EQUITY OR ASSETS UNDER THIS SUBDIVISION WITHIN SIXTY DAYS OF THE DATE OF THE RECEIPT OF A WRITTEN REQUEST FROM THE FACILITY. REQUESTS SHALL BE MADE IN A FORM ACCEPTABLE TO THE DEPARTMENT BY CERTIFIED OR REGISTERED MAIL. IN REVIEWING SUCH REQUESTS THE COMMISSIONER SHALL CONSIDER THE FACILITY'S OVERALL FINANCIAL CONDITION, ANY INDICATIONS OF FINANCIAL DISTRESS, WHETHER THE FACILITY IS DELINQUENT IN ANY PAYMENT OWED TO THE DEPARTMENT, WHETHER THE FACILITY HAS BEEN CITED FOR IMMEDIATE JEOPARDY OR SUBSTANDARD QUALITY OF CARE, AND SUCH OTHER FACTORS AS THE COMMISSIONER DEEMS APPROPRIATE. IN ADDITION TO ANY OTHER REMEDY OR PENALTY AVAILABLE UNDER THIS CHAPTER, AND AFTER OPPORTUNITY FOR A HEARING, THE COMMISSIONER MAY REQUIRE REPLACEMENT OF THE WITHDRAWN EQUITY OR ASSETS AND MAY IMPOSE A PENALTY FOR VIOLATION OF THE PROVISIONS OF THIS SUBDIVISION IN AN AMOUNT NOT TO EXCEED TEN PERCENT OF ANY AMOUNT WITHDRAWN WITHOUT PRIOR APPROVAL.

S 12. Notwithstanding any inconsistent provision of law or regulation, effective April 1, 2009, for rates of payment by government agencies for impatient services provided by residential health care facilities, in determining the operating component of a facility's rate for care provided for an AIDS patient in a residential health care facility designated as an AIDS facility or having a discrete AIDS unit, the operating component shall not reflect an occupancy factor increase.

S 13. Intentionally omitted.

S 14. Intentionally omitted.

S 15. Intentionally omitted.

S 16. Subdivision 3 of section 461-l of the social services law is amended by adding a new paragraph (i) to read as follows:

(I) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ADD UP TO SIX THOUSAND ASSISTED LIVING PROGRAM BEDS TO THE GROSS NUMBER OF ASSISTED LIVING PROGRAM BEDS HAVING BEEN DETERMINED TO BE AVAILABLE AS OF APRIL FIRST, TWO THOUSAND NINE, PROVIDED THAT, FOR EACH ASSISTED LIVING PROGRAM BED SO ADDED, A NURSING HOME BED HAS BEEN DECERTIFIED UPON THE APPLICATION OF THE NURSING HOME OPERATOR OR THAT THE COMMISSIONER OF HEALTH HAS FOUND PURSUANT TO SUBDIVISION SIX OF SECTION TWENTY-EIGHT HUNDRED SIX OF THE PUBLIC HEALTH LAW THAT ANY ASSISTED LIVING PROGRAM BED SO ADDED WOULD SERVE AS A MORE APPROPRIATE ALTERNATIVE TO A CERTIFIED NURSING HOME BED AND HAS ACCORDINGLY LIMITED OR REVOKED THE OPERATING CERTIFICATE OF THE NURSING HOME PROVIDING THAT CERTIFIED NURSING HOME BED, PROVIDED FURTHER THAT NOTHING HEREIN SHALL BE INTERPRETED AS PROHIBITING ANY ELIGIBLE APPLICANT FROM SUBMITTING AN APPLICATION FOR ANY ASSISTED LIVING PROGRAM BED SO ADDED. THE COMMISSIONER OF HEALTH SHALL NOT BE REQUIRED TO REVIEW ON A COMPARATIVE BASIS APPLICATIONS SUBMITTED FOR ASSISTED LIVING PROGRAM BEDS MADE AVAILABLE UNDER THIS PARAGRAPH. THE

COMMISSIONER OF HEALTH SHALL ONLY AUTHORIZE THE ADDITION OF SIX THOUSAND BEDS PURSUANT TO A FIVE YEAR PLAN.

S 17. Paragraph (a) of subdivision 6 of section 3614 of the public health law, as amended by chapter 645 of the laws of 2003, is amended to read as follows:

(a) The commissioner shall, subject to the approval of the state director of the budget, establish capitated rates of payment for services provided by assisted living programs as defined by paragraph (a) of subdivision one of section four hundred sixty-one-l of the social services law. Such rates of payment shall be related to costs incurred by residential health care facilities. The rates shall reflect the wage equalization factor established by the commissioner for residential health care facilities in the region in which the assisted living program is provided and real property capital construction costs associated with the construction of a free-standing assisted living program such rate shall include a payment equal to the cost of interest owed and depreciation costs of such construction. The rates shall also reflect the efficient provision of a quality and quantity of services to patients in such residential health care facilities, with needs comparable to the needs of residents served in such assisted living programs. Such rates of payment shall be equal to fifty percent of the amounts which otherwise would have been expended, BASED UPON THE MEAN PRICES FOR THE FIRST OF JULY, NINETEEN HUNDRED NINETY-TWO (UTILIZING NINETEEN HUNDRED EIGHTY-THREE COSTS) FOR FREESTANDING, LOW INTENSITY RESIDENTIAL HEALTH CARE FACILITIES WITH LESS THAN THREE HUNDRED BEDS, AND FOR YEARS SUBSEQUENT TO NINETEEN HUNDRED NINETY-TWO, ADJUSTED FOR INFLATION IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS CHAPTER, to provide the appropriate level of care for such residents in residential health care facilities in the applicable wage equalization factor regions plus an amount equal to capital construction costs associated with the construction of an assisted living program facility as provided for in this subdivision.

S 18. Section 21 of chapter 1 of the laws of 1999 amending the public health law and other laws relating to enacting the New York Health Care Reform Act of 2000, as amended by section 8 of part A of chapter 57 of the laws of 2000, is amended to read as follows:

S 21. Notwithstanding any inconsistent provision of law, effective April 1, 2000, in determining rates of payment for residential health care facilities pursuant to section 2808 of the public health law, hospital outpatient services and diagnostic and treatment centers pursuant to section 2807 of the public health law, unless otherwise subject to the limits set forth in section 4 of chapter 81 of the laws of 1995, as amended by this act, certified home health agencies and long term home health care programs pursuant to section 3614-a of the public health law and personal care services pursuant to section 367-i of the social services law, AND FOR PERIODS ON AND AFTER APRIL 1, 2009, ADULT DAY HEALTH CARE SERVICES PROVIDED TO PATIENTS DIAGNOSED WITH AIDS AS DEFINED BY APPLICABLE REGULATIONS, the commissioner of health shall apply trend factors using the methodology described in paragraph (c) of subdivision 10 of section 2807-c of the public health law, except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. Nothing in this section is intended to reduce a change in any existing provision of law establishing maximum reimbursement rates.

S 19. Intentionally omitted.

S 20. Subparagraph (iii) of paragraph (a) of subdivision 23 of section 2808 of the public health law, as added by section 29 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(iii) For such programs which have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to April first, two thousand seven, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the first calendar year after two thousand six in which such a program achieves an occupancy percentage of ninety percent or greater effective January first of such calendar year except for calendar year two thousand seven, effective no earlier than April first of such year, provided, however, that effective January first, two thousand nine, for programs that have not achieved an occupancy percentage of ninety percent or greater for a calendar year prior to January first, two thousand nine, the operating component of the rate of payment established pursuant to this article shall be calculated utilizing allowable costs reported in the two thousand nine cost report filed by the sponsoring residential health care facility divided by visits imputed at actual or ninety percent occupancy, whichever is greater. THIS SUBPARAGRAPH SHALL ALSO APPLY TO PROGRAMS WHICH ACHIEVED AN OCCUPANCY PERCENTAGE OF NINETY PERCENT OR GREATER PRIOR TO CALENDAR YEAR TWO THOUSAND FOUR BUT IN SUCH YEAR HAD AN APPROVED CAPACITY THAT WAS NOT THE SAME AS IN CALENDAR YEAR TWO THOUSAND FOUR.

S 21. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 64 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

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

S 22. Intentionally omitted.

S 23. Paragraph (a) of subdivision 5 of section 3614 of the public health law, as added by chapter 884 of the laws of 1990, is amended to read as follows:

(a) During the period July first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety, the period January first, nineteen hundred ninety-one through December thirty-first, nineteen hundred ninety-one and for each calendar year period commencing on January first thereafter, rates of payment by governmental agencies

established in accordance with subdivision three of this section applicable for services provided by certified home health agencies to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for certified home health agencies which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during the base year period as used in determining such rates may include an allowance determined in accordance with this subdivision to reflect the needs of the certified home health agency for the financing of losses resulting from bad debt and the cost of charity care. Losses resulting from bad debt and the delivery of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the certified home health agency and the availability of other financial support, including state local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the certified home health agency. The bad debt and charity care allowance for a certified home health agency for a rate period shall be determined by the commissioner in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. For purposes of distribution of bad debt and charity care allowances to eligible certified home health agencies, the commissioner, in accordance with rules and regulations adopted by the state hospital review and planning council and approved by the commissioner, may limit application of a bad debt and charity care allowance to a particular home care services unit or units of service, such as nursing service. A certified home health agency applying for a bad debt and charity care allowance pursuant to this subdivision shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this subdivision, a certified home health agency shall: have professional assistance available on a seven day per week, twenty-four hour per day basis to all registered clients [and must]; demonstrate compliance with minimum charity care certification obligation levels established pursuant to rules and regulations adopted by the state hospital review and planning council and approved by the commissioner; AND PROVIDE TO THE COMMISSIONER AND MAINTAIN A COMMUNITY SERVICE PLAN WHICH OUTLINES THE AGENCY'S ORGANIZATIONAL MISSION AND COMMITMENT TO MEET THE HOME CARE NEEDS OF THE COMMUNITY, IN ACCORDANCE WITH PARAGRAPH (H) OF THIS SUBDIVISION.

S 24. Paragraph (h) of subdivision 5 of section 3614 of the public health law is relettered paragraph (i) and a new paragraph (h) is added to read as follows:

(H) COMMUNITY SERVICE PLANS. (I) THE GOVERNING BODY OF A CERTIFIED HOME HEALTH AGENCY SHALL ISSUE AN ORGANIZATIONAL MISSION STATEMENT IDENTIFYING AT A MINIMUM THE POPULATIONS AND COMMUNITIES SERVED BY THE AGENCY AND THE AGENCY'S COMMITMENT TO MEETING THE HOME CARE NEEDS OF THE COMMUNITY. THE COMMISSIONER SHALL TAKE INTO CONSIDERATION THE LIMITATIONS OF AGENCY SIZE AND RESOURCES, AND ALLOW FLEXIBILITY IN COMPLYING WITH THE PROVISIONS OF THIS SECTION.

(II) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL AT LEAST ONCE EVERY THREE YEARS:

(A) REVIEW AND AMEND AS NECESSARY THE AGENCY'S MISSION STATEMENT;

(B) SOLICIT THE VIEWS OF THE COMMUNITIES SERVED BY THE AGENCY ON SUCH ISSUES AS THE AGENCY'S PERFORMANCE AND SERVICE PRIORITIES;

(C) DEMONSTRATE THE AGENCY'S OPERATIONAL AND FINANCIAL COMMITMENT TO MEETING COMMUNITY HOME CARE NEEDS, TO PROVIDE CHARITY CARE SERVICE AND TO IMPROVE ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED; AND

(D) PREPARE AND MAKE AVAILABLE TO THE PUBLIC A STATEMENT SHOWING THE PROVISION OF FREE, REDUCED CHARGE AND/OR OTHER SERVICES OF A CHARITABLE OR COMMUNITY NATURE.

(III) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL ANNUALLY MAKE AVAILABLE TO THE PUBLIC A REVIEW OF THE AGENCY'S PERFORMANCE IN MEETING THE HOME CARE NEEDS OF THE COMMUNITY, PROVIDING CHARITY CARE SERVICES, AND IMPROVING ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED.

(IV) THE GOVERNING BODY OF THE CERTIFIED HOME HEALTH AGENCY SHALL FILE WITH THE COMMISSIONER ITS MISSION STATEMENT, ITS ANNUAL PERFORMANCE REVIEW, AND AT LEAST EVERY THREE YEARS A REPORT DETAILING AMENDMENTS TO THE STATEMENT REFLECTING CHANGES IN THE AGENCY'S OPERATIONAL AND FINANCIAL COMMITMENT TO MEETING THE HOME CARE NEEDS OF THE COMMUNITY, PROVIDING CHARITY CARE SERVICES, AND IMPROVING ACCESS TO HOME CARE SERVICES BY THE UNDERSERVED.

(V) THE COMMISSIONER SHALL PROMULGATE REGULATIONS ESTABLISHING A REVISED PERCENTAGE FOR THE CHARITY CARE REQUIREMENT.

S 25. Intentionally omitted.

S 26. Intentionally omitted.

S 27. Intentionally omitted.

S 28. Intentionally omitted.

S 29. The social services law is amended by adding a new section 367-w to read as follows:

S 367-W. REGIONAL LONG-TERM CARE ASSESSMENT CENTERS. 1. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE DEPARTMENT OF HEALTH IS AUTHORIZED TO ESTABLISH A DEMONSTRATION PROGRAM, WHICH SHALL BE THREE YEARS IN DURATION, UNDER WHICH THE DEPARTMENT SHALL DESIGNATE TWO LONG-TERM CARE ASSESSMENT CENTERS, THE FIRST OF WHICH SHALL BE ESTABLISHED IN A COUNTY WITHIN THE CITY OF NEW YORK AND THE SECOND OF WHICH WILL BE ESTABLISHED IN ANOTHER REGION CONSISTING OF ONE OR MORE CONTIGUOUS COUNTIES ELSEWHERE IN THE STATE. SUCH CENTERS SHALL SERVE THE PURPOSE OF TRANSFERRING FROM THE SOCIAL SERVICES DISTRICT TO THE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS RESPONSIBILITY FOR ACTIVITIES RELATED TO THE ASSESSMENT OF A PERSON'S NEED FOR, AND THE AUTHORIZATION OF, LONG-TERM CARE SERVICES AND PROGRAMS IDENTIFIED IN SUBDIVISIONS TWO, THREE AND FOUR OF THIS SECTION. THE DEPARTMENT IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO OPERATE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS.

2. THE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS SHALL HAVE RESPONSIBILITY FOR ASSESSMENT OF LONG-TERM CARE NEEDS OF AN APPLICANT FOR, OR RECIPIENT OF, MEDICAL ASSISTANCE AND FOR AUTHORIZATION OF SERVICES AND PARTICIPATION IN PROGRAMS INCLUDING: PERSONAL CARE SERVICES, INCLUDING PERSONAL EMERGENCY RESPONSE SERVICES, UNDER PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE; CONSUMER-DIRECTED PERSONAL ASSISTANCE SERVICES UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE; THE ASSISTED LIVING PROGRAM UNDER SECTION FOUR HUNDRED SIXTY-ONE-L OF THIS CHAPTER; AND PARTICIPATION IN THE LONG-TERM HOME HEALTH CARE PROGRAM UNDER SECTION THREE HUNDRED SIXTY-SEVEN-C OF THIS TITLE AND SECTION THIRTY-SIX HUNDRED SIXTEEN OF

THE PUBLIC HEALTH LAW, INCLUDING THE AIDS HOME CARE PROGRAM UNDER THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-SEVEN-E OF THIS TITLE AND SECTION THIRTY-SIX HUNDRED TWENTY OF THE PUBLIC HEALTH LAW.

3. NOTWITHSTANDING ANY PROVISION OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW TO THE CONTRARY, THE REGIONAL LONG-TERM CARE ASSESSMENT CENTER SHALL HAVE RESPONSIBILITY FOR REVIEWING ASSESSMENTS TO VERIFY THAT AN INDIVIDUAL REQUIRES A NURSING HOME LEVEL OF CARE AND, AFTER CONFIRMING THAT AN ENROLLMENT IS VOLUNTARY, FOR AUTHORIZING PARTICIPATION IN A MANAGED LONG-TERM CARE PLAN OR AN APPROVED MANAGED LONG-TERM CARE DEMONSTRATION UNDER PARAGRAPH (O) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

4. THE REGIONAL LONG-TERM CARE ASSESSMENT CENTERS SHALL HAVE RESPONSIBILITY FOR REVIEWING DOCUMENTATION FROM A PERSON'S PHYSICIAN AND A CERTIFIED HOME HEALTH AGENCY AND FOR MAKING THE DETERMINATION AS TO THE CONTINUING NEED FOR HOME HEALTH SERVICES AUTHORIZED UNDER PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE BEYOND SIXTY DAYS.

5. THIS SECTION SHALL APPLY TO THOSE CONSUMERS WHO APPLY FOR THE SERVICES SPECIFIED IN THIS SECTION ON AND AFTER THE LATER OF JANUARY FIRST, TWO THOUSAND TEN OR THE DATE SPECIFIED IN THE CONTRACT BETWEEN THE DEPARTMENT AND THE ENTITY SELECTED TO BE A REGIONAL LONG-TERM CARE ASSESSMENT CENTER.

6. WHEN A LONG-TERM CARE ASSESSMENT CENTER IS AUTHORIZED TO ASSESS LONG-TERM CARE NEEDS OR AUTHORIZE SERVICES PURSUANT TO THIS SECTION, AN APPLICANT OR RECIPIENT MAY CHALLENGE ANY ACTION TAKEN OR FAILURE TO ACT IN CONNECTION THEREWITH AS IF SUCH ASSESSMENT OR AUTHORIZATION WERE MADE BY A GOVERNMENT ENTITY, AND SHALL BE ENTITLED TO THE SAME MEDICAL ASSISTANCE BENEFITS AND STANDARDS AND TO THE SAME NOTICE AND PROCEDURAL DUE PROCESS RIGHTS, INCLUDING A RIGHT TO A FAIR HEARING AND AID CONTINUING PURSUANT TO SECTION TWENTY-TWO OF THIS CHAPTER, AS IF THE ASSESSMENT OR AUTHORIZATION WERE MADE BY A GOVERNMENT ENTITY.

7. THE COMMISSIONER OF HEALTH SHALL SUBMIT A REPORT BIANNUALLY TO THE GOVERNOR, TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY AND THE MINORITY LEADERS OF THE SENATE AND THE ASSEMBLY. SUCH REPORT SHALL ALSO BE POSTED ON THE DEPARTMENT'S WEBSITE. SUCH REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN ASSESSMENT OF THE PROJECT, AN ANALYSIS OF THE LEVEL AND COSTS OF SERVICES MANAGED UNDER THE CONTRACTS, RECIPIENT SATISFACTION AND OTHER MATTERS AS MAY BE PERTINENT. IN ADDITION, THE COMMISSIONER SHALL CONVENE AN ANNUAL MEETING OF STAKEHOLDERS TO DISCUSS IMPLEMENTATION OF THE DEMONSTRATION PROGRAM ESTABLISHED PURSUANT TO THIS SECTION.

S 30. Intentionally omitted.

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 33. Intentionally omitted.

S 34. Intentionally omitted.

S 35. Intentionally omitted.

S 36. Intentionally omitted.

S 37. Paragraph (a) of subdivision 1 of section 367-f of the social services law, as amended by section 51 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(a) "Medicaid extended coverage" shall mean eligibility for medical assistance (i) without regard to the resource requirements of section three hundred sixty-six of this title, or in the case of an individual covered under an insurance policy or certificate described in subdivision two of this section that provided a residential health care facili-

ty benefit less than three years in duration, without consideration of an amount of resources equivalent to the value of benefits received by the individual under such policy or certificate, as determined under the rules of the partnership for long-term care program[, and]; (ii) without regard to the recovery of medical assistance from the estates of individuals and the imposition of liens on the homes of persons pursuant to section three hundred sixty-nine of this title, with respect to resources exempt from consideration pursuant to subparagraph (i) of this paragraph; provided, however, that nothing [herein] IN THIS SECTION shall prevent the imposition of a lien or recovery against property of an individual on account of medical assistance incorrectly paid; AND (III) BASED ON AN INCOME ELIGIBILITY STANDARD FOR MARRIED COUPLES EQUAL TO THE AMOUNT OF THE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE DEFINED IN PARAGRAPH (H) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SIX-C OF THIS TITLE, AND FOR SINGLE INDIVIDUALS EQUAL TO ONE-HALF OF SUCH AMOUNT; PROVIDED, HOWEVER, THAT THE COMMISSIONER OF HEALTH SHALL NOT BE REQUIRED TO IMPLEMENT THE PROVISIONS OF THIS SUBPARAGRAPH IF THE USE OF SUCH INCOME ELIGIBILITY STANDARDS WILL RESULT IN A LOSS OF FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF MEDICAID EXTENDED COVERAGE FURNISHED IN ACCORDANCE WITH SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH.

S 38. Subdivision 1 and the opening paragraph of subdivision 2 of section 365-f of the social services law, subdivision 1 as added by chapter 81 of the laws of 1995, the opening paragraph of subdivision 2 as amended by chapter 474 of the laws of 1996, are amended to read as follows:

1. Purpose and intent. The consumer directed personal assistance program is intended to permit chronically ill and/or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. The department shall[, upon request of a social services district or group of districts,] REGULARLY MONITOR DISTRICT PARTICIPATION IN THE PROGRAM BY REVIEWING THE IMPLEMENTATION PLANS SUBMITTED PURSUANT TO THIS SECTION. THE DEPARTMENT SHALL PROVIDE GUIDANCE TO THE DISTRICTS TO IMPROVE COMPLIANCE WITH IMPLEMENTATION PLANS AND PROMOTE CONSISTENCY AMONG COUNTIES REGARDING APPROVED SERVICE LEVELS BASED ON THE ASSESSMENTS REQUIRED BY THIS SECTION. IN ADDITION, THE DEPARTMENT SHALL provide technical assistance and such other assistance as may be necessary to assist such districts in assuring access to the program FOR ELIGIBLE INDIVIDUALS.

All eligible individuals receiving home care shall be provided notice of the availability of the program, AND NO LESS FREQUENTLY THAN ANNUALLY THEREAFTER, and shall have the opportunity to apply for participation in the program. [On or before October first, nineteen hundred ninety-six each] EACH social services district shall file an implementation plan with the commissioner of the department of health, WHICH SHALL BE UPDATED ANNUALLY. SUCH UPDATES SHALL BE SUBMITTED NO LATER THAN NOVEMBER THIRTIETH OF EACH YEAR. BEGINNING ON JUNE THIRTIETH, TWO THOUSAND NINE, THE PLANS AND UPDATES SUBMITTED BY DISTRICTS SHALL REQUIRE THE APPROVAL OF THE DEPARTMENT. IMPLEMENTATION PLANS SHALL INCLUDE DISTRICT ENROLLMENT TARGETS, DESCRIBE METHODS FOR THE PROVISION OF NOTICE AND ASSISTANCE TO INTERESTED INDIVIDUALS ELIGIBLE FOR ENROLLMENT IN THE PROGRAM, AND SHALL CONTAIN SUCH OTHER INFORMATION AS SHALL BE REQUIRED BY THE DEPARTMENT. An "eligible individual", for purposes of this section is a person who:

S 39. Section 2807-x of the public health law, as added by section 6 of part D of chapter 58 of the laws of 2004, the opening paragraph of subdivision 1 as amended by chapter 745 of the laws of 2004, is amended to read as follows:

S 2807-x. Grants for long term care demonstration projects. 1. The commissioner shall establish [two] THREE demonstration projects to develop, evaluate and implement programs to test new models for the organization and delivery of long term care services to encourage community based programs and smaller residential health care models in order to promote consumer choice, improve the efficiency and appropriateness of the use of state and federal resources and ensure the recruitment, retention and training of health care staff to adequately meet the needs of a community and residential long term care system. Notwithstanding the provisions of section one hundred twelve of the state finance law or any other inconsistent provision of the state finance law or any other law, funds available for distribution pursuant to this section may be allocated and distributed by the commissioner without a competitive bid or request for proposal process.

(a) The following factors shall be considered in approving each demonstration project respectively:

(i) Residential health care demonstration project. (A) the extent to which there is a reduction in the need for skilled nursing beds for a facility that is eligible to replace its existing skilled nursing facility; (B) the potential to design and develop more appropriate smaller residential health care facilities as an alternative to replacing an existing skilled nursing facility; (C) the extent to which the quality, efficiency and continuity of care will be promoted and provided for by the development of integrated long-term care services in the community; (D) the extent to which the project will provide training to health care workers to appropriately staff new community based models of long term care; (E) demonstrate the involvement and support of workforce in the program redesign; (F) the development of a new long-term care reimbursement methodology that encourages care in the least restrictive setting and adequately reflects the resources needed to serve consumers in each level of long term care; (G) and the incorporation of a research component designed to evaluate the project.

(ii) Community based care demonstration project. (A) the extent to which there is a reduction in the need for skilled nursing facility beds on a countywide basis; (B) the development of a new system to inform recently admitted residents of skilled nursing facilities of the availability of community long-term care options; (C) the extent to which the discharge planning program from skilled nursing facilities will inform, assist and maximize freedom of choice to consumers who choose to move back to the community; (D) the extent to which the project will develop community based long term care services, including funding for the recruitment and retention of direct care health care workers necessary to increase community based services; (E) the extent to which the project will provide training to health care staff; and (F) the incorporation of a research component designed to evaluate the projects.

(III) MANAGED LONG TERM CARE PROJECT. (A) THE EXTENT TO WHICH A CURRENT OPERATOR OF SKILLED NURSING FACILITIES POSSESSES THE NECESSARY AUTHORIZATIONS THROUGH A RELATED ENTITY TO ASSUME RISK AND RECEIVE CAPITATED PAYMENTS, PURSUANT TO TITLES 18 AND 19 OF THE FEDERAL SOCIAL SECURITY ACT, FOR THE PURPOSE OF PROVIDING AND ARRANGING FOR THE CARE OF INDIVIDUALS ELIGIBLE FOR ADMISSION TO A SKILLED NURSING FACILITY, (B) THE EXTENT TO WHICH SUCH SERVICES TO INDIVIDUALS ELIGIBLE FOR BENEFITS

PURSUANT TO BOTH TITLES 18 AND 19 OF THE FEDERAL SOCIAL SECURITY ACT WILL BE PROVIDED THROUGH THE CAPITATED RATE, (C) THE EXTENT TO WHICH THE QUALITY, EFFICIENCY AND CONTINUITY OF CARE WILL BE PROMOTED AND PROVIDED FOR BY THE DEVELOPMENT OF INTEGRATED LONG-TERM CARE SERVICES IN THE COMMUNITY, (D) THE EXTENT TO WHICH THE PROJECT SPONSOR WILL DIRECTLY OR INDIRECTLY IN ASSOCIATION WITH A JOINT LABOR MANAGEMENT PROGRAM, PROVIDE FOR TRAINING OF HEALTH CARE WORKERS TO APPROPRIATELY STAFF COMMUNITY BASED MODELS OF LONG-TERM CARE; AND (E) THE INCORPORATION OF A RESEARCH COMPONENT DESIGNED TO EVALUATE THE PROJECT, WITH SPECIFIC REFERENCE TO THE DETERMINATION OF COST SAVINGS TO THE STATE, THE QUALITY OF AND SATISFACTION WITH SERVICES PROVIDED TO CONSUMERS AND THEIR FAMILIES AND THE SATISFACTION OF DIRECT CARE WORKERS, WITH A REPORT OF THE PROJECT'S PROGRESS AND FINDINGS SUBMITTED ANNUALLY TO THE COMMISSIONER.

2. The commissioner is authorized to waive, modify or suspend the respective provisions of rules and regulations promulgated pursuant to this chapter if the commissioner determines that such waiver is necessary or appropriate for the successful implementation of a demonstration project and when the health, safety, and general welfare of persons receiving services under such demonstration project will not be impaired as a result of such waiver, modification or suspension, PROVIDED HOWEVER, THAT FOR THE MANAGED LONG TERM CARE PROJECT PURSUANT TO SUBPARAGRAPH (III) OF PARAGRAPH (A) OF SUBDIVISION ONE OF THIS SECTION, THE METHOD FOR SETTING THE CAPITATED RATE OF PAYMENT UNDER TITLE 19 OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE CONSISTENT WITH THE METHOD USED FOR ALL MANAGED LONG TERM CARE PLANS AUTHORIZED UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW.

3. The commissioner is authorized to seek federal waivers pursuant to titles XVIII and XIX of the federal social security act when such waivers are necessary to develop cost-effective long term care demonstration projects.

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

6-a. section fifty-seven of this act shall expire and be deemed repealed on [March] DECEMBER 31, [2010] 2013; provided that THE AMENDMENTS MADE BY such section TO SUBDIVISION 4 OF SECTION 366-C OF THE SOCIAL SERVICES LAW SHALL APPLY WITH RESPECT TO DETERMINING INITIAL AND CONTINUING ELIGIBILITY FOR MEDICAL ASSISTANCE, INCLUDING THE CONTINUED ELIGIBILITY OF RECIPIENTS ORIGINALLY DETERMINED ELIGIBLE PRIOR TO THE EFFECTIVE DATE OF THIS ACT, AND PROVIDED FURTHER THAT SUCH AMENDMENTS shall not apply to any person [as to whom] OR GROUP OF PERSONS IF IT IS SUBSEQUENTLY DETERMINED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES OR BY A COURT OF COMPETENT JURISDICTION THAT MEDICAL ASSISTANCE WITH federal financial participation is available for the costs of services provided TO SUCH PERSON OR PERSONS under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

S 41. Subdivision (m-1) of section 79 of part C of chapter 58 of the laws of 2008 amending the social services law and the public health law relating to adjustments of rates, is amended to read as follows:

(m-1) THE AMENDMENTS MADE BY section fifty-two of this act TO SUBDIVISION 4 OF SECTION 366-C OF THE SOCIAL SERVICES LAW shall [not] apply WITH RESPECT TO DETERMINING INITIAL AND CONTINUING ELIGIBILITY FOR MEDICAL ASSISTANCE, INCLUDING THE CONTINUED ELIGIBILITY OF RECIPIENTS ORIGINALLY DETERMINED ELIGIBLE PRIOR TO THE EFFECTIVE DATE OF THIS ACT; AND PROVIDED FURTHER THAT SUCH AMENDMENTS SHALL NOT APPLY to any person

[as to whom] OR GROUP OF PERSONS IF IT IS SUBSEQUENTLY DETERMINED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR BY A COURT COMPETENT JURISDICTION THAT MEDICAL ASSISTANCE WITH federal financial participation is available for the costs of services provided TO SUCH PERSON OR PERSONS under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act;

S 42. The closing paragraph of subdivision 4 of section 366-c of the social services law, as amended by section 52 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

provided, however, that, to the extent required by federal law, the terms of this subdivision shall not apply to persons who are receiving care, services and supplies pursuant to the following waivers under section 1915(c) of the federal social security act: the nursing facility transition and diversion waiver authorized pursuant to subdivision six-a of section three hundred sixty-six of this title; [and] the traumatic brain injury waiver authorized pursuant to section twenty-seven hundred forty of the public health law, THE LONG TERM HOME HEALTH CARE PROGRAM WAIVER AUTHORIZED PURSUANT TO SECTION THREE HUNDRED SIXTY-SEVEN-C OF THIS TITLE, AND THE HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES ADMINISTERED BY THE OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES PURSUANT TO AN AGREEMENT WITH THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

S 43. Notwithstanding any inconsistent provisions of section 112 or section 163 of the state finance law, section 2808-d of the public health law, or any other provision of law or regulation to the contrary, with regard to funds previously awarded by the commissioner of health pursuant to section 2808-d of the public health law to residential health care facilities that provide extensive nursing, medical, psychological and counseling support services to children and that have not yet been spent, the commissioner of health may, with the agreement of such facilities, authorize in writing the expenditure of such unspent funds for the alternative purpose of improving the work environment of such facilities, including through building improvement or replacement facilities, in such manner as the commissioner of health deems appropriate.

S 44. 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 45. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of subdivisions 4, 7, 7-a and 7-b of section 2807 of the public health law and section 18 of chapter 2 of the laws of 1988, as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and shall, for purposes of implementing the provisions of this act, be deemed to have been without any force or effect from and after November 1, 2007 for such rates effective for the period January 1, 2008 through December 31, 2008.

S 46. 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 47. This act shall take effect on April 1, 2009; provided, however, that:

1. Intentionally omitted.

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

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

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

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

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

7. Intentionally omitted.

8. Intentionally omitted.

9. the amendments to subdivision 5 of section 3614 of the public health law made by sections twenty-three and twenty-four of this act shall not affect the expiration of such subdivision and shall expire therewith;

10. Intentionally omitted.

11. Intentionally omitted.

12. the amendments to the closing paragraph of subdivision 4 of section 366-c of the social services law made by section forty-two of this act shall not affect the expiration of such subdivision and shall be deemed expired therewith; provided, further, that the amendments to the closing paragraph of subdivision 4 of section 366-c of the social services law made by section forty-two of this act shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act; and provided further that such changes shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or a court of competent jurisdiction that medical assistance with federal financial participation is available for the cost of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

PART E

Intentionally omitted.

PART F

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 2009-10 to reduce inpatient capacity in the aggregate by no more than 450 beds, through closure of wards not to exceed 150 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 450 beds in state fiscal year 2009-10, 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 2009-10 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 2009-10 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 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. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART G

Intentionally omitted.

PART H

Section 1. Subdivision (k) of section 10.06 of the mental hygiene law, as added by chapter 7 of the laws of 2007, is amended to read as follows:

(k) At the conclusion of the hearing, the court shall determine whether there is probable cause to believe that the respondent is a sex offender requiring civil management. If the court determines that probable cause has not been established, the court shall issue an order dismissing the petition, and the respondent's release shall be in accordance with other applicable provisions of law. If the court determines that probable cause has been established: (i) the court shall order that the respondent be committed to a secure treatment facility designated by the commissioner for care, treatment and control upon his or her release, PROVIDED, HOWEVER, THAT A RESPONDENT WHO OTHERWISE WOULD BE REQUIRED TO BE TRANSFERRED TO A SECURE TREATMENT FACILITY MAY, UPON A WRITTEN CONSENT SIGNED BY THE RESPONDENT AND HIS OR HER COUNSEL, CONSENT TO REMAIN IN THE CUSTODY OF THE DEPARTMENT OF CORRECTIONAL SERVICES PENDING THE OUTCOME OF THE PROCEEDINGS UNDER THIS ARTICLE, AND THAT SUCH

CONSENT MAY BE REVOKED IN WRITING AT ANY TIME; (ii) the court shall set a date for trial in accordance with subdivision (a) of section 10.07 of this article; and (iii) the respondent shall not be released pending the completion of such trial.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART I

Intentionally omitted.

PART J

Section 1. Subdivision (b) of section 13.17 of the mental hygiene law, as amended by section 1 of part N of chapter 57 of the laws of 2000, is amended to read as follows:

(b) There shall be in the office the developmental disabilities services offices named below serving the areas either currently or previously served by a school, for the care and treatment of the mentally retarded and developmentally disabled and for research and teaching in the science and skills required for the care and treatment of such mentally retarded and developmentally disabled:

Bernard M. Fineson Developmental Disabilities Services Office
Brooklyn Developmental Disabilities Services Office
Broome Developmental Disabilities Services Office
Capital District Developmental Disabilities Services Office
Central New York Developmental Disabilities Services Office
Finger Lakes Developmental Disabilities Services Office
Institute for Basic Research in Developmental Disabilities
Hudson Valley Developmental Disabilities Services Office
Metro New York Developmental Disabilities Services Office
Long Island Developmental Disabilities Services Office
Sunmount Developmental Disabilities Services Office
Taconic Developmental Disabilities Services Office
Western New York Developmental Disabilities Services Office
Staten Island Developmental Disabilities Services Office
[Valley Ridge Center for Intensive Treatment]

The New York State Institute for Basic Research in Developmental Disabilities is designated as an institute for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of mental retardation and developmental disabilities.

S 2. Notwithstanding any other provision of law to the contrary, the commissioner of the office of mental retardation and developmental disabilities is authorized to consolidate the Valley Ridge Center for Intensive Treatment and the Broome Developmental Disabilities Services Office for the purposes of administrative efficiencies, provided, however, that the state shall continue to operate an intensive treatment facility at the Valley Ridge site. The consolidated entity shall be known as the Broome Developmental Disabilities Services Office.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART K

Section 1. Subdivision (f) of section 19.17 of the mental hygiene law, as amended by section 3 of part E of chapter 405 of the laws of 1999, is amended to read as follows:

(f) There shall be in the office the facilities named below for the care, treatment and rehabilitation of the mentally disabled and for clinical research and teaching in the science and skills required for the care, treatment and rehabilitation of such mentally disabled.

R.E. Blaisdell Addiction Treatment Center
Bronx Addiction Treatment Center
C.K. Post Addiction Treatment Center
Creedmoor Addiction Treatment Center
Dick Van Dyke Addiction Treatment Center
Kingsboro Addiction Treatment Center
[Manhattan Addiction Treatment Center]
McPike Addiction Treatment Center
Richard C. Ward Addiction Treatment Center
J.L. Norris Addiction Treatment Center
South Beach Addiction Treatment Center
St. Lawrence Addiction Treatment Center
Stutzman Addiction Treatment Center

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART L

Section 1. Subdivision 3-b of section 1 of part C of chapter 57 of the laws of 2006, establishing a cost of living adjustment for designated human services programs, as added by section 2 of part I of chapter 58 of the laws of 2008, is amended and a new subdivision 3-b is added to read as follows:

3-B. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, BEGINNING APRIL 1, 2009 AND ENDING MARCH 31, 2010, THE COMMISSIONERS SHALL NOT INCLUDE A COLA FOR THE PURPOSE OF ESTABLISHING RATES OF PAYMENTS, CONTRACTS OR ANY OTHER FORM OF REIMBURSEMENT.

[3-b] 3-C. Notwithstanding any inconsistent provision of law, beginning April 1, [2009] 2010 and ending March 31, [2012] 2013, the commissioners shall develop the COLA under this section using the actual U.S. consumer price index for all urban consumers (CPI-U) published by the United States department of labor, bureau of labor statistics for the twelve month period ending in July of the budget year prior to such state fiscal year, for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006, made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART M

Intentionally omitted.

PART N

Section 1. Section 3 of chapter 119 of the laws of 1997 authorizing the department of health to establish certain payments to general hospi-

tals, as amended by section 1 of part H of chapter 57 of the laws of 2006, is amended to read as follows:

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 1997. This act shall expire April 1, [2009] 2012.

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART O

Section 1. The commissioner of mental health and the city of New York are hereby authorized to extend, for a period not exceeding fifty years, the lease of certain portions of Ward's Island authorized by chapter 2 of the laws of 1896, as amended by chapter 380 of the laws of 1900, chapter 139 of the laws of 1908, chapter 696 of the laws of 1913, chapter 101 of the laws of 1952, chapter 491 of the laws of 1952, and chapter 524 of the laws of 1962 for the purposes of the Manhattan psychiatric center, the Kirby forensic psychiatric center and the promotion of the public health, welfare and safety.

S 2. Section 18-130 of the administrative code of the city of New York is amended by adding a new subdivision g to read as follows:

G. NOTWITHSTANDING THE PROVISIONS OF SUBDIVISIONS B, C, D, E, AND F OF THIS SECTION, IN ORDER THAT THE STATE MAY RECONSTRUCT, MODERNIZE AND REBUILD SOME OR ALL OF THE BUILDINGS AND FACILITIES OF THE MANHATTAN PSYCHIATRIC CENTER AND THE KIRBY FORENSIC PSYCHIATRIC CENTER ON WARD'S ISLAND, AND CONTINUE TO MAINTAIN SAID HOSPITALS, SO AS TO FURNISH MODERN FACILITIES FOR TREATMENT AND CARE OF PATIENTS WITH MENTAL ILLNESS OF THE METROPOLITAN DISTRICT AND TO BENEFIT THE HEALTH, WELFARE AND SAFETY OF ITS RESIDENTS, THE CITY OF NEW YORK IS HEREBY AUTHORIZED TO ENTER INTO AN AGREEMENT FOR THE RENEWAL OR FURTHER EXTENSION OF THE LEASE EXECUTED BETWEEN THE CITY OF NEW YORK AND THE STATE OF NEW YORK PURSUANT TO THE PROVISIONS OF CHAPTER ONE HUNDRED ONE OF THE LAWS OF NINETEEN HUNDRED FIFTY-TWO AND CHAPTER FIVE HUNDRED TWENTY-FOUR OF THE LAWS OF NINETEEN HUNDRED SIXTY-TWO, FOR A PERIOD NOT EXCEEDING FIFTY YEARS BEYOND ITS PRESENT TERMINATION DATE WITH RESPECT TO ANY OF THE LANDS NOW OCCUPIED BY OR USED IN CONNECTION WITH THE MANHATTAN PSYCHIATRIC CENTER, THE KIRBY FORENSIC PSYCHIATRIC CENTER AND RELATED PROGRAMS. NEITHER THE PROVISIONS OF SECTION ONE HUNDRED NINETY-SEVEN-C OF THE NEW YORK CITY CHARTER, RELATING TO A UNIFORM LAND USE REVIEW PROCEDURE, NOR THE PROVISIONS OF ANY OTHER LOCAL LAW OF LIKE OR SIMILAR IMPORT SHALL APPLY TO THE RENEWAL OR EXTENSION OF SAID LEASE.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2009.

PART P

Intentionally omitted.

PART Q

Intentionally omitted.

PART R

Section 1. Paragraph (d) of subdivision 5 of section 366-a of the social services law, as amended by section 49 of part C of chapter 58 of the laws of 2008, 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 FOR ASSISTANCE UNDER THIS TITLE FOR A RECIPIENT OF MEDICAID 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 SUCH ELIGIBILITY.

S 2. This act shall take effect immediately, and be deemed to have been in full force and effect on and after April 1, 2009.

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

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