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

S. 6914 A. 9205

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

March 29, 2014

IN SENATE -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

IN ASSEMBLY -- A BUDGET BILL, submitted by the Governor pursuant to article seven of the Constitution -- read once and referred to the Committee on Ways and Means

AN ACT to amend the public health law, in relation to prenatal clinical health care services; to amend the public health law, in relation to simplifying consent for HIV testing; to amend the public health law, in relation to authorization for data sharing with providers for purposes of patient linkage and retention in care; to amend the public health law, in relation to biennial reports for the control of malignant diseases; to amend the state finance law, in relation to the breast cancer research and education fund; to amend the public health law, and the state finance law, in relation to the cancer detection and education program advisory counsel; to amend the vehicle and traffic law, in relation to a distinctive "drive for the cure" license plate; to amend the tax law, in relation to the gift for prostate and testicular research and education; to amend the public health law, in relation to the capital restructuring financing program; to amend the public health law, in relation to delivery system reform incentive payments; to amend the public health law, in relation to eligible applicants for the Medicaid redesign team initiatives; to amend the state finance law, in relation to the Alzheimer's disease assistance fund; to amend the public health law, in relation to participating borrowers; to amend the elder law, in relation to program eligibility for catastrophic coverage; to amend the public health law, in relation to the primary care service corps practitioner loan repayment program; to amend the public health law, in relation to evaluating the state's health information technology infrastructure and systems; to amend the public health law, in relation to the establishment of certain free standing clinics, outpatient health care facilities and ambulatory health care centers in the county of Bronx; in relation to payments submitted by early intervention providers to certain third party payors; to amend the public health law and the insurance law, in relation to safe patient handling; to amend the public health law and

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

LBD12676-01-4

the social services law, in relation to review of criminal history information concerning prospective employees; to amend the public health law, in relation to the provision of contact information relating to long term care; to amend the public health law and the state finance law, in relation to the operation of the New York State donate life registry; to amend the social services law and the public health law, in relation to streamlining the application process for adult care facilities and assisted living residences; to amend the public health law, in relation to the long term home health care program; to amend the public health law, in relation to resident working audits; to amend chapter 58 of the laws of 2008 amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, in relation to the effectiveness thereof; and to repeal certain provisions of the public health law and the state finance law relating thereto (Part A); to amend the New York Health Care Reform Act of 1996, in relation to extending certain provisions relating thereto; to amend the New York Health Care Reform Act of 2000, in relation to extending the effectiveness of provisions thereof; to amend the public health law, in relation to the distribution of pool allocations and graduate medical education; to amend chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, in relation to the deposit of certain funds; to amend the public health law, in relation to health care initiative pool distributions; to amend the social services law, in relation to extending payment provisions for general hospitals; to amend chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, in relation to the effectiveness of such chapter; to amend chapter 520 of the laws of 1978 relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, in relation to extending the effectiveness of portions thereof; to amend the public health law, in relation to extending access to community health care services in rural areas; to amend the public health law, in relation to rates of payment for personal care service providers; to amend the public health law, in relation to the assessment on covered lives; to amend the public health law, in relation to the comprehensive diagnostic and treatment centers indigent care program; to amend the public health law, in relation to general hospital indigent pool and general hospital inpatient reimbursement rates; to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending the applicability of certain provisions thereof; and to amend chapter 63 of the laws of 2001 amending chapter 20 of the laws of 2001 amending the military law and other laws relating to making appropriations for the support of government, in relation to extending the applicability of certain provisions thereof (Part B); to amend the social services law, in relation to eliminating prescriber prevails for brand name drugs with generic equivalents; directing the department of health to develop new methodology for pharmacy reimbursement; to amend the public health law, in relation to minimum supplemental rebates for pharmaceutical manufacturers; to amend the social services law, in relation to early refill of prescriptions; to amend the social services law, in relation to emergency and non-emergency transporta-

tion; to amend section 45-c of part A of chapter 56 of the laws of 2013, relating to the report on the transition of behavioral health services as a managed care benefit in the medical assistance program, in relation to reports on the transition of behavior health services; to amend the social services law, in relation to the integration of behavioral and physical health clinic services; to amend part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to establishing rate protections for behavioral health essential providers and the effectiveness thereof; to amend section 1 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to transfer of funds and the effectiveness thereof; to amend the social services law, in relation to spousal support for the costs of community-based long term care; to amend the social services law, in relation to fair hearings within the Fully Integrated Duals Advantage program; to amend the public health law, in relation to the establishment of a default rate for nursing homes under managed care; to amend the public health law, in relation to rates of payment for certified home health agencies and long term home health care programs; to amend social services law in relation to Community First Choice Option; to amend education law in relation to developing training curricula to educate certain home health aides; to amend public health law in relation to Development Disabilities Individual Care and Support Organization; to amend the public health law, in relation to rate setting methodologies for the ICD-10; to amend the public health law, in relation to inpatient psych base years; to amend the public health law, in relation to specialty inpatient base years; to amend the public health law, in relation to inpatient psych base years; to amend the public health law, in relation to hospital inpatient base years; to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to the determination of rates of payments by certain state governmental agencies; to amend the social services law and the public health law, in relation to requiring the use of an enrollment broker for counties that are mandated Medicaid managed care and managed long term care; to amend the public health law, in relation to establishing vital access pools for licensed home care service agencies; to amend the social services law, in relation to the expansion of the Medicaid managed care advisory review panel; to amend part H of chapter 59 of the laws of 2011 amending the public health law relating to general hospital inpatient reimbursement for annual rates, in relation to the across the board reduction of 2011; to amend the social services law, in relation to establishing a health homes criminal justice initiative; to amend the social services law, in relation to the transition of children in foster care to managed care; to amend the social services law and the state finance law, in relation to the establishment of a basic health plan; to amend the social services law, in relation to hospital presumptive eligibility under the affordable care act; to amend the state finance law, in relation to a basic health program trust fund and a state health innovation plan account; to amend the social services law, in relation to spending down procedures under the MAGI system of eligibility determination; to amend the

public health law, in relation to moving rate setting for child health plus to the department of health; to amend the public health law, in relation to eliminating the existing child health plus waiting period; to amend chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, in relation to allowing for the permanent expansion of child health plus income and benefit provisions; to amend the public health law in relation to potentially preventable negative outcomes; to amend the public health law, in relation to a rural dentistry pilot program; to amend chapter 779 of the laws of 1986, amending the social services law relating to authorizing services for non-residents in adult homes, residences for adults and enriched housing programs, in relation to extending the authorization of non-resident services within adult homes; to amend 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, in relation to extending the utilization threshold exemption; to amend chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, in relation to extending provisions related to dispensing fees; to amend the public health law, in relation to rates of payment to residential health care facilities; to amend chapter 731 of the laws of 1993, amending the public health law and other laws relating to reimbursement, delivery and capital cost of ambulatory health care services and inpatient hospital services, in relation to the effectiveness thereof; to amend chapter 904 of the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, in relation to the effectiveness thereof; providing for the repeal of certain provisions relating to the availability of funds upon expiration thereof; providing for the repeal of certain provisions relating to the availability of funds upon expiration thereof; and to repeal certain provisions of the social services law and the public health law relating thereto (Part C); to amend the education law and the public health law, in relation to the practice of pharmacy and the compounding of drugs, and establishing requirements for the registration of outsourcing facilities in New York state (Part D); to amend the mental hygiene law, in relation to establishing an integrated employment plan (Part E); directing a report by the office for people with developmental disabilities on the establishment of a direct support professional credentialing pilot program (Part F); to amend the mental hygiene law and the state finance law, in relation to community mental health support and workforce reinvestment funds; and to amend chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, in relation to extending such provisions relating thereto (Part G); to amend the insurance law, the public health law and the financial services law, in relation to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, access to out-of-network care and prohibition of excessive emergency charges (Part H); and to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services

programs, in relation to forgoing such adjustment during the 2014-2015 state fiscal year (Part I)

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 2014-2015 state fiscal year. Each component is wholly contained within a Part identified as Parts A through I. 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. Paragraph (a) of subdivision 1 of section 602 of the public health law, as added by section 16 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

(a) Family health, which shall include activities designed to reduce perinatal, infant and maternal mortality and morbidity and to promote the health of infants, children, adolescents, and people of childbearing age. Such activities shall include family centered perinatal services and other services appropriate to promote the birth of a healthy baby to a healthy mother, and services to assure that infants, young children, and school age children are enrolled in appropriate health insurance programs and other health benefit programs for which they are eligible, and that the parents or guardians of such children are provided with information concerning health care providers in their area that are willing and able to provide health services to such children. Provision of primary and preventive clinical health care services shall be eligible for state aid for uninsured persons under the age of twenty-one, provided that the municipality makes good faith efforts to assist such persons with insurance enrollment and only until such time as enrollment becomes effective. PROVISION OF PRENATAL CLINICAL HEALTH CARE SERVICES SHALL BE ELIGIBLE FOR STATE AID FOR UNINSURED WOMEN OF ANY AGE, PROVIDED THAT THE MUNICIPALITY MAKES GOOD FAITH EFFORTS TO ASSIST SUCH WOMEN WITH INSURANCE ENROLLMENT AND ONLY UNTIL SUCH TIME AS ENROLLMENT BECOMES EFFECTIVE.

S 2. Subdivisions 1, 2, 2-a, 2-b, 2-c, 3 and 4 of section 2781 of the public health law, subdivisions 1, 2, 3 and 4 as amended and subdivisions 2-a, 2-b and 2-c as added by chapter 308 of the laws of 2010, are amended to read as follows:

1. Except as provided in section three thousand one hundred twenty-one of the civil practice law and rules, or unless otherwise specifically authorized or required by a state or federal law, no person shall order the performance of an HIV related test without first having received [the written or, where authorized by this subdivision, oral,] informed consent of the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, of a person authorized pursuant to law to consent to health care for such individual. [When the test

being ordered is a rapid HIV test, such informed consent may be obtained orally and shall be documented in the subject of the test's medical record by the person ordering the performance of the test.] IN ORDER FOR THERE TO BE INFORMED CONSENT, THE PERSON ORDERING THE TEST SHALL, PRIOR TO OBTAINING INFORMED CONSENT, AT A MINIMUM ADVISE THE PROTECTED INDIVIDUAL THAT AN HIV-RELATED TEST IS BEING PERFORMED.

2. [Except where subdivision one of this section permits informed consent to be obtained orally, informed consent to HIV related testing shall consist of a statement consenting to HIV related testing signed by the subject of the test who has capacity to consent or, when the subject lacks capacity to consent, by a person authorized pursuant to law to consent to health care for the subject after the subject or such other person has received the information described in subdivision three of this section.

2-a. Where a written consent to HIV related testing is included in a signed general consent to medical care for the subject of the test or in a signed consent to any health care service for the subject of the test, the consent form shall have a clearly marked place adjacent to the signature where the subject of the test, or, when the subject lacks capacity to consent, a person authorized pursuant to law to consent to health care for such individual, shall be given an opportunity to specifically decline in writing HIV related testing on such general consent.

2-b. A written or oral informed] INFORMED consent for HIV related testing pursuant to this section shall be valid for such testing until such consent is revoked [or expires by its terms]. Each time that an HIV related test is ordered pursuant to informed consent in accordance with this section, the physician or other person authorized pursuant to law to order the performance of the HIV related test, or such person's representative, shall orally notify the subject of the test or, when the subject lacks capacity to consent, a person authorized pursuant to law to consent to health care for such individual, that an HIV related test will be conducted at such time, and shall note the notification in the patient's record.

[2-c.] 2-A. The provisions of this section regarding [oral] informed consent [for a rapid HIV test] shall not apply to tests performed in a facility operated under the correction law. FOR TESTS CONDUCTED IN A FACILITY UNDER THE CORRECTION LAW, INDIVIDUAL CONSENT FOR HIV RELATED TESTING MUST BE IN WRITING.

3. [Prior to the execution of written, or obtaining and documenting oral, informed consent, a] A person ordering the performance of an HIV related test shall provide either directly or through a representative to the subject of an HIV related test or, if the subject lacks capacity to consent, to a person authorized pursuant to law to consent to health care for the subject, an explanation that:

(a) HIV causes AIDS and can be transmitted through sexual activities and needle-sharing, by pregnant women to their fetuses, and through breastfeeding infants;

(b) there is treatment for HIV that can help an individual stay healthy;

(c) individuals with HIV or AIDS can adopt safe practices to protect uninfected and infected people in their lives from becoming infected or multiply infected with HIV;

(d) testing is voluntary and can be done anonymously at a public testing center;

(e) the law protects the confidentiality of HIV related test results;

(f) the law prohibits discrimination based on an individual's HIV status and services are available to help with such consequences; and

(g) the law allows an individual's informed consent for HIV related testing to be valid for such testing until such consent is revoked by the subject of the HIV RELATED test [or expires by its terms].

Protocols shall be in place to ensure compliance with this section.

4. A person authorized pursuant to law to order the performance of an HIV related test shall provide directly or through a representative to the person seeking such test, an opportunity to remain anonymous [and to provide written, informed consent or authorize documentation of oral informed consent,] through use of a coded system with no linking of individual identity to the test request or results. A health care provider who is not authorized by the commissioner to provide HIV related tests on an anonymous basis shall refer a person who requests an anonymous test to a test site which does provide anonymous testing. The provisions of this subdivision shall not apply to a health care provider ordering the performance of an HIV related test on an individual proposed for insurance coverage.

S 3. Section 2135 of the public health law, as amended by chapter 308 of the laws of 2010, is amended to read as follows:

S 2135. Confidentiality. All reports or information secured by the department, municipal health commissioner or district health officer under the provisions of this title shall be confidential except: (a) in so far as is necessary to carry out the provisions of this title; (b) when used in the aggregate, without patient specific identifying information, in programs approved by the commissioner for the improvement of the quality of medical care provided to persons with HIV/AIDS; [or] (c) when used within the state or local health department by public health disease programs to assess co-morbidity or completeness of reporting and to direct program needs, in which case patient specific identifying information shall not be disclosed outside the state or local health department; OR (D) WHEN USED FOR PURPOSES OF PATIENT LINKAGE AND RETENTION IN CARE, PATIENT SPECIFIC IDENTIFIED INFORMATION MAY BE SHARED BETWEEN LOCAL AND STATE HEALTH DEPARTMENTS AND HEALTH CARE PROVIDERS CURRENTLY TREATING THE PATIENT AS APPROVED BY THE COMMISSIONER.

S 4. Intentionally omitted.

S 5. Subdivision 1 of section 2411 of the public health law, as amended by chapter 219 of the laws of 1997, paragraph (e) as amended by chapter 106 of the laws of 2013, and paragraph (h) as amended by chapter 638 of the laws of 2008, is amended to read as follows:

1. The board shall:

(a) Survey state agencies, boards, programs and other state governmental entities to assess what, if any, relevant data has been or is being collected which may be of use to researchers engaged in breast[, prostate or testicular] cancer research;

(b) Consistent with the survey conducted pursuant to paragraph (a) of this subdivision, compile a list of data collected by state agencies which may be of assistance to researchers engaged in breast[, prostate or testicular] cancer research as established in section twenty-four hundred twelve of this title;

(c) Consult with the Centers for Disease Control and Prevention, the National Institutes of Health, the Federal Agency For Health Care Policy and Research, the National Academy of Sciences and other organizations or entities which may be involved in cancer research to solicit both information regarding breast[, prostate and testicular] cancer research

projects that are currently being conducted and recommendations for future research projects;

(d) Review requests made to the commissioner for access to information pursuant to paragraph b of subdivision one of section 33-1203 and paragraph c of subdivision two of section 33-1205 of the environmental conservation law for use in human health related research projects. Such data shall only be provided to researchers engaged in human health related research. The request made by such researchers shall include a copy of the research proposal or the research protocol approved by their institution and copies of their institution's Institutional Review Board (IRB) or equivalent review board approval of such proposal or protocol. In the case of research conducted outside the auspices of an institution by a researcher previously published in a peer-reviewed scientific journal, the board shall request copies of the research proposal and shall deny access to the site-specific and nine-digit zip code pesticide data if the board determines that such proposal does not follow accepted scientific practice for the design of a research project. The board shall establish guidelines to restrict the dissemination by researchers of the name, address or other information that would otherwise identify a commercial applicator or private applicator or any person who receives the services of a commercial applicator;

(e) Solicit, receive, and review applications from public and private agencies and organizations and qualified research institutions for grants from the breast cancer research and education fund, created pursuant to section ninety-seven-yy of the state finance law, to conduct research or educational programs which focus on the causes, prevention, screening, treatment and cure of breast cancer and may include, but are not limited to mapping of breast cancer, and basic, behavioral, clinical, demographic, environmental, epidemiologic and psychosocial research. The board shall make recommendations to the commissioner, and the commissioner shall, in his or her discretion, grant approval of applications for grants from those applications recommended by the board. The board shall consult with the Centers for Disease Control and Prevention, the National Institutes of Health, the Federal Agency For Health Care Policy and Research, the National Academy of Sciences, breast cancer advocacy groups, and other organizations or entities which may be involved in breast cancer research to solicit both information regarding breast cancer research projects that are currently being conducted and recommendations for future research projects. As used in this section, "qualified research institution" may include academic medical institutions, state or local government agencies, public or private organizations within this state, and any other institution approved by the department, which is conducting a breast cancer research project or educational program. If a board member submits an application for a grant from the breast cancer research and education fund, he or she shall be prohibited from reviewing and making a recommendation on the application;

(f) Consider, based on evolving scientific evidence, whether a correlation exists between pesticide use and pesticide exposure. As part of such consideration the board shall make recommendations as to methodologies which may be utilized to establish such correlation;

(g) After two years of implementation of pesticide reporting pursuant to section 33-1205 of the environmental conservation law, the board shall compare the percentage of agricultural crop production general use pesticides being reported to the total amount of such pesticides being used in this state as estimated by Cornell University, Cornell Cooper-

ative Extension, the department of environmental conservation, and the Environmental Protection Agency;

(h) Meet at least six times in the first year, at the request of the chair and at any other time as the chair deems necessary. The board shall meet at least [four] TWO times a year AND AS NEEDED thereafter. Provided, however, that at least one such meeting a year shall be a public hearing, at which the general public may question and present information and comments to the board with respect to the operation of the health research science board, the breast cancer research and education fund[, the prostate and testicular cancer research and education fund], and pesticide reporting established pursuant to sections 33-1205 and 33-1207 of the environmental conservation law. At such hearing, the commissioner of the department of environmental conservation or his or her designee shall make a report to the board with respect to the efficiency and utility of pesticide reporting established pursuant to sections 33-1205 and 33-1207 of the environmental conservation law. SHOULD THE EXISTING BYLAWS BE AMENDED BY THE BOARD, ANY SUCH AMENDMENTS SHALL BE CONSISTENT WITH THE REVISIONS OF THIS PARAGRAPH;

S 5-a. Section 2413 of the public health law, as amended by chapter 219 of the laws of 1997, is amended to read as follows:

S 2413. Biennial report. The commissioner shall submit a report on or before January first commencing in nineteen hundred ninety-nine, and biennially thereafter, to the governor, the temporary president of the senate and the speaker of the assembly concerning the operation of the health research science board. Such report shall include recommendations from the health research science board including, but not limited to, the types of data that would be useful for breast[, prostate or testicular] cancer researchers and whether private citizen use of residential pesticides should be added to the reporting requirements. The report shall also include a summary of research requests granted or denied. In addition, such report shall include an evaluation by the commissioner, the commissioner of the department of environmental conservation and the health research science board of the basis, efficiency and scientific utility of the information derived from pesticide reporting pursuant to sections 33-1205 and 33-1207 of the environmental conservation law and recommend whether such system should be modified or continued. The report shall include a summary of the comments and recommendations presented by the public at the board's public hearings.

S 5-b. Section 97-yy of the state finance law is amended by adding a new subdivision 2-b to read as follows:

2-B. ON OR BEFORE THE FIRST DAY OF FEBRUARY EACH YEAR, THE COMMISSIONER OF HEALTH SHALL PROVIDE A WRITTEN REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE FINANCE COMMITTEE, CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, CHAIR OF THE SENATE COMMITTEE ON HEALTH, AND CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. SUCH REPORT SHALL INCLUDE HOW THE MONIES OF THE FUND WERE UTILIZED DURING THE PRECEDING CALENDAR YEAR, AND SHALL INCLUDE:

(I) THE AMOUNT OF MONEY DISPERSED FROM THE FUND;

(II) RECIPIENTS OF AWARDS FROM THE FUND;

(III) THE AMOUNT AWARDED TO EACH; AND

(IV) THE PURPOSES FOR WHICH SUCH AWARDS WERE GRANTED.

S 6. Section 2409-a of the public health law, as added by section 73 of part D of chapter 60 of the laws of 2012, is amended to read as follows:

S 2409-a. Advisory council. 1. There is hereby established in the department the [breast, cervical and ovarian] cancer detection and

education program advisory council, for the purpose of advising the commissioner with regards to providing information to consumers, patients, and health care providers relating, but not limited to, breast, cervical, PROSTATE, TESTICULAR and ovarian cancer, including signs and symptoms, risk factors, the benefits of prevention and early detection, guideline concordant cancer screening and disease management, options for diagnostic testing and treatment, new technologies, and survivorship.

2. The advisory council shall: (A) make recommendations to the department regarding the promotion and implementation of programs under sections twenty-four hundred six and twenty-four hundred nine of this title; AND (B) PRIOR TO THE DEPARTMENT PROVIDING GRANTS FROM THE NEW YORK STATE PROSTATE AND TESTICULAR CANCER RESEARCH AND EDUCATION FUND, CREATED PURSUANT TO SECTION NINETY-FIVE-E OF THE STATE FINANCE LAW, ADVISE THE DEPARTMENT ON VARIOUS COMPONENTS OF THE DEPARTMENT'S SOLICITATION TO DISTRIBUTE SUCH FUNDS, INCLUDING BUT NOT LIMITED TO, THE POTENTIAL USES OF THE FUNDS, THE ENTITIES THAT MAY BE ELIGIBLE TO APPLY FOR THE FUNDS, THE RECOMMENDED CONTRACT DELIVERABLES FOR ENTITIES RECEIVING THE FUNDS, THE RECOMMENDED GEOGRAPHIC DISTRIBUTION OF THE FUNDS, AND THE RECOMMENDED AWARD AMOUNTS.

3. The commissioner shall appoint twenty-one voting members, which shall include representation of health care professionals, consumers, patients, ONE VOTING MEMBER WHO SHALL BE A PERSON WHO HAS OR HAS HAD PROSTATE OR TESTICULAR CANCER, ONE VOTING MEMBER WHO SHALL BE A PERSON WHO HAS OR HAS HAD BREAST, CERVICAL OR OVARIAN CANCER and other appropriate [interest] INTERESTS reflective of the diversity of the state, with expertise in breast, cervical, PROSTATE, TESTICULAR and/or ovarian cancer. The commissioner shall appoint one member as a chairperson. The members of the council shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in performance of their duties.

4. A majority of the appointed voting membership of the board shall constitute quorum.

5. The advisory council shall meet at least twice a year, at the request of the department.

S 7. Section 95-e of the state finance law, as added by chapter 273 of the laws of 2004, subdivision 2 as amended by section 1 of part A of chapter 58 of the laws of 2004, is amended to read as follows:

S 95-e. New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund. 1. There is hereby established in the joint custody of the commissioner of taxation and finance and the comptroller, a special fund to be known as the "New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund".

2. Such fund shall consist of all revenues received pursuant to the provisions of SECTION FOUR HUNDRED FOUR-Q OF THE VEHICLE AND TRAFFIC LAW, AS ADDED BY CHAPTER FIVE HUNDRED TWENTY-EIGHT OF THE LAWS OF NINETEEN HUNDRED NINETY-NINE, AND sections two hundred nine-E and six hundred thirty of the tax law, all revenues received pursuant to appropriations by the legislature, and all moneys appropriated, credited, or transferred thereto from any other fund or source pursuant to law. For each state fiscal year, there shall be appropriated to the fund by the state, in addition to all other moneys required to be deposited into such fund, an amount equal to the amounts of monies collected and deposited into the fund pursuant to SECTION FOUR HUNDRED FOUR-Q OF THE VEHICLE AND TRAFFIC LAW, AS ADDED BY CHAPTER FIVE HUNDRED TWENTY-EIGHT OF

THE LAWS OF NINETEEN HUNDRED NINETY-NINE, AND sections two hundred [nine-e] NINE-E and six hundred thirty of the tax law during the preceding calendar year, as certified by the comptroller. Nothing contained herein shall prevent the state from receiving grants, gifts or bequests for the purposes of the fund as defined in this section and depositing them into the fund according to law. Any interest received by the comptroller on moneys on deposit in such fund shall be retained in and become part of such fund.

3. (A) Moneys of the fund [shall be expended only to provide grants to the New York State Coalition to Cure Prostate Cancer, a not-for-profit corporation established in this state which is incorporated], FOLLOWING APPROPRIATION BY THE LEGISLATURE AND ALLOCATION BY THE DIRECTOR OF THE BUDGET, SHALL BE MADE AVAILABLE TO THE COMMISSIONER OF HEALTH TO PROVIDE GRANTS for the purpose of advancing and financing prostate AND TESTICULAR cancer research, [detection] SUPPORT PROGRAMS and education projects. [To the extent practicable, the New York State Coalition to Cure Prostate Cancer shall cooperate and coordinate its efforts with the prostate and testicular cancer detection and education advisory council established pursuant to section twenty-four hundred sixteen of the public health law.]

(B) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTION ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER PARAGRAPH (A) OF THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(I) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(1) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(2) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(3) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(4) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(II) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH; AND

(III) THE COMMISSIONER OF HEALTH SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

4. (A) On or before the first day of February each year, the comptroller shall certify to the governor, temporary president of the senate, speaker of the assembly, chair of the senate finance committee and chair of the assembly ways and means committee, the amount of money deposited by source in the New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund during the preceding calendar year as the result of revenue derived pursuant to SECTION FOUR HUNDRED FOUR-Q OF THE VEHICLE AND TRAFFIC LAW, AS ADDED BY CHAPTER FIVE HUNDRED TWENTY-EIGHT OF THE LAWS OF NINETEEN HUNDRED NINETY-NINE, AND sections two hundred nine-E and six hundred thirty of the tax law and from all other sources.

(B) ON OR BEFORE THE FIRST DAY OF FEBRUARY EACH YEAR, THE COMMISSIONER OF HEALTH SHALL PROVIDE A WRITTEN REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE FINANCE COMMITTEE, CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, CHAIR OF THE SENATE

COMMITTEE ON HEALTH, AND CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. SUCH REPORT SHALL INCLUDE HOW MONIES OF THE FUND WERE UTILIZED DURING THE PRECEDING CALENDAR YEAR AND SHALL INCLUDE:

(I) THE AMOUNT OF MONEY DISBURSED FROM THE FUND;

(II) RECIPIENTS OF AWARDS FROM THE FUND;

(III) THE AMOUNT AWARDED TO EACH; AND

(IV) THE PURPOSES FOR WHICH SUCH AWARDS WERE GRANTED.

5. [As a condition of receiving grants from the fund, the New York State Coalition To Cure Prostate Cancer shall agree to issue and shall issue, on or before the first day of February each year, a report including, but not limited to, financial statements, financial reports and reports on the issuance of grants. Such reports shall be delivered to the governor and the chairs of the senate finance committee and the assembly ways and means committee and shall also be made available to the public. Such financial statements and reports shall be audited by a nationally recognized accounting firm.

6.] Moneys shall be payable from the fund [to the New York State Coalition to Cure Prostate Cancer] on the audit and warrant of the comptroller on vouchers approved by the comptroller.

S 7-a. Subdivision 2 of section 404-q of the vehicle and traffic law, as added by chapter 528 of the laws of 1999, is amended to read as follows:

2. A distinctive "drive for the cure" license plate issued pursuant to this section shall be issued in the same manner as other number plates upon the payment of the regular registration fee prescribed by section four hundred one of this article, provided, however, that an additional annual service charge of twenty-five dollars shall be charged for such plate. Twelve dollars and fifty cents from each twenty-five dollars received as annual service charges under this section shall be deposited to the credit of the breast cancer research and education fund established pursuant to section ninety-seven-yy of the state finance law and shall be used for research and education programs undertaken pursuant to section twenty-four hundred ten of the public health law. Twelve dollars and fifty cents from each twenty-five dollars received as annual service charges under this section shall be deposited to the credit of the NEW YORK STATE prostate and testicular cancer research and education fund established pursuant to section [ninety-seven-ccc] NINETY-FIVE-E of the state finance law and shall be used for research and education programs undertaken pursuant to section [ninety-seven-ccc] NINETY-FIVE-E of the state finance law. Provided, however that one year after the effective date of this section funds in the amount of six thousand dollars, or so much thereof as may be available, shall be allocated to the department to offset costs associated with the production of such license plates.

S 7-b. Section 97-ccc of the state finance law is REPEALED.

S 7-c. Section 209-E of the tax law, as added by chapter 273 of the laws of 2004, is amended to read as follows:

S 209-E. Gift for prostate AND TESTICULAR cancer research[, detection] and education. Effective for any tax year commencing on or after January first, two thousand four, a taxpayer in any taxable year may elect to contribute to the support of the New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund. Such contribution shall be in any whole dollar amount and shall not reduce the amount of the state tax owed by such taxpayer. The commissioner shall include space on the corporate income tax return to enable a taxpayer to make such contribution. Notwithstanding any other provision of law, all revenues collected pursuant to this section shall be credit-

ed to the New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund and shall be used only for those purposes enumerated in section ninety-five-e of the state finance law.

S 7-d. Section 630 of the tax law, as added by chapter 273 of the laws of 2004, is amended to read as follows:

S 630. Gift for prostate AND TESTICULAR cancer research[, detection] and education. Effective for any tax year commencing on or after January first, two thousand four, an individual in any taxable year may elect to contribute to the New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund. Such contribution shall be in any whole dollar amount and shall not reduce the amount of state tax owed by such individual. The commissioner shall include space on the personal income tax return to enable a taxpayer to make such contribution. Notwithstanding any other provision of law all revenues collected pursuant to this section shall be credited to the New York [state] STATE prostate AND TESTICULAR cancer research[, detection] and education fund and used only for those purposes enumerated in section ninety-five-e of the state finance law.

S 8. The public health law is amended by adding a new section 2825 to read as follows:

S 2825. CAPITAL RESTRUCTURING FINANCING PROGRAM. 1. A CAPITAL RESTRUCTURING FINANCING PROGRAM IS HEREBY ESTABLISHED UNDER THE JOINT ADMINISTRATION OF THE COMMISSIONER AND THE PRESIDENT OF THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK FOR THE PURPOSE OF ENHANCING THE QUALITY, FINANCIAL VIABILITY AND EFFICIENCY OF NEW YORK'S HEALTH CARE DELIVERY SYSTEM BY TRANSFORMING THE SYSTEM INTO A MORE RATIONAL PATIENT-CENTERED CARE SYSTEM THAT PROMOTES POPULATION HEALTH AND IMPROVED WELL-BEING FOR ALL NEW YORKERS. THE ISSUANCE OF ANY BONDS OR NOTES HEREUNDER SHALL FURTHER BE SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, AND ANY PROJECTS FUNDED THROUGH THE ISSUANCE OF BONDS OR NOTES HEREUNDER SHALL BE APPROVED BY THE NEW YORK STATE PUBLIC AUTHORITIES CONTROL BOARD, AS REQUIRED UNDER SECTION FIFTY-ONE OF THE PUBLIC AUTHORITIES LAW.

2. FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND TWENTY-ONE, FUNDS MADE AVAILABLE FOR EXPENDITURE PURSUANT TO THIS SECTION MAY BE DISTRIBUTED BY THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND OFFICE FOR ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AS APPLICABLE, FOR:

(A) CAPITAL GRANTS TO GENERAL HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTICS AND TREATMENT CENTERS, AND CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL HYGIENE LAW, ASSISTED LIVING PROGRAMS, PRIMARY CARE PROVIDERS, AND HOME CARE PROVIDERS CERTIFIED OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER (COLLECTIVELY "APPLICANTS") THAT QUALIFY FOR PAYMENTS UNDER THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM (DSRIP), IN WHICH CASE FUNDING UNDER THIS PARAGRAPH SHALL BE REQUESTED IN SUCH APPLICANT'S DSRIP APPLICATION. SUCH CAPITAL GRANT PROJECTS INCLUDE, BUT ARE NOT LIMITED TO; CLOSURES, MERGERS, RESTRUCTURING, IMPROVEMENTS TO INFRASTRUCTURE, DEVELOPMENT OF PRIMARY CARE SERVICE CAPACITY, DEVELOPMENT OF TELEHEALTH INFRASTRUCTURE, THE PROMOTION OF INTEGRATED DELIVERY SYSTEMS THAT STRENGTHEN AND PROTECT CONTINUED ACCESS TO ESSENTIAL HEALTH CARE SERVICES AND OTHER TRANSFORMATIONAL PROJECTS AS DETERMINED BY THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY.

(B) CAPITAL GRANTS TO GENERAL HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AND CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL HYGIENE LAW, ASSISTED LIVING PROGRAMS, PRIMARY CARE PROVIDERS, HOME CARE PROVIDERS, CERTIFIED OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER (COLLECTIVELY "APPLICANTS") THAT ARE NON-QUALIFYING AND NON-PARTICIPATING APPLICANTS UNDER PARAGRAPH (A) OF THIS SUBDIVISION, FOR CAPITAL NON-OPERATIONAL WORKS OR PURPOSES THAT SUPPORT THE PURPOSES SET FORTH IN THIS SECTION. SUCH CAPITAL GRANT PROJECTS INCLUDE, BUT ARE NOT LIMITED TO; CLOSURES, MERGERS, RESTRUCTURING, IMPROVEMENTS TO INFRASTRUCTURE, DEVELOPMENT OF PRIMARY CARE SERVICE CAPACITY, DEVELOPMENT OF TELEHEALTH INFRASTRUCTURE, THE PROMOTION OF INTEGRATED DELIVERY SYSTEMS THAT STRENGTHEN AND PROTECT CONTINUED ACCESS TO ESSENTIAL HEALTH CARE SERVICES.

3. THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY SHALL ENTER INTO AN AGREEMENT, SUBJECT TO APPROVAL BY THE DIRECTOR OF THE BUDGET AND SUBJECT TO SECTION SIXTEEN HUNDRED EIGHTY-R OF THE PUBLIC AUTHORITIES LAW, AS ADDED BY A CHAPTER OF THE LAWS OF TWO THOUSAND FOURTEEN, FOR THE PURPOSES OF AWARDING, DISTRIBUTING, AND ADMINISTERING THE FUNDS MADE AVAILABLE PURSUANT TO THIS SECTION.

(A) FOR CAPITAL GRANT PROJECTS UNDER PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION, THE EVALUATION OF APPLICATIONS SHALL BE SUBMITTED PURSUANT TO THE PROCESS DESCRIBED IN PARAGRAPH (B) OF SUBDIVISION TWENTY OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE; PROVIDED, HOWEVER, THAT SUCH CAPITAL GRANT PROJECTS SHALL NOT BE SUBJECT TO REVIEW BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

(B) FOR MONIES ALLOCATED UNDER PARAGRAPH (B) OF SUBDIVISION TWO OF THIS SECTION:

(I) THE DEPARTMENT SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(A) THE PROCESS BY WHICH SUCH APPLICATIONS SHALL BE REVIEWED;

(B) THE CRITERIA BY WHICH SUCH APPLICATIONS SHALL BE JUDGED; AND

(C) A LIST OF APPROVED AND DENIED APPLICATIONS SUBSEQUENT TO SUCH DETERMINATION.

(II) THE EVALUATION OF APPLICATIONS SHALL BE REVIEWED BY THE DEPARTMENT, PURSUANT TO A PROCESS TO BE DETERMINED BY THE DEPARTMENT. APPLICATIONS SHALL THEN BE SUBJECT TO REVIEW BY THE PANEL ESTABLISHED PURSUANT TO PARAGRAPH (B) OF SUBDIVISION TWENTY OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE, WHICH SHALL SUBMIT ITS RECOMMENDATIONS TO THE COMMISSIONER FOR FINAL DETERMINATION. DETERMINATION OF AWARDS FOR FUNDS ALLOCATED UNDER PARAGRAPH (B) OF SUBDIVISION TWO OF THIS SECTION, SHALL INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING CRITERIA:

(A) ELIGIBILITY REQUIREMENTS FOR APPLICANTS;

(B) STATEWIDE GEOGRAPHIC DISTRIBUTION OF FUNDS;

(C) MINIMUM AND MAXIMUM AMOUNTS OF FUNDING TO BE AWARDED UNDER THE PROGRAM;

(D) THE RELATIONSHIP BETWEEN THE PROJECT PROPOSED BY AN APPLICANT AND IDENTIFIED COMMUNITY NEED;

(E) THE EXTENT TO WHICH THE APPLICANT HAS ACCESS TO ALTERNATIVE FINANCING;

(F) THE EXTENT TO WHICH THE PROPOSED PROJECT FURTHERS THE PURPOSES SET FORTH IN THIS SECTION;

(G) THE EXTENT THAT THE PROPOSED PROJECT FURTHERS THE DEVELOPMENT OF PRIMARY CARE;

(H) THE EXTENT TO WHICH THE PROPOSED PROJECT BENEFITS MEDICAID ENROLLEES AND UNINSURED INDIVIDUALS;

(I) THE EXTENT TO WHICH THE PROPOSED PROJECT ADDRESSES POTENTIAL RISK TO PATIENT SAFETY AND WELFARE;

(J) THE EXTENT THAT THE PROPOSED PROJECT INVOLVES AN APPLICANT THAT RECEIVES OR HAS APPLIED FOR A TEMPORARY RATE ADJUSTMENT PURSUANT TO APPLICABLE REGULATIONS; AND

(K) THE EXTENT TO WHICH THE PROPOSED PROJECT WILL CONTRIBUTE TO THE LONG TERM SUSTAINABILITY OF THE APPLICANT.

THE COMMISSIONER SHALL PROVIDE A REPORT ON A QUARTERLY BASIS TO THE CHAIRS OF THE SENATE FINANCE, ASSEMBLY WAYS AND MEANS, SENATE HEALTH AND ASSEMBLY HEALTH COMMITTEES. SUCH REPORTS SHALL BE SUBMITTED NO LATER THAN SIXTY DAYS AFTER THE CLOSE OF THE QUARTER, AND SHALL CONFORM TO THE REPORTING REQUIREMENTS OF SUBDIVISION TWENTY OF SECTION TWENTY-EIGHT HUNDRED SEVEN OF THIS ARTICLE, AS APPLICABLE.

S 8-a. Subdivision 20 of section 2807 of the public health law, as added by section 9 of part Q of chapter 56 of the laws of 2013, is amended to read as follows:

20. (A) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for Delivery System Reform Incentive Payments ("[DSRIPS] DSRIP") to such facilities. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the DSRIP funds. THE COMMISSIONER SHALL, TO THE MAXIMUM DEGREE PRACTICABLE, AND TO THE EXTENT PERMITTED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES ("CMS"), ENSURE THAT THE DSRIP PROGRAM IS IMPLEMENTED THROUGHOUT THE ENTIRE STATE.

(B) THE COMMISSIONER SHALL ESTABLISH AN ADVISORY PANEL TO PROVIDE ASSISTANCE WITH REGARD TO THE DSRIP PROGRAM. THE PANEL SHALL BE CHARGED WITH REVIEWING RECOMMENDATIONS FOR DSRIP FUNDING MADE BY THE STATE'S CONTRACTED DSRIP ASSESSOR AND ADVISING THE COMMISSIONER REGARDING THE RESULTS OF SUCH REVIEW. SUCH PANEL SHALL ALSO REVIEW APPLICATIONS UNDER PARAGRAPH (B) OF SUBDIVISION TWO OF SECTION TWENTY-EIGHT HUNDRED TWENTY-FIVE OF THIS ARTICLE. PANEL MEMBERSHIP SHALL BE COMPRISED OF INDIVIDUALS WITH SIGNIFICANT HEALTH CARE SYSTEM EXPERIENCE. MEMBERS MAY NOT BE ELECTED OFFICIALS OR EMPLOYED BY PROVIDERS THAT WOULD BENEFIT FROM DSRIP FUNDING, AND MUST NOT HAVE ANY CONFLICT OF INTEREST THAT WOULD PREVENT THEM FROM PROVIDING AN IMPARTIAL REVIEW OF DSRIP ASSESSOR RECOMMENDATIONS. THE PANEL SHALL CONSIST OF MEMBERS APPOINTED BY THE COMMISSIONER AND SHALL IN ADDITION CONSIST OF ONE MEMBER APPOINTED BY THE MAJORITY LEADER OF THE NEW YORK STATE SENATE, AND ONE MEMBER APPOINTED BY THE SPEAKER OF THE NEW YORK STATE ASSEMBLY. THE PANEL SHALL CARRY OUT THE REVIEW OF DSRIP RECOMMENDATIONS IN STRICT ACCORDANCE WITH ALL REQUIREMENTS SET FORTH IN THE STATE'S FEDERAL 1115 MEDICAID WAIVER STANDARD TERMS AND CONDITIONS. THE PANEL SHALL SUBMIT ITS RECOMMENDATIONS TO THE COMMISSIONER FOR FINAL DETERMINATION, IN ACCORDANCE WITH ALL REQUIREMENTS SET FORTH IN THE STATE'S FEDERAL 1115 MEDICAID WAIVER STANDARD TERMS AND CONDITIONS. THE COMMISSIONER MAY MODIFY THE REQUIREMENTS OF

THIS PARAGRAPH AND PARAGRAPH (C) OF THIS SUBDIVISION IF SUCH MODIFICATIONS ARE REQUIRED BY THE FEDERAL CMS.

(C) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER SHALL PROVIDE A REPORT ON A QUARTERLY BASIS TO THE CHAIRS OF THE SENATE FINANCE, ASSEMBLY WAYS AND MEANS, SENATE HEALTH AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE STATUS OF THE DSRIP PROGRAM. SUCH REPORTS SHALL BE SUBMITTED NO LATER THAN SIXTY DAYS AFTER THE CLOSE OF THE QUARTER, AND SHALL INCLUDE THE MOST CURRENT INFORMATION SUBMITTED BY PROVIDERS TO THE STATE AND THE FEDERAL CMS. THE REPORTS SHALL INCLUDE:

(I) ANALYSIS OF PROGRESS MADE TOWARD DSRIP GOALS;

(II) THE IMPACT ON THE STATE'S HEALTH CARE DELIVERY SYSTEM;

(III) INFORMATION ON THE NUMBER AND TYPES OF PROVIDERS WHO PARTICIPATE;

(IV) PLANS AND PROGRESS FOR MONITORING PROVIDER COMPLIANCE WITH REQUIREMENTS;

(V) A STATUS UPDATE ON PROJECT MILESTONE PROGRESS;

(VI) INFORMATION ON PROJECT SPENDING AND BUDGET;

(VII) ANALYSIS OF IMPACT ON MEDICAID BENEFICIARIES SERVED;

(VIII) A SUMMARY OF PUBLIC ENGAGEMENT AND PUBLIC COMMENTS RECEIVED;

(IX) A DESCRIPTION OF DSRIP FUNDING APPLICATIONS THAT WERE DENIED;

(X) A DESCRIPTION OF ALL REGULATION WAIVERS ISSUED PURSUANT TO PARAGRAPH (E) OF THIS SUBDIVISION; AND

(XI) A SUMMARY OF THE STATEWIDE GEOGRAPHIC DISTRIBUTION OF FUNDS.

(D) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN THE COMMISSIONER SHALL PROMPTLY MAKE ALL DSRIP GOVERNING DOCUMENTS, INCLUDING 1115 WAIVER STANDARD TERMS AND CONDITIONS, SUPPORTING ATTACHMENTS AND DETAILED PROJECT DESCRIPTIONS, AND ALL MATERIALS MADE AVAILABLE TO THE LEGISLATURE PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION, AVAILABLE ON THE DEPARTMENT'S WEBSITE. THE COMMISSIONER SHALL ALSO PROVIDE A DETAILED OVERVIEW ON THE DEPARTMENT'S WEBSITE OF THE OPPORTUNITIES FOR PUBLIC COMMENT ON THE DSRIP PROGRAM.

(E) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH, THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO WAIVE ANY REGULATORY REQUIREMENTS AS ARE NECESSARY, CONSISTENT WITH APPLICABLE LAW, TO ALLOW APPLICANTS UNDER THIS SUBDIVISION AND PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION TWENTY-EIGHT HUNDRED TWENTY-FIVE OF THIS ARTICLE TO AVOID DUPLICATION OF REQUIREMENTS AND TO ALLOW THE EFFICIENT IMPLEMENTATION OF THE PROPOSED PROJECT; PROVIDED, HOWEVER, THAT REGULATIONS PERTAINING TO PATIENT SAFETY MAY NOT BE WAIVED, NOR SHALL ANY REGULATIONS BE WAIVED IF SUCH WAIVER WOULD RISK PATIENT SAFETY. SUCH WAIVER SHALL NOT EXCEED THE LIFE OF THE PROJECT OR SUCH SHORTER TIME PERIODS AS THE AUTHORIZING COMMISSIONER MAY DETERMINE. ANY REGULATORY RELIEF GRANTED PURSUANT TO THIS SUBDIVISION SHALL BE DESCRIBED, INCLUDING EACH REGULATIONS WAIVED AND THE PROJECT IT RELATES TO, IN THE REPORT PROVIDED PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION.

S 8-b. Subdivision 21 of section 2807 of the public health law, as added by section 10 of part Q of chapter 56 of the laws of 2013, is amended to read as follows:

21. (A) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other

public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for implementation of Medicaid Redesign Team initiatives. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the Medicaid Redesign Team initiatives funds.

(B) APPLICATIONS BY ELIGIBLE APPLICANTS FOR MEDICAID REDESIGN TEAM INITIATIVES FUNDED BY MONIES MADE AVAILABLE PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE SUBMITTED FOR REVIEW TO THE ADVISORY PANEL ESTABLISHED PURSUANT TO PARAGRAPH (B) OF SUBDIVISION TWENTY OF THIS SECTION AND SUCH PANEL SHALL SUBMIT THEIR RECOMMENDATIONS TO THE COMMISSIONER FOR FINAL DETERMINATION. FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER SHALL PROVIDE A REPORT ON A QUARTERLY BASIS TO THE MAJORITY LEADER OF THE NEW YORK STATE SENATE AND TO THE SPEAKER OF THE NEW YORK STATE ASSEMBLY WITH REGARD TO THE STATUS OF SUCH APPLICATIONS AND APPROVED PROJECTS. SUCH REPORTS SHALL BE SUBMITTED NO LATER THAN SIXTY DAYS AFTER THE CLOSE OF THE QUARTER, AND SHALL INCLUDE THE MOST CURRENT INFORMATION SUBMITTED BY APPLICANTS TO THE STATE. THE REPORTS SHALL BE SUBMITTED IN CONJUNCTION WITH AND AS A PART OF THE REPORTS SUBMITTED PURSUANT TO PARAGRAPH (C) OF SUBDIVISION TWENTY OF THIS SECTION AND SHALL INCLUDE:

(I) ANALYSIS OF PROGRESS MADE TOWARD PROJECT GOALS;

(II) THE IMPACT ON THE STATE'S HEALTH CARE DELIVERY SYSTEM;

(III) INFORMATION ON THE NUMBER AND TYPES OF PROVIDERS WHO PARTICIPATE;

(IV) PLANS AND PROGRESS FOR MONITORING PROVIDER COMPLIANCE WITH REQUIREMENTS;

(V) A STATUS UPDATE ON PROJECT MILESTONE PROGRESS;

(VI) INFORMATION ON PROJECT SPENDING AND BUDGET;

(VII) ANALYSIS OF IMPACT ON MEDICAID BENEFICIARIES SERVED;

(VIII) A SUMMARY OF PUBLIC ENGAGEMENT AND PUBLIC COMMENTS RECEIVED;

(IX) A DESCRIPTION OF APPLICATIONS THAT WERE DENIED;

(X) A DESCRIPTION OF ALL REGULATION WAIVERS ISSUED PURSUANT TO PARAGRAPH (E) OF THIS SUBDIVISION; AND

(XI) A SUMMARY OF THE STATEWIDE GEOGRAPHIC DISTRIBUTION OF FUNDS.

(C) THE COMMISSIONER SHALL MAKE ALL REPORTS PREPARED PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION AND ALL SUPPORTING ATTACHMENTS AND MATERIALS AVAILABLE ON THE DEPARTMENT'S WEBSITE.

(D) NOTWITHSTANDING ANY INCONSISTENT LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, AND SUBJECT TO AMOUNTS APPROPRIATED FOR PURPOSES HEREIN, THE DEPARTMENT MAY DISTRIBUTE FUNDS TO MAKE RATE ADJUSTMENTS FOR HEALTH HOME PROVIDERS AS DESCRIBED IN SECTION THREE HUNDRED SIXTY-FIVE-L OF THE SOCIAL SERVICES LAW FOR MEMBER ENGAGEMENT, STAFF TRAINING AND RETRAINING, HEALTH INFORMATION TECHNOLOGY IMPLEMENTATION, JOINT GOVERNANCE TECHNICAL ASSISTANCE, AND OTHER SUCH PURPOSES AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES DETERMINES.

(E) NOTWITHSTANDING ANY PROVISIONS OF LAW TO THE CONTRARY, THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH, THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND THE OFFICE OF

ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE AUTHORIZED TO WAIVE ANY REGULATORY REQUIREMENTS AS ARE NECESSARY, CONSISTENT WITH APPLICABLE LAW, TO ALLOW APPLICANTS UNDER THIS SUBDIVISION AND PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION TWENTY-EIGHT HUNDRED TWENTY-FIVE OF THIS ARTICLE TO AVOID DUPLICATION OF REQUIREMENTS AND TO ALLOW THE EFFICIENT IMPLEMENTATION OF THE PROPOSED PROJECT; PROVIDED, HOWEVER, THAT REGULATIONS PERTAINING TO PATIENT SAFETY MAY NOT BE WAIVED, NOT SHALL ANY REGULATION BE WAIVED IF SUCH WAIVER WOULD RISK PATIENT SAFETY. SUCH WAIVER SHALL NOT EXCEED THE LIFE OF THE PROJECT OR SUCH SHORTER TIME PERIOD AS THE AUTHORIZING COMMISSIONER ANY DETERMINE. ANY REGULATORY RELIEF GRANTED PURSUANT TO THIS SUBDIVISION SHALL BE DESCRIBED, INCLUDING EACH REGULATION WAIVED AND THE PROJECT IT RELATES TO, IN THE REPORT PROVIDED PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION.

S 9. Section 89-e of the state finance law is amended by adding a new subdivision 2-b to read as follows:

(2-B) ON OR BEFORE THE FIRST DAY OF FEBRUARY EACH YEAR, THE COMMISSIONER OF HEALTH SHALL PROVIDE A WRITTEN REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE FINANCE COMMITTEE, CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, CHAIR OF THE SENATE COMMITTEE ON HEALTH, AND CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. SUCH REPORT SHALL INCLUDE HOW THE MONIES OF THE FUND WERE UTILIZED DURING THE PRECEDING CALENDAR YEAR AND SHALL INCLUDE:

(I) THE AMOUNT OF MONEY DISPERSED FROM THE FUND;

(II) RECIPIENTS OF AWARDS FROM THE FUND;

(III) THE AMOUNT AWARDED TO EACH; AND

(IV) THE PURPOSES FOR WHICH SUCH AWARDS WERE GRANTED.

S 10. Paragraph (c) of subdivision 1 of section 2815 of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

(c) "Participating [general hospital] BORROWER" shall mean a not-for-profit general hospital, A NOT-FOR-PROFIT DIAGNOSTIC CENTER, A NOT-FOR-PROFIT TREATMENT CENTER, A NOT-FOR-PROFIT RESIDENTIAL HEALTH CARE FACILITY OR ANY OTHER NOT-FOR-PROFIT ENTITY IN POSSESSION OF A VALID OPERATING CERTIFICATE ISSUED PURSUANT TO THIS ARTICLE, EACH organized under the laws of this state, which has been approved for participation in this program by the commissioner.

S 11. Paragraphs (b), (c), and (d) of subdivision 3 and subdivisions 3-a, 4, 5, and 6 of section 2815 of the public health law, as added by chapter 639 of the laws of 1996, subdivision 3-a as added by chapter 1 of the laws of 1999, are amended to read as follows:

(b) for the development and implementation of business plans for participating [general hospitals] BORROWERS, addressing the development of service delivery strategies, including strategies for the formation or strengthening of networks, affiliations or other business combinations, designed to provide long-term financial stability within and among participating [general hospitals] BORROWERS;

(c) for the expenditure or loan of funds by the authority from the restructuring pool to reimburse the authority or the agency, where appropriate, for the costs of engaging management, legal or accounting consultants to identify, develop and implement improved strategies for one or more participating [general hospitals] BORROWERS for implementing the recommendations of such consultants, where appropriate, and for the payment of debt service on bonds, notes or other obligations issued or incurred by the authority or the agency to fund loans to one or more participating [general hospitals] BORROWERS;

(d) for assurances that participating [general hospitals] BORROWERS will address the recommendations of such consultants and furnish the commissioner, the authority, and where applicable, the agency, with such additional financial, management, legal and operational information as each may deem necessary to monitor the performance of a participating [general hospital] BORROWER; and

3-a. Any participating [general hospital] BORROWER may apply for restructuring pool funds to the extent such funds are derived from deposits made pursuant to paragraph (d) of subdivision one of section twenty-eight hundred seven-l of this article, provided, however, that, in reviewing such applications, the commissioner and the authority shall consider the extent to which the applicant hospital has alternative available sources of funds, including, but not limited to, funds available through affiliation agreements with other hospitals OR ENTITIES.

4. To the extent funds are available from a participating [general hospital] BORROWER therefor, expenditures from the restructuring pool shall be repaid to the restructuring pool from repayments received by the authority, or the agency where applicable, from a participating [general hospital] BORROWER pursuant to the terms of any financing agreement, mortgage or loan document permitting the recovery from the participating [general hospital] BORROWER of such expenditures. The authority shall record and account for all such payments, which shall be deposited in the restructuring pool.

5. Loans from the restructuring pool shall be made pursuant to an agreement with the participating [general hospital] BORROWER specifying the terms thereof, including repayment terms. The authority shall record and account for all such repayments, which shall be deposited in the restructuring pool. The authority shall notify the chair of the senate finance committee, the director of the division of budget, the chair of the assembly ways and means committee, THE CHAIR OF THE SENATE COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE, five days prior to the making of a loan from the restructuring pool. The authority shall also report quarterly to such chairpersons on the transactions in the pool, including but not limited to RECEIPTS OR deposits to the pool, DISBURSEMENTS OR loans made from the pool, investment income, and the balance on hand as of the end of the month for each such quarter.

6. The commissioner is authorized, with the assistance and cooperation of the authority, to provide a program of technical assistance to participating [general hospitals] BORROWERS.

S 12. Subdivision 2 of section 242 of the elder law, as added by section 5 of part T of chapter 56 of the laws of 2012, is amended to read as follows:

2. Persons eligible for catastrophic coverage under section two hundred forty-eight of this title shall include:

(a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand one, is more than twenty thousand and less than or equal to [thirty-five] SEVENTY-FIVE thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

(b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person's spouse beginning on or after January first, two thousand one, is more than twenty-six thousand

dollars and less than or equal to [fifty] ONE HUNDRED thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

S 13. Paragraphs (a) and (b) of subdivision 2 of section 248 of the elder law, as added by section 17 of part T of chapter 56 of the laws of 2012, are amended to read as follows:

(a) Annual personal covered drug expenditures for unmarried individual eligible program participants:

individual income of $20,001 to $21,000	$530
individual income of $21,001 to $22,000	$550
individual income of $22,001 to $23,000	$580
individual income of $23,001 to $24,000	$720
individual income of $24,001 to $25,000	$750
individual income of $25,001 to $26,000	$780
individual income of $26,001 to $27,000	$810
individual income of $27,001 to $28,000	$840
individual income of $28,001 to $29,000	$870
individual income of $29,001 to $30,000	$900
individual income of $30,001 to $31,000	$930
individual income of $31,001 to $32,000	$960
individual income of $32,001 to $33,000	$1,160
individual income of $33,001 to $34,000	$1,190
individual income of $34,001 to $35,000	$1,230
INDIVIDUAL INCOME OF $35,001 TO $36,000	$1,260
INDIVIDUAL INCOME OF $36,001 TO $37,000	$1,290
INDIVIDUAL INCOME OF $37,001 TO $38,000	$1,320
INDIVIDUAL INCOME OF $38,001 TO $39,000	$1,350
INDIVIDUAL INCOME OF $39,001 TO $40,000	$1,380
INDIVIDUAL INCOME OF $40,001 TO $41,000	$1,410
INDIVIDUAL INCOME OF $41,001 TO $42,000	$1,440
INDIVIDUAL INCOME OF $42,001 TO $43,000	$1,470
INDIVIDUAL INCOME OF $43,001 TO $44,000	$1,500
INDIVIDUAL INCOME OF $44,001 TO $45,000	$1,530
INDIVIDUAL INCOME OF $45,001 TO $46,000	$1,560
INDIVIDUAL INCOME OF $46,001 TO $47,000	$1,590
INDIVIDUAL INCOME OF $47,001 TO $48,000	$1,620
INDIVIDUAL INCOME OF $48,001 TO $49,000	$1,650
INDIVIDUAL INCOME OF $49,001 TO $50,000	$1,680
INDIVIDUAL INCOME OF $50,001 TO $51,000	$1,710
INDIVIDUAL INCOME OF $51,001 TO $52,000	$1,740
INDIVIDUAL INCOME OF $52,001 TO $53,000	$1,770
INDIVIDUAL INCOME OF $53,001 TO $54,000	$1,800
INDIVIDUAL INCOME OF $54,001 TO $55,000	$1,830
INDIVIDUAL INCOME OF $55,001 TO $56,000	$1,860
INDIVIDUAL INCOME OF $56,001 TO $57,000	$1,890
INDIVIDUAL INCOME OF $57,001 TO $58,000	$1,920
INDIVIDUAL INCOME OF $58,001 TO $59,000	$1,950
INDIVIDUAL INCOME OF $59,001 TO $60,000	$1,980
INDIVIDUAL INCOME OF $60,001 TO $61,000	$2,010
INDIVIDUAL INCOME OF $61,001 TO $62,000	$2,040
INDIVIDUAL INCOME OF $62,001 TO $63,000	$2,070
INDIVIDUAL INCOME OF $63,001 TO $64,000	$2,100
INDIVIDUAL INCOME OF $64,001 TO $65,000	$2,130
INDIVIDUAL INCOME OF $65,001 TO $66,000	$2,160
INDIVIDUAL INCOME OF $66,001 TO $67,000	$2,190
INDIVIDUAL INCOME OF $67,001 TO $68,000	$2,220

INDIVIDUAL INCOME OF $68,001 TO $69,000	$2,250
INDIVIDUAL INCOME OF $69,001 TO $70,000	$2,280
INDIVIDUAL INCOME OF $70,001 TO $71,000	$2,310
INDIVIDUAL INCOME OF $71,001 TO $72,000	$2,340
INDIVIDUAL INCOME OF $72,001 TO $73,000	$2,370
INDIVIDUAL INCOME OF $73,001 TO $74,000	$2,400
INDIVIDUAL INCOME OF $74,001 TO $75,000	$2,430

(b) Annual personal covered drug expenditures for each married individual eligible program participant:

joint income of $26,001 to $27,000	$650
joint income of $27,001 to $28,000	$675
joint income of $28,001 to $29,000	$700
joint income of $29,001 to $30,000	$725
joint income of $30,001 to $31,000	$900
joint income of $31,001 to $32,000	$930
joint income of $32,001 to $33,000	$960
joint income of $33,001 to $34,000	$990
joint income of $34,001 to $35,000	$1,020
joint income of $35,001 to $36,000	$1,050
joint income of $36,001 to $37,000	$1,080
joint income of $37,001 to $38,000	$1,110
joint income of $38,001 to $39,000	$1,140
joint income of $39,001 to $40,000	$1,170
joint income of $40,001 to $41,000	$1,200
joint income of $41,001 to $42,000	$1,230
joint income of $42,001 to $43,000	$1,260
joint income of $43,001 to $44,000	$1,290
joint income of $44,001 to $45,000	$1,320
joint income of $45,001 to $46,000	$1,575
joint income of $46,001 to $47,000	$1,610
joint income of $47,001 to $48,000	$1,645
joint income of $48,001 to $49,000	$1,680
joint income of $49,001 to $50,000	$1,715
JOINT INCOME OF $50,001 TO $51,000	$1,745
JOINT INCOME OF $51,001 TO $52,000	$1,775
JOINT INCOME OF $52,001 TO $53,000	$1,805
JOINT INCOME OF $53,001 TO $54,000	$1,835
JOINT INCOME OF $54,001 TO $55,000	$1,865
JOINT INCOME OF $55,001 TO $56,000	$1,895
JOINT INCOME OF $56,001 TO $57,000	$1,925
JOINT INCOME OF $57,001 TO $58,000	$1,955
JOINT INCOME OF $58,001 TO $59,000	$1,985
JOINT INCOME OF $59,001 TO $60,000	$2,015
JOINT INCOME OF $60,001 TO $61,000	$2,045
JOINT INCOME OF $61,001 TO $62,000	$2,075
JOINT INCOME OF $62,001 TO $63,000	$2,105
JOINT INCOME OF $63,001 TO $64,000	$2,135
JOINT INCOME OF $64,001 TO $65,000	$2,165
JOINT INCOME OF $65,001 TO $66,000	$2,195
JOINT INCOME OF $66,001 TO $67,000	$2,225
JOINT INCOME OF $67,001 TO $68,000	$2,255
JOINT INCOME OF $68,001 TO $69,000	$2,285
JOINT INCOME OF $69,001 TO $70,000	$2,315
JOINT INCOME OF $70,001 TO $71,000	$2,345
JOINT INCOME OF $71,001 TO $72,000	$2,375
JOINT INCOME OF $72,001 TO $73,000	$2,405

JOINT INCOME OF $73,001 TO $74,000	$2,435
JOINT INCOME OF $74,001 TO $75,000	$2,465
JOINT INCOME OF $75,001 TO $76,000	$2,495
JOINT INCOME OF $76,001 TO $77,000	$2,525
JOINT INCOME OF $77,001 TO $78,000	$2,555
JOINT INCOME OF $78,001 TO $79,000	$2,585
JOINT INCOME OF $79,001 TO $80,000	$2,615
JOINT INCOME OF $80,001 TO $81,000	$2,645
JOINT INCOME OF $81,001 TO $82,000	$2,675
JOINT INCOME OF $82,001 TO $83,000	$2,705
JOINT INCOME OF $83,001 TO $84,000	$2,735
JOINT INCOME OF $84,001 TO $85,000	$2,765
JOINT INCOME OF $85,001 TO $86,000	$2,795
JOINT INCOME OF $86,001 TO $87,000	$2,825
JOINT INCOME OF $87,001 TO $88,000	$2,855
JOINT INCOME OF $88,001 TO $89,000	$2,885
JOINT INCOME OF $89,001 TO $90,000	$2,915
JOINT INCOME OF $90,001 TO $91,000	$2,945
JOINT INCOME OF $91,001 TO $92,000	$2,975
JOINT INCOME OF $92,001 TO $93,000	$3,005
JOINT INCOME OF $93,001 TO $94,000	$3,035
JOINT INCOME OF $94,001 TO $95,000	$3,065
JOINT INCOME OF $95,001 TO $96,000	$3,095
JOINT INCOME OF $96,001 TO $97,000	$3,125
JOINT INCOME OF $97,001 TO $98,000	$3,155
JOINT INCOME OF $98,001 TO $99,000	$3,185
JOINT INCOME OF $99,001 TO $100,000	$3,215

S 14. Paragraphs (a) and (b) of subdivision 4 of section 248 of the elder law, as added by section 17 of part T of chapter 56 of the laws of 2012, are amended to read as follows:

(a) Limits on co-payments by unmarried individual eligible program participants:

individual income of $20,001 to $21,000	no more than $1,050
individual income of $21,001 to $22,000	no more than $1,100
individual income of $22,001 to $23,000	no more than $1,150
individual income of $23,001 to $24,000	no more than $1,200
individual income of $24,001 to $25,000	no more than $1,250
individual income of $25,001 to $26,000	no more than $1,300
individual income of $26,001 to $27,000	no more than $1,350
individual income of $27,001 to $28,000	no more than $1,400
individual income of $28,001 to $29,000	no more than $1,450
individual income of $29,001 to $30,000	no more than $1,500
individual income of $30,001 to $31,000	no more than $1,550
individual income of $31,001 to $32,000	no more than $1,600
individual income of $32,001 to $33,000	no more than $1,650
individual income of $33,001 to $34,000	no more than $1,700
individual income of $34,001 to [$35,000] $75,000	no more than $1,750

(b) Limits on co-payments by each married individual eligible program participant:

joint income of $26,001 to $27,000	no more than $1,080
joint income of $27,001 to $28,000	no more than $1,120
joint income of $28,001 to $29,000	no more than $1,160
joint income of $29,001 to $30,000	no more than $1,200
joint income of $30,001 to $31,000	no more than $1,240
joint income of $31,001 to $32,000	no more than $1,280

joint income of $32,001 to $33,000	no more than $1,320
joint income of $33,001 to $34,000	no more than $1,360
joint income of $34,001 to $35,000	no more than $1,400
joint income of $35,001 to $36,000	no more than $1,440
joint income of $36,001 to $37,000	no more than $1,480
joint income of $37,001 to $38,000	no more than $1,520
joint income of $38,001 to $39,000	no more than $1,560
joint income of $39,001 to $40,000	no more than $1,600
joint income of $40,001 to $41,000	no more than $1,640
joint income of $41,001 to $42,000	no more than $1,680
joint income of $42,001 to $43,000	no more than $1,720
joint income of $43,001 to $44,000	no more than $1,760
joint income of $44,001 to $45,000	no more than $1,800
joint income of $45,001 to $46,000	no more than $1,840
joint income of $46,001 to $47,000	no more than $1,880
joint income of $47,001 to $48,000	no more than $1,920
joint income of $48,001 to $49,000	no more than $1,960
joint income of $49,001 to [$50,000] $100,000	no more than $2,000

S 15. Subdivision 1 of section 924 of the public health law, as added by section 23 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

1. [The] NOTWITHSTANDING ANY CONTRARY PROVISION OF THIS SECTION, SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR ANY OTHER CONTRARY PROVISION OF LAW, THE commissioner is authorized, within amounts available therefor, to make loan repayment awards to eligible primary care service corps practitioners who agree to practice full-time in an underserved area in New York state, in amounts to be determined by the commissioner, but not to exceed thirty-two thousand dollars per year for any year in which such practitioners provide full-time eligible obligated service, WITHOUT COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS.

S 16. Paragraph (b) of subdivision 18-a of section 206 of the public health law, as amended by section 38-a of part H of chapter 59 of the laws of 2011, is amended and paragraph (c) is added to read as follows:

(b) The commissioner shall:

(I) CONVENE A WORKGROUP TO:

(A) EVALUATE THE STATE'S HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE AND SYSTEMS, AS WELL AS OTHER RELATED PLANS AND PROJECTS DESIGNED TO MAKE IMPROVEMENTS OR MODIFICATIONS TO SUCH INFRASTRUCTURE AND SYSTEMS INCLUDING, BUT NOT LIMITED TO, THE ALL PAYOR DATABASE (APD), THE STATE PLANNING AND RESEARCH COOPERATIVE SYSTEM (SPARCS), REGIONAL HEALTH INFORMATION ORGANIZATIONS (RHIOS), THE STATEWIDE HEALTH INFORMATION NETWORK OF NEW YORK (SHIN-NY) AND MEDICAL ASSISTANCE ELIGIBILITY SYSTEMS; AND

(B) DEVELOP RECOMMENDATIONS FOR THE STATE TO MOVE TOWARD A COMPREHENSIVE HEALTH CLAIMS AND CLINICAL DATABASE AIMED AT IMPROVING QUALITY OF CARE, EFFICIENCY, COST OF CARE AND PATIENT SATISFACTION AVAILABLE IN A SELF-SUSTAINABLE, NON-DUPLICATIVE, INTERACTIVE AND INTEROPERABLE MANNER THAT ENSURES SAFEGUARDS FOR PRIVACY, CONFIDENTIALITY AND SECURITY;

(II) SUBMIT A REPORT TO THE GOVERNOR AND THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY, WHICH SHALL FULLY CONSIDER THE EVALUATION AND RECOMMENDATIONS OF THE WORKGROUP, ON OR BEFORE DECEMBER FIRST, TWO THOUSAND FOURTEEN.

(C) THE MEMBERS OF THE WORKGROUP SHALL INCLUDE, AT A MINIMUM, THREE MEMBERS WHO REPRESENT RHIOS, TWO MEMBERS EMPLOYED BY THE DEPARTMENT WHO

ARE INVOLVED IN THE DEVELOPMENT OF THE SHIN-NY AND THE APD, TWO MEMBERS WHO REPRESENT PHYSICIANS, TWO MEMBERS WHO REPRESENT HOSPITALS, ONE MEMBER WHO REPRESENTS FEDERALLY QUALIFIED HEALTH CENTERS, THE CHAIR OF THE SENATE HEALTH COMMITTEE OR HIS OR HER DESIGNEE, THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE OR HIS OR HER DESIGNEE, AND OTHER INDIVIDUALS WITH EXPERTISE IN MATTERS RELEVANT TO THE CHARGE OF THE WORKGROUP.

(D) THE COMMISSIONER MAY make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a [statewide health information network of New York (] SELF-SUFFICIENT SHIN-NY[)] to enable widespread, NON-DUPLICATIVE interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, PAYMENT and other administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY OR ANY OTHER STATEWIDE HEALTH INFORMATION SYSTEM RECOMMENDED BY THE WORKGROUP. THE COMMISSIONER SHALL CONSIDER THE RECOMMENDATIONS OF THE WORKGROUP. IF THE COMMISSIONER ACTS IN A MANNER INCONSISTENT WITH THE RECOMMENDATIONS OF THE WORKGROUP, HE OR SHE SHALL PROVIDE THE REASONS THEREFOR.

S 17. Section 2818 of the public health law is amended to add a new subdivision 8 to read as follows:

8. ON OR BEFORE DECEMBER FIRST, TWO THOUSAND FOURTEEN, THE DEPARTMENT SHALL ISSUE A REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY REGARDING GRANTS MADE PURSUANT TO THIS SECTION TO SUPPORT HEALTH INFORMATION TECHNOLOGY.

S 18. The public health law is amended by adding a new section 2801-h to read as follows:

S 2801-H. COMMUNITY FORUM ON ESTABLISHMENT OF CERTAIN FACILITIES IN THE COUNTY OF BRONX. 1. FOR ANY PROPOSED FREE STANDING CLINIC, OUTPATIENT HEALTH CARE FACILITY OR AMBULATORY HEALTH CARE CENTER THAT: (I) IS TO BE OVER THREE STORIES IN HEIGHT OR TO CONTAIN OVER THIRTY THOUSAND SQUARE FEET, (II) IS PROPOSED TO BE LOCATED IN THE COUNTY OF BRONX, AND (III) IS SPONSORED, DIRECTLY OR INDIRECTLY, BY A HOSPITAL, THEN THE SPONSORING HOSPITAL SHALL, PRIOR TO THE ESTABLISHMENT OF SUCH CLINIC, FACILITY OR CENTER, FILE A NOTICE THEREOF WITH THE DEPARTMENT, THE EDUCATION DEPARTMENT AND THE COMMUNITY BOARD OF THE LOCALITY IN WHICH THE CLINIC, FACILITY OR CENTER IS TO BE ESTABLISHED.

2. NOT LESS THAN ONE HUNDRED EIGHTY DAYS NOR MORE THAN TWO HUNDRED SEVENTY DAYS AFTER RECEIPT OF A SPONSORING HOSPITAL'S NOTICE PURSUANT TO SUBDIVISION ONE OF THIS SECTION, THE COMMISSIONER SHALL HOLD A PUBLIC COMMUNITY FORUM FOR THE PURPOSE OF OBTAINING PUBLIC AND COMMUNITY BOARD INPUT CONCERNING THE ANTICIPATED IMPACT OF THE ESTABLISHMENT OF A FREE STANDING CLINIC, OUTPATIENT HEALTH CARE FACILITY OR AMBULATORY HEALTH CARE FACILITY. SUCH IMPACT MAY INCLUDE AND RELATE TO: (I) THE APPROPRIATENESS OF THE SIZE, HEIGHT, BULK DIMENSIONS AND SCOPE OF SUCH CLINIC, FACILITY OR CENTER WHEN COMPARED TO THE SURROUNDING PHYSICAL CHARACTERISTICS AND SOCIAL FABRIC OF SUCH COMMUNITY, (II) THE PROVISION OF ADEQUATE MOTOR VEHICLE PARKING TO ACCOMMODATE SUCH FACILITY NEEDS AND WHICH DOES NOT DIMINISH THE CURRENT SUPPLY OF PARKING FOR NEARBY RESIDENTS OR INCREASE TRAFFIC CONGESTION NEAR SUCH FACILITY, (III) THE CURRENT ACCESS TO APPROPRIATE MEDICAL FACILITIES OR THE PROVISION OF ESSENTIAL MEDICAL SERVICES TO SUCH COMMUNITY, SERVICE AREA AND SURROUNDING COMMUNITIES, AND (IV) OPTIONS AND PROPOSALS TO AMELIORATE OR MITI-

GATE ANTICIPATED ADVERSE IMPACTS TO THE LOCAL COMMUNITY. THE COMMISSIONER SHALL AFFORD COMMUNITY MEMBERS, REPRESENTATIVES OF THE LOCAL COMMUNITY BOARD, LOCAL BUSINESSES AND CONSUMERS A REASONABLE OPPORTUNITY TO SPEAK ABOUT RELEVANT MATTERS AT SUCH COMMUNITY FORUM. EVERY SUCH FORUM SHALL BE HELD UPON NOT LESS THAN THIRTY DAYS NOTICE TO THE AFFECTED COMMUNITY AND THE LOCAL COMMUNITY BOARD.

3. THE COMMISSIONER SHALL, PRIOR TO ESTABLISHING THE DATE, TIME AND LOCATION OF THE PUBLIC COMMUNITY FORUM, CONSULT WITH, AND OBTAIN THE ADVICE AND CONSENT OF THE APPROPRIATE COMMUNITY BOARD, AS TO ESTABLISHING A CONVENIENT DATE, TIME AND LOCATION TO CONDUCT THE FORUM FOR THE LOCALLY IMPACTED COMMUNITY. SUCH HEARING LOCATION SHALL BE WITHIN REASONABLE PROXIMITY TO THE PROPOSED CLINIC, FACILITY OR CENTER, AND IN SUITABLE FACILITIES THAT PROVIDE ADEQUATE ROOM AND ACCESS TO HEAR PUBLIC COMMENTS PRESENTED.

4. NOT LATER THAN NINETY DAYS AFTER HOLDING A COMMUNITY FORUM THE COMMISSIONER SHALL MAKE AVAILABLE TO THE PUBLIC ON THE DEPARTMENT'S WEBSITE THE REASONS WHY SUCH FACILITY IS, BY A PREPONDERANCE OF THE EVIDENCE, IN THE BEST INTERESTS OF THOSE WHO LIVE WITHIN THE LOCAL COMMUNITY AND WITHIN THE LOCAL SERVICE AREA AS IT RELATES TO: (I) THE APPROPRIATENESS OF THE SIZE, HEIGHT, BULK DIMENSIONS AND SCOPE OF SUCH CLINIC, FACILITY OR CENTER WHEN COMPARED TO THE SURROUNDING PHYSICAL CHARACTERISTICS AND SOCIAL FABRIC OF SUCH COMMUNITY, (II) THE PROVISION OF ADEQUATE MOTOR VEHICLE PARKING TO ACCOMMODATE SUCH FACILITY NEEDS AND WHICH DOES NOT DIMINISH THE CURRENT SUPPLY OF PARKING FOR NEARBY RESIDENTS OR INCREASE TRAFFIC CONGESTION NEAR SUCH FACILITY, AND (III) THE CURRENT ACCESS TO APPROPRIATE MEDICAL FACILITIES OR THE PROVISION OF ESSENTIAL MEDICAL SERVICES TO SUCH COMMUNITY, SERVICE AREA AND SURROUNDING COMMUNITIES.

5. AFTER DUE CONSIDERATION OF THE COMMENTS AT THE COMMUNITY FORUM AND CONSULTATION WITH THE EDUCATION DEPARTMENT, THE COMMISSIONER SHALL EITHER APPROVE, MODIFY OR DENY AUTHORIZATION FOR THE ESTABLISHMENT OF ANY SUCH CLINIC, FACILITY OR CENTER.

S 19. For claims for payment submitted by early intervention providers to third party payors between the period April 1, 2013 until June 30, 2013 in accordance with title 2-A of article 25 of the public health law, for which the third party payor has not, on the effective date of this section, made payment of the claim in whole or in part or rendered a determination that it is not obligated to pay the claim, the provider shall be authorized to seek payment of such claim from the municipality, through the fiscal agent under contract with the department of health; provided, however, that the provider shall continue to render any assistance needed, and provide any information and documentation requested by the third party payor to facilitate payment of the claim even if the provider has already received payment from the municipality. If such third party payor makes payment of the claim after the provider has received payment from the municipality, the third party payment shall be reconciled against future payments due the provider from the municipality. This section shall only apply to claims submitted by approved early intervention providers to third party payors during the period April 1, 2013 until June 30, 2013 for which no payment or determination has been made, as specified in this section, on April 1, 2014. Payment shall be made on the forty-fifth day after this act shall take effect. The provisions in subdivision 2 of section 2557 of the public health law that prohibit state reimbursement from being paid prior to April first of the year in which the approved costs are paid by the

municipality shall not apply to the municipal payments made under this section.

S 20. Article 29-D of the public health law is amended by adding a new title 1-A to read as follows:

TITLE 1-A

SAFE PATIENT HANDLING

SECTION 2997-G. LEGISLATIVE INTENT.
2997-H. DEFINITIONS.
2997-I. SAFE PATIENT HANDLING WORKGROUP.
2997-J. DISSEMINATION OF BEST PRACTICES, EXAMPLES OF SAMPLE SAFE PATIENT HANDLING POLICIES AND OTHER RESOURCES AND TOOLS.
2997-K. SAFE PATIENT HANDLING COMMITTEES; PROGRAMS.
2997-L. ACTIVITIES.

S 2997-G. LEGISLATIVE INTENT. THE LEGISLATURE HEREBY FINDS AND DECLARES THAT IT IS IN THE PUBLIC INTEREST FOR HEALTH CARE FACILITIES TO IMPLEMENT SAFE PATIENT HANDLING POLICIES. THERE ARE MANY BENEFITS THAT CAN BE DERIVED FROM SAFE PATIENT HANDLING PROGRAMS. PATIENTS BENEFIT THROUGH IMPROVED QUALITY OF CARE AND QUALITY OF LIFE BY REDUCING THE RISK OF INJURY. CAREGIVERS ALSO BENEFIT FROM THE REDUCED RISK OF CAREER ENDING AND DEBILITATING INJURIES LEADING TO INCREASED MORALE, IMPROVED JOB SATISFACTION, AND LONGEVITY IN THE PROFESSION. HEALTH CARE FACILITIES MAY REALIZE A RETURN ON THEIR INVESTMENT THROUGH REDUCED WORKERS' COMPENSATION MEDICAL AND INDEMNITY COSTS, REDUCED LOST WORKDAYS, AND IMPROVED RECRUITMENT AND RETENTION OF CAREGIVERS. ALL OF THIS COULD LEAD TO FISCAL IMPROVEMENT IN HEALTH CARE IN NEW YORK STATE.

S 2997-H. DEFINITIONS. FOR THE PURPOSES OF THIS TITLE:

1. "HEALTH CARE FACILITY" SHALL MEAN GENERAL HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AND CLINICS LICENSED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER, FACILITIES WHICH PROVIDE HEALTH CARE SERVICES AND ARE LICENSED OR OPERATED PURSUANT TO ARTICLE EIGHT OF THE EDUCATION LAW, ARTICLE NINETEEN-G OF THE EXECUTIVE LAW OR THE CORRECTION LAW, AND HOSPITALS AND SCHOOLS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW.

2. "NURSE" SHALL MEAN A REGISTERED PROFESSIONAL NURSE OR A LICENSED PRACTICAL NURSE AS DEFINED BY ARTICLE ONE HUNDRED THIRTY-NINE OF THE EDUCATION LAW.

3. "DIRECT CARE WORKER" SHALL MEAN ANY EMPLOYEE OF A HEALTH CARE FACILITY WHO IS RESPONSIBLE FOR PATIENT HANDLING OR PATIENT ASSESSMENT AS A REGULAR OR INCIDENTAL PART OF HIS OR HER EMPLOYMENT, INCLUDING ANY LICENSED OR UNLICENSED HEALTH CARE WORKER.

4. "EMPLOYEE REPRESENTATIVE" SHALL MEAN THE RECOGNIZED OR CERTIFIED COLLECTIVE BARGAINING AGENT FOR NURSES OR DIRECT CARE WORKERS OF A HEALTH CARE FACILITY.

5. "SAFE PATIENT HANDLING" SHALL MEAN THE USE OF ENGINEERING CONTROLS, LIFTING AND TRANSFER AIDS, OR ASSISTIVE DEVICES BY STAFF TO PERFORM THE ACTS OF LIFTING, TRANSFERRING AND REPOSITIONING HEALTH CARE PATIENTS AND RESIDENTS.

6. "MUSCULOSKELETAL DISORDERS" SHALL MEAN CONDITIONS THAT INVOLVE THE NERVES, TENDONS, MUSCLES AND SUPPORTING STRUCTURES OF THE BODY.

S 2997-I. SAFE PATIENT HANDLING WORKGROUP. 1. THE COMMISSIONER SHALL ESTABLISH A SAFE PATIENT HANDLING WORKGROUP (REFERRED TO IN THIS SECTION AS THE "WORKGROUP") WITHIN THE DEPARTMENT. THE WORKGROUP SHALL CONSIST OF, AT THE MINIMUM, THE COMMISSIONER OR HIS OR HER DESIGNEE; THE COMMISSIONER OF LABOR OR HIS OR HER DESIGNEE; REPRESENTATIVES OF HEALTH CARE PROVIDER ORGANIZATIONS; REPRESENTATIVES FROM EMPLOYEE ORGANIZATIONS

REPRESENTING NURSES AND REPRESENTATIVES FROM EMPLOYEE ORGANIZATIONS REPRESENTING DIRECT CARE WORKERS; REPRESENTATIVES OF NURSE EXECUTIVES; REPRESENTATIVES WHO ARE CERTIFIED ERGONOMIST EVALUATION SPECIALISTS; AND REPRESENTATIVES WHO HAVE EXPERTISE IN FIELDS OF DISCIPLINE RELATED TO HEALTH CARE OR OCCUPATIONAL SAFETY.

2. WORKGROUP MEMBERS SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES AS MEMBERS OF THE WORKGROUP, BUT SHALL BE REIMBURSED FOR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE OF THEIR DUTIES.

3. THE WORKGROUP SHALL BE ESTABLISHED NO LATER THAN JANUARY FIRST, TWO THOUSAND FIFTEEN.

4. THE WORKGROUP SHALL:

(A) REVIEW EXISTING SAFE PATIENT HANDLING PROGRAMS OR POLICIES, INCLUDING DEMONSTRATION PROGRAMS PREVIOUSLY AUTHORIZED BY CHAPTER SEVEN HUNDRED THIRTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE AND NATIONAL DATA AND RESULTS;

(B) CONSULT WITH ANY ORGANIZATION, EDUCATIONAL INSTITUTION, OTHER GOVERNMENT ENTITY OR AGENCY OR PERSON THAT THE WORKGROUP DETERMINES MAY BE ABLE TO PROVIDE INFORMATION AND EXPERTISE ON THE DEVELOPMENT AND IMPLEMENTATION OF SAFE PATIENT HANDLING PROGRAMS;

(C) IDENTIFY OR DEVELOP TRAINING MATERIALS FOR CONSIDERATION BY HEALTH CARE FACILITIES; AND

(D) SUBMIT A REPORT TO THE COMMISSIONER BY JULY FIRST, TWO THOUSAND FIFTEEN IDENTIFYING SAFE PATIENT HANDLING PROGRAM BEST PRACTICES, PROVIDING EXAMPLES OF SAMPLE POLICIES, AND IDENTIFYING RESOURCES AND TOOLS USEFUL FOR PROVIDERS TO MEET THE GOALS OF SAFE PATIENT HANDLING POLICIES.

5. ALL STATE DEPARTMENTS, COMMISSIONS, AGENCIES, AND PUBLIC AUTHORITIES SHALL PROVIDE THE WORKGROUP WITH ANY REASONABLY REQUESTED ASSISTANCE OR ADVICE IN A TIMELY MANNER.

S 2997-J. DISSEMINATION OF BEST PRACTICES, EXAMPLES OF SAMPLE SAFE PATIENT HANDLING POLICIES AND OTHER RESOURCES AND TOOLS. THE COMMISSIONER SHALL DISSEMINATE BEST PRACTICES, EXAMPLES OF SAMPLE SAFE PATIENT HANDLING POLICIES, AND OTHER RESOURCES AND TOOLS TO HEALTH CARE FACILITIES, TAKING INTO CONSIDERATION THE RECOMMENDATIONS OF THE SAFE PATIENT HANDLING WORKGROUP. SUCH BEST PRACTICES, EXAMPLES OF SAMPLE SAFE PATIENT HANDLING POLICIES, AND OTHER RESOURCES AND TOOLS SHALL BE MADE AVAILABLE TO ALL FACILITIES COVERED BY THIS TITLE ON OR BEFORE JANUARY FIRST, TWO THOUSAND SIXTEEN.

S 2997-K. SAFE PATIENT HANDLING COMMITTEES; PROGRAMS. 1. ON OR BEFORE JANUARY FIRST, TWO THOUSAND SIXTEEN, EACH HEALTH CARE FACILITY SHALL ESTABLISH A SAFE PATIENT HANDLING COMMITTEE (REFERRED TO IN THIS SECTION AS A "COMMITTEE" EXCEPT WHERE THE CONTEXT CLEARLY REQUIRES OTHERWISE) EITHER BY CREATING A NEW COMMITTEE OR ASSIGNING THE FUNCTIONS OF A SAFE PATIENT HANDLING COMMITTEE TO AN EXISTING COMMITTEE, INCLUDING BUT NOT LIMITED TO A SAFETY COMMITTEE OR QUALITY ASSURANCE COMMITTEE, OR SUBCOMMITTEE THEREOF. THE PURPOSE OF A COMMITTEE IS TO DESIGN AND RECOMMEND THE PROCESS FOR IMPLEMENTING A SAFE PATIENT HANDLING PROGRAM FOR THE HEALTH CARE FACILITY. THE COMMITTEE SHALL INCLUDE INDIVIDUALS WITH EXPERTISE OR EXPERIENCE THAT IS RELEVANT TO SAFE PATIENT HANDLING, INCLUDING RISK MANAGEMENT, NURSING, PURCHASING, OR OCCUPATIONAL SAFETY AND HEALTH, AND IN FACILITIES WHERE THERE ARE EMPLOYEE REPRESENTATIVES, AT LEAST ONE SHALL BE APPOINTED ON BEHALF OF NURSES AND AT LEAST ONE SHALL BE APPOINTED ON BEHALF OF DIRECT CARE WORKERS. ONE HALF OF THE MEMBERS OF THE COMMITTEE SHALL BE FRONTLINE NON-MANAGERIAL EMPLOYEES WHO PROVIDE DIRECT CARE TO PATIENTS. AT LEAST ONE NON-MANAGERIAL NURSE AND ONE NON-MANAGERIAL DIRECT CARE WORKER SHALL BE ON THE SAFE PATIENT

HANDLING COMMITTEE. IN HEALTH CARE FACILITIES WHERE A RESIDENT COUNCIL IS ESTABLISHED, AND WHERE FEASIBLE, AT LEAST ONE MEMBER OF THE SAFE PATIENT HANDLING COMMITTEE SHALL BE A REPRESENTATIVE FROM THE RESIDENT COUNCIL. THE COMMITTEE SHALL HAVE TWO CO-CHAIRS WITH ONE FROM MANAGEMENT AND ONE FRONTLINE NON-MANAGERIAL NURSE OR DIRECT CARE WORKER.

2. ON OR BEFORE JANUARY FIRST, TWO THOUSAND SEVENTEEN, EACH HEALTH CARE FACILITY, IN CONSULTATION WITH THE COMMITTEE, SHALL ESTABLISH A SAFE PATIENT HANDLING PROGRAM. AS PART OF THIS PROGRAM, A HEALTH CARE FACILITY SHALL:

(A) IMPLEMENT A SAFE PATIENT HANDLING POLICY, CONSIDERING THE ELEMENTS OF THE SAMPLE SAFE PATIENT HANDLING POLICIES AND BEST PRACTICES DISSEMINATED BY THE COMMISSIONER, AS WELL AS THE TYPE OF FACILITY AND ITS SERVICES, PATIENT POPULATIONS AND CARE PLANS, TYPES OF CAREGIVERS, AND PHYSICAL ENVIRONMENT, FOR ALL SHIFTS AND UNITS OF THE HEALTH CARE FACILITY. IMPLEMENTATION OF THE SAFE PATIENT HANDLING POLICY MAY BE PHASED-IN;

(B) CONDUCT A PATIENT HANDLING HAZARD ASSESSMENT. THIS ASSESSMENT SHOULD CONSIDER SUCH VARIABLES AS PATIENT-HANDLING TASKS, TYPES OF NURSING UNITS, PATIENT POPULATIONS AND THE PHYSICAL ENVIRONMENT OF PATIENT CARE AREAS;

(C) DEVELOP A PROCESS TO IDENTIFY THE APPROPRIATE USE OF THE SAFE PATIENT HANDLING POLICY BASED ON THE PATIENT'S PHYSICAL AND MEDICAL CONDITION AND THE AVAILABILITY OF SAFE PATIENT HANDLING EQUIPMENT. THE POLICY SHALL INCLUDE A MEANS TO ADDRESS CIRCUMSTANCES UNDER WHICH IT WOULD BE CONTRAINDICATED BASED ON A PATIENT'S PHYSICAL, MEDICAL, WEIGHT-BEARING, COGNITIVE AND/OR REHABILITATIVE STATUS TO USE LIFTING OR TRANSFER AIDS OR ASSISTIVE DEVICES FOR PARTICULAR PATIENTS;

(D) PROVIDE INITIAL AND ON-GOING YEARLY TRAINING AND EDUCATION ON SAFE PATIENT HANDLING FOR CURRENT EMPLOYEES AND NEW HIRES, AND ESTABLISH PROCEDURES TO ENSURE THAT RETRAINING FOR THOSE FOUND TO BE DEFICIENT IS PROVIDED AS NEEDED;

(E) SET UP AND UTILIZE A PROCESS FOR INCIDENT INVESTIGATION AND POST-INVESTIGATION REVIEW WHICH MAY INCLUDE A PLAN OF CORRECTION AND IMPLEMENTATION OF CONTROLS;

(F) CONDUCT AN ANNUAL PERFORMANCE EVALUATION OF THE PROGRAM TO DETERMINE ITS EFFECTIVENESS, WITH THE RESULTS OF THE EVALUATION REPORTED TO THE COMMITTEE. THE EVALUATION SHALL DETERMINE THE EXTENT TO WHICH IMPLEMENTATION OF THE PROGRAM HAS RESULTED IN A REDUCTION IN THE RISK OF INJURY TO PATIENTS, MUSCULOSKELETAL DISORDER CLAIMS AND DAYS OF LOST WORK ATTRIBUTABLE TO MUSCULOSKELETAL DISORDERS BY EMPLOYEES CAUSED BY PATIENT HANDLING, AND INCLUDE RECOMMENDATIONS TO INCREASE THE PROGRAM'S EFFECTIVENESS;

(G) WHEN DEVELOPING ARCHITECTURAL PLANS FOR CONSTRUCTING OR REMODELING A HEALTH CARE FACILITY OR A UNIT OF A HEALTH CARE FACILITY IN WHICH PATIENT HANDLING AND MOVEMENT OCCURS, CONSIDER THE FEASIBILITY OF INCORPORATING PATIENT HANDLING EQUIPMENT OR THE PHYSICAL SPACE AND CONSTRUCTION DESIGN NEEDED TO INCORPORATE THAT EQUIPMENT AT A LATER DATE; AND

(H) DEVELOP A PROCESS BY WHICH EMPLOYEES MAY REFUSE TO PERFORM OR BE INVOLVED IN PATIENT HANDLING OR MOVEMENT THAT THE EMPLOYEE REASONABLY BELIEVES IN GOOD FAITH WILL EXPOSE A PATIENT OR HEALTH CARE FACILITY EMPLOYEE TO AN UNACCEPTABLE RISK OF INJURY. SUCH PROCESS SHALL REQUIRE THAT THE NURSE OR DIRECT CARE WORKER MAKE A GOOD FAITH EFFORT TO ENSURE PATIENT SAFETY AND BRING THE MATTER TO THE ATTENTION OF THE FACILITY IN A TIMELY MANNER. A HEALTH CARE FACILITY EMPLOYEE WHO REASONABLY AND IN GOOD FAITH FOLLOWS THE PROCESS DEVELOPED BY THE HEALTH CARE FACILITY IN

ACCORDANCE WITH THIS SUBDIVISION SHALL NOT BE THE SUBJECT OF DISCIPLINARY ACTION BY THE HEALTH CARE FACILITY FOR THE REFUSAL TO PERFORM OR BE INVOLVED IN THE PATIENT HANDLING OR MOVEMENT.

S 2997-L. ACTIVITIES. THE ACTIVITIES ENUMERATED IN SECTION TWENTY-NINE HUNDRED NINETY-SEVEN-K OF THIS TITLE SHALL BE UNDERTAKEN CONSISTENT WITH SECTION TWENTY-EIGHT HUNDRED FIVE-J OF THIS CHAPTER BY A COVERED HEALTH CARE PROVIDER AND SHALL BE DEEMED ACTIVITIES OF SUCH PROGRAM AS DESCRIBED IN SUCH SECTION AND ANY AND ALL INFORMATION ATTRIBUTABLE TO SUCH ACTIVITIES SHALL BE SUBJECT TO PROVISIONS OF SECTION TWENTY-EIGHT HUNDRED FIVE-M OF THIS CHAPTER AND SECTION SIXTY-FIVE HUNDRED TWENTY-SEVEN OF THE EDUCATION LAW.

S 21. Section 2304 of the insurance law is amended by adding a new subsection (j) to read as follows:

(J)(1) ON OR BEFORE JULY FIRST, TWO THOUSAND SIXTEEN, THE DEPARTMENT SHALL MAKE RULES ESTABLISHING REQUIREMENTS FOR HEALTH CARE FACILITIES TO OBTAIN A REDUCED WORKER'S COMPENSATION RATE FOR SAFE PATIENT HANDLING PROGRAMS IMPLEMENTED PURSUANT TO TITLE ONE-A OF ARTICLE TWENTY-NINE-A OF THE PUBLIC HEALTH LAW.

(2) THE DEPARTMENT SHALL COMPLETE AN EVALUATION OF THE RESULTS OF THE REDUCED RATE, INCLUDING CHANGES IN CLAIM FREQUENCY AND COSTS, AND SHALL REPORT TO THE APPROPRIATE COMMITTEES OF THE LEGISLATURE ON OR BEFORE DECEMBER FIRST, TWO THOUSAND EIGHTEEN AND AGAIN ON OR BEFORE DECEMBER FIRST, TWO THOUSAND TWENTY.

S 22. Subdivision 6 of section 2899 of the public health law, as amended by chapter 331 of the laws of 2006, is amended to read as follows:

6. "Provider" shall mean any residential health care facility licensed under article twenty-eight of this chapter; or any certified home health agency, licensed home care services agency or long term home health care program certified under article thirty-six of this chapter; OR ANY ADULT CARE FACILITY LICENSED UNDER ARTICLE SEVEN OF THE SOCIAL SERVICES LAW.

S 23. Paragraph (a) of subdivision 9 of section 2899-a of the public health law, as amended by chapter 331 of the laws of 2006, is amended to read as follows:

(a) In the event that funds are appropriated in any given fiscal year for the reimbursement for the costs of providing such criminal history information, reimbursement shall be made available in an equitable and direct manner for the projected cost of the fee established pursuant to law by the division of criminal justice services for processing a criminal history information check, the fee imposed by the federal bureau of investigation for a national criminal history check, and costs associated with obtaining the fingerprints to all providers licensed, but not certified under article thirty-six of this chapter, AND ALL ADULT CARE FACILITIES LICENSED UNDER ARTICLE SEVEN OF THE SOCIAL SERVICES LAW, including those that are subject to this article and are unable to access direct reimbursement from state and/or federal funded health programs.

S 24. The social services law is amended by adding a new section 461-t to read as follows:

S 461-T. REVIEW OF CRIMINAL HISTORY INFORMATION CONCERNING PROSPECTIVE DIRECT CARE EMPLOYEES. EVERY ADULT CARE FACILITY SHALL CONDUCT A CRIMINAL HISTORY RECORD CHECK OF PROSPECTIVE DIRECT CARE EMPLOYEES UTILIZING THE PROCEDURES AND STANDARDS SET FORTH IN ARTICLE TWENTY-EIGHT-E OF THE PUBLIC HEALTH LAW.

S 25. The public health law is amended by adding a new section 2997-e to read as follows:

S 2997-E. PROVISION OF CONTACT INFORMATION RELATING TO LONG TERM CARE. WHENEVER A HEALTH CARE PROVIDER OR PRACTITIONER MAKES A RECOMMENDATION REGARDING THE NECESSITY OF LONG TERM CARE SERVICES OR A REFERRAL FOR THE RECEIPT OF LONG TERM CARE SERVICES TO A PATIENT, THE PATIENT OR PATIENT'S DESIGNATED REPRESENTATIVE SHALL BE PROVIDED BY THE HEALTH CARE PROVIDER OR PRACTITIONER THE CONTACT INFORMATION FOR NY CONNECTS: CHOICES FOR LONG TERM CARE, ESTABLISHED PURSUANT TO SUBDIVISION EIGHT OF SECTION TWO HUNDRED THREE OF THE ELDER LAW, THAT CORRESPONDS TO THE PATIENT'S COUNTY OF RESIDENCE OR PROSPECTIVE COUNTY OF RESIDENCE BASED ON THE PREFERENCE OF THE PATIENT.

S 26. Intentionally omitted.

S 27. Section 4310 of the public health law, as amended by chapter 639 of the laws of 2006, the section heading as separately amended by chapter 640 of the laws of 2006, subdivisions 1 and 3 as amended by chapter 158 of the laws of 2012, subdivision 2 as separately amended by chapters 158 and 465 of the laws of 2012, is amended to read as follows:

S 4310. New York state donate life registry for organ, EYE and tissue donations. 1. The department shall establish an organ, EYE, and tissue donor registry, which shall be called and be referred to as the "donate life registry", WHICH SHALL PROVIDE A MEANS TO MAKE AND REGISTER A GIFT OF ORGANS, EYES AND TISSUES TO TAKE PLACE AFTER DEATH PURSUANT TO THIS ARTICLE. [Such] THE DONATE LIFE registry shall contain a listing of all donors who have declared their consent to make an anatomical gift.

2. THE COMMISSIONER MAY ENTER INTO A MULTI-YEAR CONTRACT FOR THE OPERATION AND PROMOTION OF THE DONATE LIFE REGISTRY SUBJECT TO SUCH TERMS AND CONDITIONS AS MAY BE CONTAINED WITHIN SUCH CONTRACT WITH A NOT-FOR-PROFIT ORGANIZATION THAT HAS EXPERIENCE WORKING WITH ORGAN, EYE AND TISSUE PROCUREMENT ORGANIZATIONS, HAS EXPERTISE IN CONDUCTING ORGAN, EYE AND TISSUE DONOR PROMOTIONAL CAMPAIGNS, AND IS AFFILIATED WITH THE ORGAN, EYE AND TISSUE DONATION COMMUNITY THROUGHOUT THE STATE. THE CONTRACTOR MAY SUBCONTRACT AS NEEDED FOR THE EFFECTIVE PERFORMANCE OF THE CONTRACT. ALL SUCH SUBCONTRACTORS AND THE TERMS OF SUCH SUBCONTRACTS SHALL BE SUBJECT TO APPROVAL BY THE COMMISSIONER. ANY APPLICABLE STATE AGENCY, INCLUDING, BUT NOT LIMITED TO, THE DEPARTMENT, THE DEPARTMENT OF MOTOR VEHICLES AND THE BOARD OF ELECTIONS, SHALL COOPERATE IN THE COLLECTION AND TRANSFER OF REGISTRANT DATA TO THE DONATE LIFE REGISTRY.

3. THE DUTIES OF THE CONTRACTOR SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(A) THE DEVELOPMENT, IMPLEMENTATION AND MAINTENANCE OF THE DONATE LIFE REGISTRY THAT INCLUDES ONLINE, MAILED AND OTHER FORMS OF ORGAN, EYE AND TISSUE DONOR REGISTRATION, VERIFICATION, AMENDMENT AND REVOCATION;

(B) PREPARATION AND SUBMISSION OF A PLAN TO ENCOURAGE ORGAN, EYE AND TISSUE DONATION THROUGH EDUCATION AND MARKETING EFFORTS AND OTHER RECOMMENDATIONS THAT WOULD STREAMLINE AND ENHANCE THE COST-EFFECTIVE OPERATION OF THE DONATE LIFE REGISTRY;

(C) PROVISION OF WRITTEN OR ELECTRONIC NOTIFICATION OF REGISTRATION IN THE DONATE LIFE REGISTRY TO AN INDIVIDUAL ENROLLING IN THE DONATE LIFE REGISTRY; AND

(D) PREPARATION AND SUBMISSION OF AN ANNUAL WRITTEN REPORT TO THE DEPARTMENT. SUCH REPORT SHALL INCLUDE:

(I) A PERFORMANCE MATRIX INCLUDING THE NUMBER OF REGISTRANTS ON THE DONATE LIFE REGISTRY AND AN ANALYSIS OF THE REGISTRATION RATES, INCLUDING BUT NOT LIMITED TO, LOCATION, METHOD OF REGISTRATION, DEMOGRAPHIC, AND STATE COMPARISONS;

(II) THE CHARACTERISTICS OF REGISTRANTS AS DETERMINED FROM THE DONATE LIFE REGISTRY INFORMATION;

(III) THE ANNUAL DOLLAR AMOUNT OF VOLUNTARY CONTRIBUTIONS RECEIVED BY THE CONTRACTOR FOR THE PURPOSES OF MAINTAINING THE DONATE LIFE REGISTRY AND/OR EDUCATIONAL AND PROMOTIONAL CAMPAIGNS AND INITIATIVES;

(IV) A DESCRIPTION OF THE PROMOTIONAL CAMPAIGNS AND INITIATIVES IMPLEMENTED DURING THE YEAR; AND

(V) ACCOUNTING STATEMENTS OF EXPENDITURES FOR THE PURPOSES OF MAINTAINING THE DONATE LIFE REGISTRY AND PROMOTIONAL CAMPAIGNS AND INITIATIVES.

4. (A) FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, PAYMENTS TO THE CONTRACTOR SHALL BE PAID BY THE DEPARTMENT.

(B) FOR THE PERIOD BEGINNING APRIL FIRST, TWO THOUSAND FIFTEEN AND THEREAFTER, PAYMENTS TO THE CONTRACTOR SHALL BE PAID BY THE DEPARTMENT FROM FUNDS AVAILABLE FOR THESE PURPOSES, INCLUDING, BUT NOT LIMITED TO, THE FUNDS DEPOSITED INTO THE LIFE PASS IT ON TRUST FUND PURSUANT TO SECTION NINETY-FIVE-D OF THE STATE FINANCE LAW.

(C) IN ADDITION, THE CONTRACTOR MAY RECEIVE AND USE VOLUNTARY CONTRIBUTIONS.

5. (A) Such ORGAN, EYE AND TISSUE registration of consent to make an anatomical gift can be made through [(a)]: (I) indication made on the application or renewal form of a DRIVER'S license, [(b)] (II) indication made on a non-driver identification card application or renewal form, [(c) enrolling in the registry website maintained by the department, which may include using an electronic signature subject to article three of the state technology law, (d)] (III) indication made on a voter registration form pursuant to subdivision five of section 5-210 of the election law, (IV) ENROLLMENT THROUGH THE DONATE LIFE REGISTRY WEBSITE, (V) PAPER ENROLLMENT SUBMITTED TO THE DONATE LIFE REGISTRY, or [(e)] (VI) through any other method identified by the commissioner.

(B)(I) Where required by law for [consent] REGISTRATION forms described in [paragraphs (a) and (b)] SUBPARAGRAPHS (I) AND (II) of PARAGRAPH (A) OF this subdivision, the commissioner shall ensure that space is provided on any [consent] REGISTRATION form so that the applicant shall register or decline registration in the donate life registry for organ, EYE and tissue donations under this section and that the following is stated on the form in clear and conspicuous type:

"You must fill out the following section: Would you like to be added to the Donate Life Registry? Check box for 'yes' or 'skip this question'."

(II) The commissioner shall not maintain records of any person who checks "skip this question". Failure to check a box shall not impair the validity of an application, and failure to check "yes" or checking "skip this question" shall not be construed to imply a wish not to donate. In the case of an applicant under eighteen years of age, checking "yes" shall not constitute consent to make an anatomical gift or registration in the donate life registry. Where an applicant has previously consented to make an anatomical gift or registered in the donate life registry, checking "skip this question" or failing to check a box shall not impair that consent or registration.

(C) ENROLLMENT OR AMENDMENT OR REVOCATION THROUGH THE DONATE LIFE REGISTRY WEBSITE THROUGH ANY OF THE MEANS LISTED IN THIS SUBDIVISION MAY BE SIGNED BY ELECTRONIC SIGNATURE, IN ACCORDANCE WITH THE PROVISIONS OF ARTICLE THREE OF THE STATE TECHNOLOGY LAW, SUPPORTED BY THE USE OF SUITABLE MECHANISMS INCLUDING UNIQUE IDENTIFIERS TO PROVIDE CONFIDENCE IN THE IDENTITY OF THE PERSON PROVIDING THE ELECTRONIC SIGNATURE. The registration shall take effect upon the provision of written or elec-

tronic notice of the registration to the [person] INDIVIDUAL enrolling in the DONATE LIFE registry.

[3. (a) Information contained in the registry shall be accessible to (i) federally designated organ procurement organizations, (ii) eye and tissue banks licensed by the department pursuant to article forty-three-B of this chapter, and (iii) any other entity formally approved by the commissioner.

(b) The information contained in the registry shall not be released to any person except as expressly authorized by this section solely for the purpose of identifying potential organ and tissue donors at or near the time of death.

4. If the department had an established registry prior to the effective date of this section, it shall be deemed to meet the requirements of this section.

5. The registry shall provide persons enrolled the opportunity to specify which organs and tissues they want to donate and if the donation can be used for transplantation, research, or both.]

(D) AMENDMENTS OR REVOCATIONS FROM THE DONATE LIFE REGISTRY SHALL BE MADE BY THE FOLLOWING, SUBJECT TO THE REQUIREMENTS OF THE COMMISSIONER:

(I) REGISTRANTS SUBMITTING AN AMENDMENT OR REVOCATION IN WRITING TO THE DONATE LIFE REGISTRY; OR

(II) REGISTRANTS SUBMITTING AN AMENDMENT OR REVOCATION ELECTRONICALLY THROUGH THE DONATE LIFE REGISTRY WEBSITE.

(E) REMOVAL FROM THE DONATE LIFE REGISTRY SHALL NOT BE DEEMED A REFUSAL OF ANY OTHER OR FUTURE ANATOMICAL GIFT.

(F) THE DONATE LIFE REGISTRY SHALL PROVIDE INDIVIDUALS ENROLLED THE OPPORTUNITY TO SPECIFY WHICH ORGANS, EYES AND TISSUES THEY WANT TO DONATE AND IF THE DONATION MAY BE USED FOR TRANSPLANTATION, RESEARCH, OR BOTH.

6. [A person] AN INDIVIDUAL registered in the [organ and tissue] DONATE LIFE registry before [the effective date of this subdivision] JULY TWENTY-THIRD, TWO THOUSAND EIGHT shall be deemed to have expressed intent to donate, until and unless he or she files an amendment to his or her registration or a new registration expressing consent to donate.

7. [The commissioner shall contact each person registered before the effective date of this subdivision in the organ and tissue registry in writing to inform him or her that at the time he or she registered, the registry was that of intent and that the registry is now one of consent, to explain in clear and understandable terms the difference between intent and consent, and to provide opportunity for the person to change his or her registration to provide consent by amending his or her current registration or executing a new registration.] (A) THE DONATE LIFE REGISTRY SHALL BE MAINTAINED IN A MANNER THAT ALLOWS IMMEDIATE ACCESS TO ORGAN, EYE AND TISSUE DONATION RECORDS TWENTY-FOUR HOURS A DAY, SEVEN DAYS A WEEK TO THE CONTRACTOR, THE DEPARTMENT, FEDERALLY DESIGNATED ORGAN PROCUREMENT ORGANIZATIONS, LICENSED EYE AND TISSUE BANKS, AND SUCH OTHER ENTITIES WHICH MAY BE APPROVED BY THE DEPARTMENT FOR ACCESS. ACCESS SHALL BE AVAILABLE TO REGISTRANTS TO CONFIRM THE ACCURACY AND VALIDITY OF THEIR REGISTRATION AND TO AMEND OR REVOKE THEIR REGISTRATION, SUBJECT TO REASONABLE PROCEDURES TO VERIFY IDENTITY.

(B) ACCESS TO THE DONATE LIFE REGISTRY SHALL HAVE SECURITY MEASURES SET FORTH IN THE CONTRACT TO PROTECT THE INTEGRITY OF THE IDENTIFIABLE DATA IN THE DONATE LIFE REGISTRY, WHICH MAY ONLY BE ACCESSED BY THE PARTIES DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION AND ONLY FOR THE PURPOSES OF DETERMINING DONOR STATUS AT OR NEAR THE TIME OF DEATH OF AN INDIVIDUAL, BY THE DEPARTMENT FOR ANY PURPOSE, BY THE CONTRACTOR ONLY

FOR PURPOSES OF QUALITY ASSESSMENT AND IMPROVEMENT, TECHNICAL SUPPORT AND DONOR SERVICES, OR BY INDIVIDUAL REGISTRANTS FOR THE PURPOSES OF CONFIRMING THE ACCURACY AND VALIDITY OF THEIR REGISTRATION OR MAKING, AMENDING OR REVOKING THEIR REGISTRATION.

(C) DE-IDENTIFIED INFORMATION MAY BE ACCESSED BY THE ENTITIES LISTED IN PARAGRAPH (A) OF THIS SUBDIVISION OR THEIR DESIGNEES FOR PURPOSES OF ANALYSIS, PROMOTION, EDUCATION, QUALITY IMPROVEMENT AND TECHNICAL SUPPORT FOR THE DONATE LIFE REGISTRY. THE INFORMATION CONTAINED IN THE REGISTRY SHALL NOT BE RELEASED TO ANY PERSON EXCEPT AS EXPRESSLY AUTHORIZED BY THIS SECTION, SOLELY FOR THE PURPOSES SO AUTHORIZED.

8. The commissioner is authorized to promulgate rules and regulations necessary to implement the provisions of this section.

9. AN INTERAGENCY WORK GROUP, COMPOSED OF THE COMMISSIONER, THE COMMISSIONER OF THE DEPARTMENT OF MOTOR VEHICLES, A CHAIR OF THE BOARD OF ELECTIONS, OR THEIR DESIGNEES, AND SUCH OTHER INDIVIDUALS AS MAY BE DESIGNATED BY THE COMMISSIONER, SHALL BE ESTABLISHED TO MEET WITH THE CONTRACTOR ANNUALLY AND AS NEEDED TO REVIEW THE STATUS OF THE DONATE LIFE REGISTRY, TO EXAMINE THE STEPS THAT MIGHT BE TAKEN BY STATE AGENCIES TO ENHANCE ITS PERFORMANCE AND TO MAKE RECOMMENDATIONS TO THE CONTRACTOR.

S 28. Intentionally omitted.

S 29. Subdivision 3 of section 95-d of the state finance law, as added by chapter 415 of the laws of 2003, is amended to read as follows:

3. Monies of the fund shall be expended only for organ transplant research and education projects approved by the commissioner of health, or to provide grants to not-for-profit corporations in this state which are incorporated for the purpose of increasing and promoting organ and tissue donation awareness PROVIDED, HOWEVER, BEGINNING APRIL FIRST, TWO THOUSAND FIFTEEN, ANY REVENUES RECEIVED OR ANY MONIES APPROPRIATED, CREDITED OR TRANSFERRED TO THE FUND ON AND AFTER MAY FIRST, TWO THOUSAND FOURTEEN MAY ALSO BE EXPENDED TO SUPPORT THE MAINTENANCE AND OPERATION OF THE DONATE LIFE REGISTRY IN ACCORDANCE WITH THE PROVISIONS OF SECTION FORTY-THREE HUNDRED TEN OF THE PUBLIC HEALTH LAW.

S 30. Section 461-b of the social services law is amended by adding two new subdivisions 9 and 10 to read as follows:

9. (A) THE PRIOR WRITTEN APPROVAL OF THE DEPARTMENT IS REQUIRED FOR: (I) ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF TEN PERCENT OR MORE OF AN INTEREST OR VOTING RIGHTS IN A PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY WHICH IS THE OPERATOR OF AN ADULT CARE FACILITY TO A NEW PARTNER, SHAREHOLDER OR MEMBER; OR (II) ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF INTEREST OR VOTING RIGHTS IN A PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY WHICH IS THE OPERATOR OF AN ADULT CARE FACILITY WHICH RESULTS IN THE OWNERSHIP OR CONTROL OF MORE THAN TEN PERCENT OF THE INTEREST OR VOTING RIGHTS THEREUNDER BY ANY PERSON WHO HAS NOT BEEN PREVIOUSLY APPROVED BY THE DEPARTMENT FOR THAT OPERATOR.

(B) WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION INVOLVING LESS THAN TEN PERCENT OF AN INTEREST OR VOTING RIGHTS IN SUCH PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY TO A NEW PARTNER, SHAREHOLDER OR MEMBER, NO PRIOR APPROVAL OF THE DEPARTMENT SHALL BE REQUIRED EXCEPT WHERE REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION. HOWEVER, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST NINETY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY FULLY COMPLETES AND FILES WITH THE DEPARTMENT NOTICE ON A FORM, TO BE DEVELOPED BY THE DEPARTMENT, WHICH SHALL DISCLOSE SUCH INFORMATION AS MAY REASONABLY BE

NECESSARY FOR THE DEPARTMENT TO DETERMINE WHETHER IT SHOULD PROHIBIT THE TRANSACTION. WITHIN NINETY DAYS FROM THE DATE OF RECEIPT OF SUCH NOTICE, THE DEPARTMENT MAY PROHIBIT ANY SUCH TRANSACTION UNDER THIS SUBPARAGRAPH IF IT FINDS: (I) THERE ARE REASONABLE GROUNDS TO BELIEVE THE PROPOSED TRANSACTION DOES NOT SATISFY THE CHARACTER AND COMPETENCE REVIEW, AS MAY BE APPROPRIATE; OR (II) IF THE TRANSACTION, TOGETHER WITH ALL OTHER SUCH TRANSACTIONS DURING ANY FIVE YEAR PERIOD, WOULD IN THE AGGREGATE, INVOLVE TWENTY-FIVE PERCENT OR MORE OF THE INTEREST IN THE ENTITY THAT CONSTITUTES THE OPERATOR. THE DEPARTMENT SHALL STATE THE SPECIFIC REASONS FOR PROHIBITING ANY TRANSACTION UNDER THIS SUBPARAGRAPH AND SHALL SO NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

(C) WITH RESPECT TO A TRANSFER, ASSIGNMENT OR DISPOSITION OF AN INTEREST OR VOTING RIGHTS IN A PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY TO ANY EXISTING PARTNER, SHAREHOLDER OR MEMBER, NO PRIOR APPROVAL OF THE DEPARTMENT SHALL BE REQUIRED. HOWEVER, IF THE TRANSACTION INVOLVES THE WITHDRAWAL OF THE TRANSFEROR FROM THE PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY, NO SUCH TRANSACTION SHALL BE EFFECTIVE UNLESS AT LEAST NINETY DAYS PRIOR TO THE INTENDED EFFECTIVE DATE THEREOF, THE PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY FULLY COMPLETES AND FILES WITH THE DEPARTMENT NOTICE OF SUCH TRANSACTION. WITHIN NINETY DAYS FROM THE DATE OF RECEIPT OF SUCH NOTICE, THE DEPARTMENT MAY PROHIBIT ANY SUCH TRANSACTION UNDER THIS PARAGRAPH IF THE EQUITY POSITION OF THE PARTNERSHIP, BUSINESS CORPORATION OR LIMITED LIABILITY COMPANY, DETERMINED IN ACCORDANCE WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES, WOULD BE REDUCED AS A RESULT OF THE TRANSFER, ASSIGNMENT OR DISPOSITION. THE DEPARTMENT SHALL STATE THE SPECIFIC REASON FOR PROHIBITING ANY TRANSACTION UNDER THIS PARAGRAPH AND SHALL SO NOTIFY EACH PARTY TO THE PROPOSED TRANSACTION.

10. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE DEPARTMENT IS AUTHORIZED TO APPROVE A CERTIFICATE OF INCORPORATION OR ARTICLES OF ORGANIZATION FOR ESTABLISHMENT OF AN ADULT CARE FACILITY ON AN EXPEDITED BASIS WHERE: (A) THE CERTIFICATE OF INCORPORATION OR ARTICLES OF ORGANIZATION REFLECTS SOLELY A CHANGE IN THE FORM OF THE BUSINESS ORGANIZATION OF AN EXISTING ENTITY WHICH HAD BEEN APPROVED BY THE DEPARTMENT TO OPERATE AN ADULT CARE FACILITY; (B) EVERY INCORPORATOR, STOCKHOLDER, MEMBER AND DIRECTOR OF THE NEW ENTITY SHALL HAVE BEEN AN OWNER, PARTNER, INCORPORATOR, STOCKHOLDER, MEMBER OR DIRECTOR OF THE EXISTING ENTITY; (C) THE DISTRIBUTION OF OWNERSHIP INTERESTS AND VOTING RIGHTS IN THE NEW ENTITY SHALL BE THE SAME AS IN THE EXISTING ENTITY; AND (D) THERE SHALL BE NO CHANGE IN THE OPERATOR OF THE ADULT CARE FACILITY OTHER THAN THE FORM OF ITS BUSINESS ORGANIZATION, AS A RESULT OF THE APPROVAL OF SUCH CERTIFICATE OF INCORPORATION OR ARTICLES OF ORGANIZATION. UPON SUBMISSION, IF THE DEPARTMENT DOES NOT OBJECT TO THE PROPOSAL WITHIN NINETY DAYS OF THE RECEIPT OF A COMPLETE APPLICATION, THE PROPOSAL WILL BE DEEMED ACCEPTABLE TO THE DEPARTMENT AND AN AMENDED OPERATING CERTIFICATE SHALL BE ISSUED.

S 31. Subdivisions 1 and 2 of section 461-k of the social services law, as added by chapter 779 of the laws of 1986, are amended to read as follows:

1. (a) "Services for non-residents in adult homes, residences for adults and enriched housing programs" shall mean an organized program of services which the facility is authorized to provide to residents of such facility but which are provided to non-residents for the purpose of restoring, maintaining or developing the capacity of aged or disabled persons to remain in or return to the community. Such services may include but shall not be limited to day programs and temporary residen-

tial care as defined herein. A person participating in a program of services for non-residents in an adult care facility shall be considered a resident of the facility and shall be afforded all the rights and protections afforded residents of the facility under this chapter except that the provisions of sections four hundred sixty-one-g and four hundred sixty-one-h of this title relating to termination of admission agreements shall not apply and that persons receiving services pursuant to this section shall not be considered to be receiving residential care as defined in section two hundred nine of this chapter for purposes of determining eligibility for and the amount of supplemental security income benefits and additional state payments.

(b) "Day programs" shall mean an organized program for non-residents which shall include personal care, supervision and other adult services which the facility is authorized to provide to residents of such facility which may include but are not limited to, activities, meals, information and referral, and transportation services, provided in an adult home, residence for adults or enriched housing program.

(c) "Temporary residential care" shall mean the provision of temporary residential care of frail or disabled adults on behalf of or in the absence of the caregiver for up to [six weeks] ONE HUNDRED TWENTY DAYS in any twelve month period, provided in an adult home, residence for adults or enriched housing program.

2. A program to provide services for non-residents in an adult care facility may be established and operated in an adult home, residence for adults or enriched housing program provided that such facility has a current operating certificate issued in accordance with section four hundred sixty-one-b of this title. No operator may establish and operate a DAY program to provide services for non-residents, AS DEFINED IN SUBPARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION, unless the operator has received the prior written approval of the department. The department shall grant such approval TO OPERATE A DAY PROGRAM only to those operators that are operating in compliance with applicable law and regulations. NO OPERATOR MAY PROVIDE TEMPORARY RESIDENTIAL CARE AS DEFINED IN SUBPARAGRAPH (C) OF SUBDIVISION ONE OF THIS SECTION, UNLESS THE OPERATOR HAS NOTIFIED THE DEPARTMENT OF ITS INTENT TO DO SO.

S 32. Intentionally omitted.

S 33. Subdivision 4 of section 4656 of the public health law, as added by chapter 2 of the laws of 2004, is amended to read as follows:

4. The department shall develop an expedited review and approval process FOR APPLICATIONS FOR UP TO NINE ADDITIONAL BEDS TO AN EXISTING ENHANCED OR SPECIAL NEEDS ASSISTED LIVING CERTIFICATE QUALIFIED AS BEING IN GOOD STANDING UNDER SECTION FORTY-SIX HUNDRED FIFTY-THREE OF THIS ARTICLE.

S 34. Paragraph (b) of subdivision 5 of section 3610 of the public health law is REPEALED.

S 35. Subdivision 2 of section 3610 of the public health law, as amended by section 65 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

2. A hospital, residential health care facility, or certified home health agency seeking authorization to provide a long term home health care program shall transmit to the commissioner an application setting forth the scope of the proposed program. Such application shall be in a format and shall be submitted in a quantity determined by the commissioner. The commissioner shall transmit the application to the public health and health planning council and to the health systems agency, if any, having geographic jurisdiction of the area where the proposed

program is to be located. The application shall include a detailed description of the proposed program including, but not limited to, the following:

(a) an outline of the institution's or agency's plans for the program;

(b) the need for the proposed program;

(c) the number and types of personnel to be employed;

(d) the ability of the agency, hospital, or facility to provide the program;

(e) the estimated number of visits to be provided;

(f) the geographic area in which the proposed programs will be provided;

(g) any special or unusual services, programs, or equipment to be provided;

(h) a demonstration that the proposed program is feasible and adequate in terms of both short range and long range goals;

(i) such other information as the commissioner may require.

The health systems agency and the public health and health planning council shall review the application and submit their recommendations to the commissioner. At the time members of the public health and health planning council are notified that an application is scheduled for consideration, the applicant and the health systems agency shall be so notified in writing. The health systems agency or the public health and health planning council shall not recommend approval of the application unless it is satisfied as to:

(a) the public need for the program at the time and place and under the circumstances proposed;

(b) the financial resources of the provider of the proposed program and its sources of future revenues;

(c) the ability of the proposed program to meet those standards established for participation as a home health agency under title XVIII of the federal Social Security Act; and

(d) such other matters as it shall deem pertinent.

After receiving and considering the recommendations of the public health and health planning council and the health systems agency, the commissioner shall make his or her determination. The commissioner shall act upon an application after the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations. The commissioner shall not take any action contrary to the advice of either until he or she affords to either an opportunity to request a public hearing and, if so requested, a public hearing shall be held. The commissioner shall not approve the application unless he or she is satisfied as to the detailed description of the proposed program and

(a) the public need for the existence of the program at the time and place and under the circumstances proposed;

(b) the financial resources of the provider of the proposed program and its sources of future revenues;

(c) the ability of the proposed program to meet those standards established for participation as a home health agency under title XVIII of the federal Social Security Act; and

(d) such other matters as he or she shall deem pertinent.

If the application is approved, the applicant shall be so notified in writing. The commissioner's written approval of the application shall constitute authorization to provide a long term home health care program. [In making his or her authorization, the commissioner shall stipulate the maximum number of persons which a provider of a long term

home health care program may serve.] If the commissioner proposes to disapprove the application, he or she shall notify the applicant in writing, stating his or her reasons for disapproval, and afford the applicant an opportunity for a public hearing.

S 36. Intentionally omitted.

S 37. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, as amended by section 26 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 32. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2008; provided however, that sections one, six-a, nineteen, twenty, twenty-four, and twenty-five of this act shall take effect July 1, 2008; provided however that sections sixteen, seventeen and eighteen of this act shall expire April 1, [2014] 2017; provided, however, that the amendments made by section twenty-eight of this act shall take effect on the same date as section 1 of chapter 281 of the laws of 2007 takes effect; provided further, that sections twenty-nine, thirty, and thirty-one of this act shall take effect October 1, 2008; provided further, that section twenty-seven of this act shall take effect January 1, 2009; and provided further, that section twenty-seven of this act shall expire and be deemed repealed March 31, [2014] 2015; and provided, further, however, that the amendments to subdivision 1 of section 241 of the education law made by section twenty-nine of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided that the amendments to section 272 of the public health law made by section thirty of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

S 38. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2014; provided, however, that the amendments to subdivisions 1 and 2 of section 461-k of the social services law made by section thirty-one of this act shall not affect the expiration of such section and shall be deemed to expire therewith; and provided, further, that the amendments made to paragraph (b) of subdivision 18-a of section 206 of the public health law made by section sixteen of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith.

PART B

Section 1. Subdivision 5 of section 168 of chapter 639 of the laws of 1996, constituting the New York Health Care Reform Act of 1996, as amended by section 1 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

5. sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, as amended or as added by this act, shall expire on December 31, [2014] 2017, and shall be thereafter effective only in respect to any act done on or before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s and 2807-t of the public health law related to patient services provided before December 31,

[2014] 2017, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 2. Subdivision 1 of section 138 of chapter 1 of the laws of 1999, constituting the New York Health Care Reform Act of 2000, as amended by section 2 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

1. sections 2807-c, 2807-j, 2807-s, and 2807-t of the public health law, as amended by this act, shall expire on December 31, [2014] 2017, and shall be thereafter effective only in respect to any act done before such date or action or proceeding arising out of such act including continued collections of funds from assessments and allowances and surcharges established pursuant to sections 2807-c, 2807-j, 2807-s and 2807-t of the public health law, and administration and distributions of funds from pools established pursuant to sections 2807-c, 2807-j, 2807-k, 2807-l, 2807-m, 2807-s, 2807-t, 2807-v and 2807-w of the public health law, as amended or added by this act, related to patient services provided before December 31, [2014] 2017, and continued expenditure of funds authorized for programs and grants until the exhaustion of funds therefor;

S 3. The opening paragraph, subparagraph (xiv) and (xv) of paragraph (a), subparagraph (v) of paragraph (c) and paragraph (e) of subdivision 6 of section 2807-s of the public health law, the opening paragraph as amended by section 4 of part A3 of chapter 62 of the laws of 2003, subparagraphs (xiv) and (xv) of paragraph (a) as amended by section 5 of part C of chapter 59 of the laws of 2011, subparagraph (v) of paragraph (c) as amended by section 5-a of part C of chapter 59 of the laws of 2011 and paragraph (e) as amended by section 6 of part A3 of chapter 62 of the laws of 2003, subparagraphs (i) and (ii) of paragraph (e) as amended by section 5-b of part C of chapter 59 of the laws of 2011, are amended to read as follows:

The amount allocated to each region for purposes of calculating the regional allowance percentage pursuant to this section for each year during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and the regional assessments pursuant to section twenty-eight hundred seven-t of this article for each year during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and for each year on and after January first, two thousand, shall be the sum of the factors computed in paragraphs (b), (d) and (f) of this subdivision, IF SUCH FACTORS ARE APPLICABLE TO A GIVEN YEAR, as follows:

(xiv) A gross annual statewide amount for the period January first, two thousand nine through December thirty-first, two thousand [thirteen] FOURTEEN, shall be nine hundred forty-four million dollars.

(xv) A gross ANNUAL statewide amount for the period January first, two thousand [fourteen] FIFTEEN through [March] DECEMBER thirty-first, two thousand [fourteen] SEVENTEEN, shall be [two hundred thirty-six] ONE BILLION FORTY-FIVE million dollars.

(v) A further gross ANNUAL statewide amount for the period January first, two thousand fourteen through [March] DECEMBER thirty-first, two thousand fourteen, shall be [twenty-two] EIGHTY-NINE million [two hundred fifty thousand] dollars.

(e) [(i)] A further gross annual statewide amount shall be twelve million dollars for each period prior to January first, two thousand [fourteen] FIFTEEN.

[(ii) A further gross statewide amount for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen shall be three million dollars.]

S 4. Subparagraph (xiii) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as added by section 30 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(xiii) twenty-three million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand [fourteen] SEVENTEEN;

S 5. Subparagraphs (iv) and (v) of paragraph (a) of subdivision 9 of section 2807-j of the public health law, as amended by section 3 of part C of chapter 59 of the laws of 2011, are amended to read as follows:

(iv) seven hundred sixty-five million dollars annually of the funds accumulated for the periods January first, two thousand through December thirty-first, two thousand [thirteen] SIXTEEN, and

(v) one hundred ninety-one million two hundred fifty thousand dollars of the funds accumulated for the period January first, two thousand [fourteen] SEVENTEEN through March thirty-first, two thousand [fourteen] SEVENTEEN.

S 6. Section 34 of part A3 of chapter 62 of the laws of 2003 amending the general business law and other laws relating to enacting major components necessary to implement the state fiscal plan for the 2003-04 state fiscal year, as amended by section 4 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

S 34. (1) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated pursuant to section 2807-v of the public health law, including income from invested funds, for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by section 2807-v of the public health law.

(2) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the state comptroller is authorized and directed to receive for deposit to the credit of the department of health's special revenue fund - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, within amounts appropriated each year, those funds collected and accumulated and interest earned through surcharges on payments for health care services pursuant to section 2807-s of the public health law and from assessments pursuant to section 2807-t of the public health law for the purpose of payment for administrative costs of the department of health related to administration of statutory duties for the collections and distributions authorized by sections 2807-s, 2807-t, and 2807-m of the public health law.

(3) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (a) of subdivision 1 of section 2807-l of the public health

law for the purposes of payment for administrative costs of the department of health related to the child health insurance plan program authorized pursuant to title 1-A of article 25 of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, child health insurance account, established within the department of health.

(4) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of paragraph (e) of subdivision 1 of section 2807-l of the public health law for the purpose of payment for administrative costs of the department of health related to the health occupation development and workplace demonstration program established pursuant to section 2807-h and the health workforce retraining program established pursuant to section 2807-g of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health occupation development and workplace demonstration program account, established within the department of health.

(5) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds allocated pursuant to paragraph (j) of subdivision 1 of section 2807-v of the public health law for the purpose of payment for administrative costs of the department of health related to administration of the state's tobacco control programs and cancer services provided pursuant to sections 2807-r and 1399-ii of the public health law into such accounts established within the department of health for such purposes.

(6) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, the funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to the programs funded pursuant to section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, pilot health insurance account, established within the department of health.

(7) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with the provisions of subparagraph (ii) of paragraph (f) of subdivision 19 of section 2807-c of the public health law from monies accumulated and interest earned in the bad debt and charity care and capital statewide pools through an assessment charged to general hospitals pursuant to the provisions of subdivision 18 of section 2807-c of the public health law and those funds authorized for distribution in accordance with the provisions of section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund -

061, primary care initiatives account, established within the department of health.

(8) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized for distribution in accordance with section 2807-l of the public health law for the purposes of payment for administrative costs of the department of health related to programs funded under section 2807-l of the public health law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, health care delivery administration account, established within the department of health.

(9) Notwithstanding any inconsistent provision of law, rule or regulation and effective April 1, 2008 through March 31, [2014] 2017, the commissioner of health is authorized to transfer and the comptroller is authorized to deposit, within amounts appropriated each year, those funds authorized pursuant to sections 2807-d, 3614-a and 3614-b of the public health law and section 367-i of the social services law and for distribution in accordance with the provisions of subdivision 9 of section 2807-j of the public health law for the purpose of payment for administration of statutory duties for the collections and distributions authorized by sections 2807-c, 2807-d, 2807-j, 2807-k, 2807-l, 3614-a and 3614-b of the public health law and section 367-i of the social services law into the special revenue funds - other, health care reform act (HCRA) resources fund - 061, provider collection monitoring account, established within the department of health.

S 7. Section 2807-l of the public health law, as amended by section 7 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

S 2807-l. Health care initiatives pool distributions. 1. Funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, or the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following.

(a) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to programs to provide health care coverage for uninsured or underinsured children pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter from the respective health care initiatives pools established for the following periods in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, up to one hundred twenty million six hundred thousand dollars;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, up to one hundred sixty-four million five hundred thousand dollars;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to one hundred eighty-one million dollars;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand, two hundred seven million dollars;

(v) from the pool for the period January first, two thousand one through December thirty-first, two thousand one, two hundred thirty-five million dollars;

(vi) from the pool for the period January first, two thousand two through December thirty-first, two thousand two, three hundred twenty-four million dollars;

(vii) from the pool for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred fifty million three hundred thousand dollars;

(viii) from the pool for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred sixty million nine hundred thousand dollars;

(ix) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to one hundred fifty-three million eight hundred thousand dollars;

(x) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to three hundred twenty-five million four hundred thousand dollars;

(xi) from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred twenty-eight million fifty-nine thousand dollars;

(xii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to four hundred fifty-three million six hundred seventy-four thousand dollars annually;

(xiii) from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven, through March thirty-first, two thousand eleven, up to one hundred thirteen million four hundred eighteen thousand dollars;

(xiv) from the health care reform act (HCRA) resources fund for the period April first, two thousand eleven, through March thirty-first, two thousand twelve, up to three hundred twenty-four million seven hundred forty-four thousand dollars;

(xv) from the health care reform act (HCRA) resources fund for the period April first, two thousand twelve, through March thirty-first, two thousand thirteen, up to three hundred forty-six million four hundred forty-four thousand dollars; [and]

(xvi) from the health care reform act (HCRA) resources fund for the period April first, two thousand thirteen, through March thirty-first, two thousand fourteen, up to three hundred seventy million six hundred ninety-five thousand dollars[.]; AND

(XVII) FROM THE HEALTH CARE REFORM ACT (HCRA) RESOURCES FUND FOR EACH STATE FISCAL YEAR FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, WITHIN AMOUNTS APPROPRIATED.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions for health insurance programs under the individual subsidy programs established pursuant to the expanded health care coverage act of nineteen hundred eighty-eight as amended, and for evaluation of such programs from the respective health care initiatives pools or

the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following amounts:

(i) (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 nine, shall be allocated to individual subsidy programs; and

(B) an amount not to exceed seven million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and four million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, and three million dollars for the period January first, two thousand three through December thirty-first, two thousand three, and two million dollars for the period January first, two thousand four through December thirty-first, two thousand four, and two million dollars for the period January first, two thousand five through June thirtieth, two thousand five shall be allocated to the catastrophic health care expense program.

(ii) Notwithstanding any law to the contrary, the characterizations of the New York state small business health insurance partnership program as in effect prior to June thirtieth, two thousand three, voucher program as in effect prior to December thirty-first, two thousand one, individual subsidy program as in effect prior to June thirtieth, two thousand five, and catastrophic health care expense program, as in effect prior to June thirtieth, two thousand five, may, for the purposes of identifying matching funds for the community health care conversion demonstration project described in a waiver of the provisions of title XIX of the federal social security act granted to the state of New York and dated July fifteenth, nineteen hundred ninety-seven, may continue to be used to characterize the insurance programs in sections four thousand three hundred twenty-one-a, four thousand three hundred twenty-two-a, four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law, which are successor programs to these programs.

(c) Up to seventy-eight million dollars shall be reserved and accumulated from year to year from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, for purposes of public health programs, up to seventy-six million dollars shall be reserved and accumulated from year to year from the pools for the periods January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-

eight and January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, up to eighty-four million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand through December thirty-first, two thousand, up to eighty-five million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand one through December thirty-first, two thousand one, up to eighty-six million dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand two through December thirty-first, two thousand two, up to eighty-six million one hundred fifty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand three through December thirty-first, two thousand three, up to fifty-eight million seven hundred eighty thousand dollars shall be reserved and accumulated from year to year from the pools for the period January first, two thousand four through December thirty-first, two thousand four, up to sixty-eight million seven hundred thirty thousand dollars shall be reserved and accumulated from year to year from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand five through December thirty-first, two thousand five, up to ninety-four million three hundred fifty thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, up to seventy million nine hundred thirty-nine thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand seven through December thirty-first, two thousand seven, up to fifty-five million six hundred eighty-nine thousand dollars annually shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eight through December thirty-first, two thousand ten, up to thirteen million nine hundred twenty-two thousand dollars shall be reserved and accumulated from year to year from the health care reform act (HCRA) resources fund for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and for periods on and after April first, two thousand eleven [through March thirty-first, two thousand fourteen], up to funding amounts specified below and shall be available, including income from invested funds, for:

(i) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, hospital based grants program account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of services and expenses related to general hospital based grant programs, up to twenty-two million dollars annually from the nineteen hundred ninety-seven pool, nineteen hundred ninety-eight pool, nineteen hundred ninety-nine pool, two thousand pool, two thousand one pool and two thousand two pool, respectively, up to twenty-two million dollars from the two thousand three pool, up to ten million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to eleven million dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-two million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to

twenty-two million ninety-seven thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million five hundred twenty-four thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to thirteen million four hundred forty-five thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, and up to thirteen million three hundred seventy-five thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen;

(ii) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the emergency medical services training account established in section ninety-seven-q of the state finance law or the health care reform act (HCRA) resources fund, whichever is applicable, up to sixteen 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 twenty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to twenty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to twenty-two million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to twenty-two million five hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to nine million six hundred eighty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to twelve million one hundred thirty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to twenty-four million two hundred fifty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to twenty million four hundred ninety-two thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to five million one hundred twenty-three thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to eighteen million three hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to eighteen million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, [and] up to nineteen million four hundred nineteen thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, AND UP TO NINETEEN MILLION SIX HUNDRED FIFTY-NINE THOUSAND SEVEN HUNDRED DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD OF APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN;

(iii) priority distributions by the commissioner up to thirty-two million dollars on an annualized basis for the period January first, two thousand through December thirty-first, two thousand four, up to thirty-eight million dollars on an annualized basis for the period January first, two thousand five through December thirty-first, two thousand six, up to eighteen million two hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to three million dollars annually for the period January first, two thousand eight through December thirty-first, two

thousand ten, up to seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO TWO MILLION NINE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN to be allocated (A) for the purposes established pursuant to subparagraph (ii) of paragraph (f) of subdivision nineteen of section twenty-eight hundred seven-c of this article as in effect on December thirty-first, nineteen hundred ninety-six and as may thereafter be amended, up to fifteen million dollars annually for the periods January first, two thousand through December thirty-first, two thousand four, up to twenty-one million dollars annually for the period January first, two thousand five through December thirty-first, two thousand six, and up to seven million five hundred thousand dollars for the period January first, two thousand seven through March thirty-first, two thousand seven;

(B) pursuant to a memorandum of understanding entered into by the commissioner, the majority leader of the senate and the speaker of the assembly, for the purposes outlined in such memorandum upon the recommendation of the majority leader of the senate, up to eight million five hundred thousand dollars annually for the period January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, and for the purposes outlined in such memorandum upon the recommendation of the speaker of the assembly, up to eight million five hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand six, and up to four million two hundred fifty thousand dollars for the period January first, two thousand seven through June thirtieth, two thousand seven; and

(C) for services and expenses, including grants, related to emergency assistance distributions as designated by the commissioner. Notwithstanding section one hundred twelve or one hundred sixty-three of the state finance law or any other contrary provision of law, such distributions shall be limited to providers or programs where, as determined by the commissioner, emergency assistance is vital to protect the life or safety of patients, to ensure the retention of facility caregivers or other staff, or in instances where health facility operations are jeopardized, or where the public health is jeopardized or other emergency situations exist, up to three million dollars annually for the period April first, two thousand seven through March thirty-first, two thousand eleven, [and] up to two million nine hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO TWO MILLION NINE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN. Upon any distribution of such funds, the commissioner shall immediately notify the chair and ranking minority member of the senate finance committee, the assembly ways and means committee, the senate committee on health, and the assembly committee on health;

(iv) distributions by the commissioner related to poison control centers pursuant to subdivision seven of section twenty-five hundred-d of this chapter, up to five million dollars for the period January first, nineteen hundred ninety-seven through December thirty-first,

nineteen hundred ninety-seven, up to three million dollars on an annualized basis for the periods during the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-nine, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four million six hundred thousand dollars annually for the periods January first, two thousand three through December thirty-first, two thousand four, up to five million one hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand six annually, up to five million one hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand nine, up to three million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to seven hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] up to two million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO THREE MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN; and

(v) deposit by the commissioner, within amounts appropriated, and the state comptroller is hereby authorized and directed to receive for deposit to, to the credit of the department of health's special revenue fund - other, miscellaneous special revenue fund - 339 maternal and child HIV services account or the health care reform act (HCRA) resources fund, whichever is applicable, for purposes of a special program for HIV services for women and children, including adolescents pursuant to section twenty-five hundred-f-one of [the public health law] THIS CHAPTER, up to five million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to two million five hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to two million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to five million dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and up to five million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen;

(d) (i) An amount of up to twenty million dollars annually for the period January first, two thousand through December thirty-first, two thousand six, up to ten million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven, up to twenty million dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, up to five million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] up to nineteen million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO NINETEEN MILLION SIX HUNDRED THOUSAND

DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, shall be transferred to the health facility restructuring pool established pursuant to section twenty-eight hundred fifteen of this article;

(ii) provided, however, amounts transferred pursuant to subparagraph (i) of this paragraph may be reduced 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 health facility restructuring program.

(e) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions to organizations to support the health workforce retraining program established pursuant to section twenty-eight hundred seven-g of this article from the respective health care initiatives pools established for the following periods in the following amounts from the pools or the health care reform act (HCRA) resources fund, whichever is applicable, during the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, up to fifty million dollars on an annualized basis, up to thirty million dollars for the period January first, two thousand through December thirty-first, two thousand, up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one, up to fifty million dollars for the period January first, two thousand two through December thirty-first, two thousand two, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to forty-one million one hundred fifty thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to fifty-eight million three hundred sixty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to fifty-two million three hundred sixty thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to thirty-five million four hundred thousand dollars annually for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eight million eight hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] up to twenty-eight million four hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO TWENTY-SIX MILLION EIGHT HUNDRED SEVENTEEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, less the amount of funds available for allocations for rate adjustments for workforce training programs for payments by state governmental agencies for inpatient hospital services.

(f) Funds shall be accumulated and transferred from as follows:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, (A) thirty-four million six hundred thousand dollars shall be transferred to funds reserved and accumulated pursuant to paragraph (b) of subdivision nineteen of section twenty-eight hundred seven-c of this article, and (B) eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, eighty-two million dollars shall be transferred and deposited and credited to the credit of the state general fund medical assistance local assistance account;

(iv) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand through December thirty-first, two thousand four, eighty-two million dollars annually, and for the period January first, two thousand five through December thirty-first, two thousand five, eighty-two million dollars, and for the period January first, two thousand six through December thirty-first, two thousand six, eighty-two million dollars, and for the period January first, two thousand seven through December thirty-first, two thousand seven, eighty-two million dollars, and for the period January first, two thousand eight through December thirty-first, two thousand eight, ninety million seven hundred thousand dollars shall be deposited by the commissioner, 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;

(v) from the health care reform act (HCRA) resources fund for the period January first, two thousand nine through December thirty-first, two thousand nine, one hundred eight million nine hundred seventy-five thousand dollars, and for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-six million one hundred thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, twenty million five hundred thousand dollars, and for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, one hundred forty-six million four hundred thousand dollars, shall be deposited by the commissioner, 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.

(g) Funds shall be transferred to primary health care services pools created by the commissioner, and shall be available, including income from invested funds, for distributions in accordance with former section twenty-eight hundred seven-bb of this article from the respective health care initiatives pools for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, fifteen and eighty-seven-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, fifteen and eighty-seven-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, sixteen and thirteen-hundredths percent.

(h) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for purposes of primary care education and training pursuant to article nine of this chapter from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision and shall be available for distributions as follows:

(i) funds shall be reserved and accumulated:

(A) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(B) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(C) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(ii) funds shall be available for distributions including income from invested funds as follows:

(A) for purposes of the primary care physician loan repayment program in accordance with section nine hundred three of this chapter, up to five million dollars on an annualized basis;

(B) for purposes of the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter, up to two million dollars on an annualized basis;

(C) for purposes of minority participation in medical education grants in accordance with section nine hundred six of this chapter, up to one million dollars on an annualized basis; and

(D) provided, however, that the commissioner may reallocate any funds remaining or unallocated for distributions for the primary care practitioner scholarship program in accordance with section nine hundred four of this chapter.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for distributions in accordance with section twenty-nine hundred fifty-two and section twenty-nine hundred fifty-eight of this chapter for rural health care delivery development and rural health care access development, respectively, from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirteen and forty-nine-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirteen and forty-nine-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirteen and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, seventeen million dollars annually, and for the period January first, two thousand three through

December thirty-first, two thousand three, up to fifteen million eight hundred fifty thousand dollars;

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thousand four through December thirty-first, two thousand four, up to fifteen million eight hundred fifty thousand dollars, [and] for the period January first, two thousand five through December thirty-first, two thousand five, up to nineteen million two hundred thousand dollars, [and] for the period January first, two thousand six through December thirty-first, two thousand six, up to nineteen million two hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to eighteen million one hundred fifty thousand dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million five hundred thirty-eight thousand dollars, [and] for each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to sixteen million two hundred thousand dollars, AND UP TO SIXTEEN MILLION TWO HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions related to health information and health care quality improvement pursuant to former section twenty-eight hundred seven-n of this article from the respective health care initiatives pools established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, six and thirty-five-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, six and thirty-five-hundredths percent; and

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent.

(k) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for allocations and distributions in accordance with section twenty-eight hundred seven-p of this article for diagnostic and treatment center uncompensated care from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, thirty-eight and one-tenth percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, thirty-eight and one-tenth percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine, thirty-eight and seventy-one-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, forty-eight million dollars annually, and for the period January first, two thousand three through June thirtieth, two thousand three, twenty-four million dollars;

(v) (A) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period July first, two thousand three through December thirty-first, two thousand three, up to six million dollars, for the period January first, two thousand four through December thirty-first, two thousand six, up to twelve million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, up to forty-eight million dollars annually, [and] for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, up to twelve million dollars AND FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, UP TO FORTY-EIGHT MILLION DOLLARS ANNUALLY;

(B) from the health care reform act (HCRA) resources fund for the period January first, two thousand six through December thirty-first, two thousand six, an additional seven million five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand thirteen, an additional seven million five hundred thousand dollars annually, [and] for the period January first, two thousand fourteen through March thirty-first, two thousand fourteen, an additional one million eight hundred seventy-five thousand dollars, AND FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, AN ADDITIONAL SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS ANNUALLY for voluntary non-profit diagnostic and treatment center uncompensated care in accordance with subdivision four-c of section twenty-eight hundred seven-p of this article; and

(vi) funds reserved and accumulated pursuant to this paragraph for periods on and after July first, two thousand three, 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, for purposes of funding the state share of rate adjustments made pursuant to section twenty-eight hundred seven-p of this article, provided, however, that in the event federal financial participation is not available for rate adjustments made pursuant to paragraph (b) of subdivision one of section twenty-eight hundred seven-p of this article, funds shall be distributed pursuant to paragraph (a) of subdivision one of section twenty-eight hundred seven-p of this article from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable.

(l) Funds shall be reserved and accumulated from year to year by the commissioner and shall be available, including income from invested funds, for transfer to and allocation for services and expenses for the payment of benefits to recipients of drugs under the AIDS drug assistance program (ADAP) - HIV uninsured care program as administered by Health Research Incorporated from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, nine and fifty-two-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, nine and fifty-two-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, nine and sixty-eight-hundredths percent;

(iv) from the pool for the periods January first, two thousand through December thirty-first, two thousand two, up to twelve million dollars annually, and for the period January first, two thousand three through December thirty-first, two thousand three, up to forty million dollars; and

(v) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the periods January first, two thousand four through December thirty-first, two thousand four, up to fifty-six million dollars, for the period January first, two thousand five through December thirty-first, two thousand six, up to sixty million dollars annually, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to sixty million dollars annually, for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to fifteen million dollars, [and] each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, up to forty-two million three hundred thousand dollars AND UP TO FORTY-ONE MILLION FIFTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(m) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of distributions pursuant to section twenty-eight hundred seven-r of this article for cancer related services from the respective health care initiatives pools or the health care reform act (HCRA) resources fund, whichever is applicable, established for the following periods in the following percentage amounts of funds remaining after allocations in accordance with paragraphs (a) through (f) of this subdivision, and for periods on and after January first, two thousand, in the following amounts:

(i) from the pool for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-seven, seven and ninety-four-hundredths percent;

(ii) from the pool for the period January first, nineteen hundred ninety-eight through December thirty-first, nineteen hundred ninety-eight, seven and ninety-four-hundredths percent;

(iii) from the pool for the period January first, nineteen hundred ninety-nine and December thirty-first, nineteen hundred ninety-nine, six and forty-five-hundredths percent;

(iv) from the pool for the period January first, two thousand through December thirty-first, two thousand two, up to ten million dollars on an annual basis;

(v) from the pool for the period January first, two thousand three through December thirty-first, two thousand four, up to eight million nine hundred fifty thousand dollars on an annual basis;

(vi) from the pool or the health care reform act (HCRA) resources fund, whichever is applicable, for the period January first, two thou-

sand five through December thirty-first, two thousand six, up to ten million fifty thousand dollars on an annual basis, for the period January first, two thousand seven through December thirty-first, two thousand ten, up to nineteen million dollars annually, and for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to four million seven hundred fifty thousand dollars.

(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 November thirtieth, two thousand 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.

2. Notwithstanding any inconsistent provision of law, rule or regulation, any funds accumulated in the health care initiatives pools pursuant to paragraph (b) of subdivision nine of section twenty-eight hundred seven-j of this article, as a result of surcharges, assessments or other obligations during the periods January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine, which are unused or uncommitted for distributions pursuant to this section shall be reserved and accumulated from year to year by the commissioner and, within amounts appropriated, transferred and deposited into the special revenue funds - other, miscellaneous special revenue fund - 339, child health insurance account or any successor fund or account, for purposes of distributions to implement the child health insurance program established pursuant to sections twenty-five hundred ten and twenty-five hundred eleven of this chapter for periods on and after January first, two thousand one; provided, however, funds reserved and accumulated for priority distributions pursuant to subparagraph (iii) of paragraph (c) of subdivision one of this section shall not be transferred and deposited into such account pursuant to this subdivision; and provided further, however, that any unused or uncommitted pool funds accumulated and allocated pursuant to paragraph (j) of subdivision one of this section shall be distributed for purposes of the health information and quality improvement act of 2000.

3. Revenue from distributions pursuant to this section shall not be included in gross revenue received for purposes of the assessments pursuant to subdivision eighteen of section twenty-eight hundred seven-c of this article, subject to the provisions of paragraph (e) of subdivision eighteen of section twenty-eight hundred seven-c of this article, and shall not be included in gross revenue received for purposes of the assessments pursuant to section twenty-eight hundred seven-d of this article, subject to the provisions of subdivision twelve of section twenty-eight hundred seven-d of this article.

S 8. Section 2807-v of the public health law, as amended by section 5 of part B of chapter 58 of the laws of 2008, subdivision 1 as amended by section 8 of part C of chapter 59 of the laws of 2011, clause (K) of subparagraph (i) of paragraph (bb) of subdivision 1 as amended by section 35-a, subparagraph (xi) of paragraph (cc) of subdivision 1 as amended by section 35-b and subparagraph (vii) of paragraph (ccc) of subdivision 1 as amended by section 35-c of part D of chapter 56 of the laws of 2012, paragraph (fff) of subdivision 1 as separately amended by

section 16 of part A of chapter 59 of the laws of 2011, and paragraph (iii) of subdivision 1 as added by section 52-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 2807-v. Tobacco control and insurance initiatives pool distributions. 1. Funds accumulated in the tobacco control and insurance initiatives pool or in the health care reform act (HCRA) resources fund established pursuant to section ninety-two-dd of the state finance law, whichever is applicable, including income from invested funds, shall be distributed or retained by the commissioner or by the state comptroller, as applicable, in accordance with the following:

(a) 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, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of services and expenses related to the toll-free medicaid fraud hotline established pursuant to section one hundred eight of chapter one of the laws of nineteen hundred ninety-nine from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: four hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to four hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to four hundred thousand dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to four hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five, up to four hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, up to four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to four hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to four hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to four hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and within amounts appropriated on and after April first, two thousand eleven.

(b) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of payment of audits or audit contracts necessary to determine payor and provider compliance with requirements set forth in sections twenty-eight hundred seven-j, twenty-eight hundred seven-s and twenty-eight hundred seven-t of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five million six hundred thousand dollars annually for the periods January first, two thousand through December thirty-first, two thousand two, up to five million dollars for the period January first, two thousand three through December thirty-first, two thousand three, up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, up to five million dollars for the period January first, two thousand five through December thirty first, two thousand five, up to five million dollars for the period January first, two thousand six through December thirty-first,

two thousand six, up to seven million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and up to eight million three hundred twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to eight million five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to eight million five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] up to fourteen million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO ELEVEN MILLION ONE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(c) 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, enhanced community services account, or any successor fund or account, for mental health services programs for case management services for adults and children; supported housing; home and community based waiver services; family based treatment; family support services; mobile mental health teams; transitional housing; and community oversight, established pursuant to articles seven and forty-one of the mental hygiene law and subdivision nine of section three hundred sixty-six of the social services law; and for comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the enhanced community services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law; from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) forty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand, for the period January first, two thousand through December thirty-first, two thousand;

(ii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand one, for the period January first, two thousand one through December thirty-first, two thousand one;

(iii) eighty-seven million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand two, for the period January first, two thousand two through December thirty-first, two thousand two;

(iv) eighty-eight million dollars to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand three, for the period January first, two thousand three through December thirty-first, two thousand three;

(v) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand four, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period Janu-

ary first, two thousand four through December thirty-first, two thousand four;

(vi) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand five, and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) eighty-eight million dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand six, and pursuant to FORMER section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) eighty-six million four hundred thousand dollars, plus five hundred thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand seven and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) twenty-two million nine hundred thirteen thousand dollars, plus one hundred twenty-five thousand dollars, to be reserved, to be retained or for distribution pursuant to a chapter of the laws of two thousand eight and pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, for the period January first, two thousand eight through March thirty-first, two thousand eight.

(d) 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 services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two, for administration and marketing costs associated with such program established pursuant to clause (A) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law 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 through December thirty-first, two thousand;

(ii) twenty-seven million dollars for the period January first, two thousand one through December thirty-first, two thousand one; and

(iii) fifty-seven million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(e) 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 services and expenses related to the family health plus program including up to two and one-half million dollars annually for the period January first, two thousand through December thirty-first, two thousand two for administration and marketing costs associated with such program established pursuant to clause (B) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social

services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

(iii) sixty-six million dollars for the period January first, two thousand two through December thirty-first, two thousand two.

(f) 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, medicaid fraud hotline and medicaid administration account, or any successor fund or account, for purposes of payment of administrative expenses of the department related to the family health plus program established pursuant to section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts: five hundred thousand dollars on an annual basis for the periods January first, two thousand through December thirty-first, two thousand six, five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, and five hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, five hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, five hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven and within amounts appropriated on and after April first, two thousand eleven.

(g) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the health maintenance organization direct pay market program established pursuant to sections forty-three hundred twenty-one-a and forty-three hundred twenty-two-a of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to thirty-five million dollars for the period January first, two thousand through December thirty-first, two thousand of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(ii) up to thirty-six million dollars for the period January first, two thousand one through December thirty-first, two thousand one of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iii) up to thirty-nine million dollars for the period January first, two thousand two through December thirty-first, two thousand two of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law

and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(iv) up to forty million dollars for the period January first, two thousand three through December thirty-first, two thousand three of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(v) up to forty million dollars for the period January first, two thousand four through December thirty-first, two thousand four of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vi) up to forty million dollars for the period January first, two thousand five through December thirty-first, two thousand five of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(vii) up to forty million dollars for the period January first, two thousand six through December thirty-first, two thousand six of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law;

(viii) up to forty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven of which fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty percentum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law; and

(ix) up to forty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight of which fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-one-a of the insurance law and fifty per centum shall be allocated to the program pursuant to section four thousand three hundred twenty-two-a of the insurance law.

(h) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York individual program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the healthy New York group program established pursuant to sections four thousand three hundred twenty-six and four thousand three hundred twenty-seven of the insurance law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

(vii) up to sixty-one million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(viii) up to one hundred three million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight.

(i-1) Notwithstanding the provisions of paragraphs (h) and (i) of this subdivision, the commissioner shall reserve and accumulate up to two million five hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, one million four hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, two million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, from funds otherwise available for distribution under such paragraphs for the services and expenses related to the pilot program for entertainment industry employees included in subsection (b) of section one thousand one hundred twenty-two of the insurance law, and an additional seven hundred thousand dollars annually for the periods January first, two thousand four through December thirty-first, two thousand six, an additional three hundred thousand dollars for the period January first, two

thousand seven through June thirtieth, two thousand seven for services and expenses related to the pilot program for displaced workers included in subsection (c) of section one thousand one hundred twenty-two of the insurance law.

(j) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of services and expenses related to the tobacco use prevention and control program established pursuant to sections thirteen hundred ninety-nine-ii and thirteen hundred ninety-nine-jj of this chapter, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(ii) up to forty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

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

(iv) up to thirty-six million nine hundred fifty thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;

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

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

(vii) up to eighty-one million nine hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(viii) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to support costs associated with cancer research;

(ix) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) up to ninety-four million one hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) up to eighty-seven million seven hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) up to twenty-one million four hundred twelve thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xiii) up to fifty-two million one hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen; AND

(XIV) UP TO SIX MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(k) 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, health care services account, or any successor fund or account, for purposes of services and expenses related to public health programs, including comprehensive care centers for eating disorders pursuant to the former section twenty-seven hundred ninety-nine-l of this chapter, provided however that, for such centers, funds in the amount of five hundred thousand dollars on an annualized basis shall be transferred from the health care services account, or any successor fund or account, and deposited into the fund established by section ninety-five-e of the state finance law for periods prior to March thirty-first, two thousand eleven, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(ii) up to forty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

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

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

(v) one hundred eight million five hundred seventy-five thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) ninety-one million eight hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand five through December thirty-first, two thousand five;

(vii) one hundred fifty-six million six hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) one hundred fifty-one million four hundred thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) one hundred sixteen million nine hundred forty-nine thousand dollars, plus an additional five hundred thousand dollars, for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) twenty-nine million two hundred thirty-seven thousand two hundred fifty dollars, plus an additional one hundred twenty-five thousand dollars, for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred twenty million thirty-eight thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve; and

(xiv) one hundred nineteen million four hundred seven thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen.

(l) 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 personal care and certified home health agency rate or fee increases established pursuant to subdivision three of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

(vii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to sixty-five million two hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to sixteen million three hundred thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(m) 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 services and expenses related to home care workers insurance pilot demonstration programs established pursuant to subdivision two of section three hundred sixty-seven-o of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

(vii) up to three million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(viii) up to three million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; and

(ix) up to nine hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(n) Funds shall be transferred by the commissioner and shall be deposited to the credit of the special revenue funds - other, miscellaneous special revenue fund - 339, elderly pharmaceutical insurance coverage program premium account authorized pursuant to the provisions of title three of article two of the elder law, or any successor fund or account, for funding state expenses relating to the program from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(ii) one hundred sixty-four million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

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

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

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

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

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

(viii) six hundred sixty million eight hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

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

(x) three hundred thirty-four million eight hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) three hundred forty-four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) eighty-seven million seven hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xiii) one hundred forty-three million one hundred fifty thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(xiv) one hundred twenty million nine hundred fifty thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen; [and]

(xv) one hundred twenty-eight million eight hundred fifty thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen[.]; AND

(XVI) ONE HUNDRED TWENTY-SEVEN MILLION FOUR HUNDRED SIXTEEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(o) Funds shall be reserved and accumulated and shall be transferred to the Roswell Park Cancer Institute Corporation, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(ii) up to sixty million dollars for the period January first, two thousand one through December thirty-first, two thousand one;

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

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

(v) seventy-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

(vi) seventy-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;

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

(viii) seventy-eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(ix) seventy-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(x) seventy-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(xi) seventy-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(xii) nineteen million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xiii) sixty-nine million eight hundred forty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XIV) UP TO NINETY-SIX MILLION SIX HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(p) 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, indigent care fund - 068, indigent care account, or any successor fund or account, for purposes of providing a medicaid disproportionate share payment from the high need indigent care adjustment pool established pursuant to section twenty-eight hundred seven-w of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) eighty-two million dollars annually for the periods January first, two thousand through December thirty-first, two thousand two;

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

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

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

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

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

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

(viii) up to eighty-two million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to eighty-two million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to twenty million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) up to eighty-two million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(q) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing distributions to eligible school based health centers established pursuant to section eighty-eight of chapter one of the laws of nineteen hundred ninety-nine, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

(vi) up to seven million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(vii) up to seven million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
(viii) up to seven million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
(ix) up to seven million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;
(x) up to one million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]
(xi) up to five million six hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND
(XII) UP TO FIVE MILLION TWO HUNDRED EIGHTY-EIGHTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.
(r) 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 for supplementary medical insurance for Medicare part B premiums, physicians services, outpatient services, medical equipment, supplies and other health services, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:
(i) forty-three million dollars for the period January first, two thousand through December thirty-first, two thousand;
(ii) sixty-one million dollars for the period January first, two thousand one through December thirty-first, two thousand one;
(iii) sixty-five million dollars for the period January first, two thousand two through December thirty-first, two thousand two;
(iv) sixty-seven million five hundred thousand dollars for the period January first, two thousand three through December thirty-first, two thousand three;
(v) sixty-eight million dollars for the period January first, two thousand four through December thirty-first, two thousand four;
(vi) sixty-eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five;
(vii) sixty-eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six;
(viii) seventeen million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;
(ix) sixty-eight million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;
(x) sixty-eight million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;
(xi) sixty-eight million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;
(xii) seventeen million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and
(xiii) sixty-eight million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(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-two million dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(t) Funds shall be reserved and accumulated from year to year by the commissioner and shall be made available, including income from invested funds:

(i) For the purpose of making grants to a state owned and operated medical school which does not have a state owned and operated hospital on site and available for teaching purposes. Notwithstanding sections one hundred twelve and one hundred sixty-three of the state finance law, such grants shall be made in the amount of up to five hundred thousand dollars for the period January first, two thousand through December thirty-first, two thousand;

(ii) For the purpose of making grants to medical schools pursuant to section eighty-six-a of chapter one of the laws of nineteen hundred ninety-nine in the sum of up to four million dollars for the period January first, two thousand through December thirty-first, two thousand; and

(iii) The funds disbursed pursuant to subparagraphs (i) and (ii) of this paragraph from the tobacco control and insurance initiatives pool are contingent upon meeting all funding amounts established pursuant to paragraphs (a), (b), (c), (d), (e), (f), (l), (m), (n), (p), (q), (r) and (s) of this subdivision, paragraph (a) of subdivision nine of section twenty-eight hundred seven-j of this article, and paragraphs (a), (i) and (k) of subdivision one of section twenty-eight hundred seven-l of this article.

(u) 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 services and expenses related to the nursing home quality improvement demonstration program established pursuant to section twenty-eight hundred eight-d of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to twenty-five million dollars for the period beginning April first, two thousand two and ending December thirty-first, two thousand two, and on an annualized basis, for each annual period thereafter beginning January first, two thousand three and ending December thirty-first, two thousand four;

(ii) up to eighteen million seven hundred fifty thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

(iii) up to fifty-six million five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(v) Funds shall be transferred by the commissioner and shall be deposited to the credit of the hospital excess liability pool created pursuant to section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six, or any successor fund or account, for purposes of expenses related to the purchase of excess medical malpractice insurance and the cost of administrating the pool, including costs associated with the risk management program established pursuant to section forty-two of part A of chapter one of the laws of two thousand two required by paragraph (a) of subdivision one of section eighteen of chapter two hundred sixty-six of the laws of nineteen hundred eighty-six as may be amended from time to time, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to fifty million dollars or so much as is needed for the period January first, two thousand two through December thirty-first, two thousand two;

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

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

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

(v) up to one hundred thirteen million eight hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

(vi) up to one hundred thirty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

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

(viii) up to one hundred thirty million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to one hundred thirty million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to thirty-two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xi) up to one hundred twenty-seven million four hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XII) UP TO ONE HUNDRED TWENTY-SEVEN MILLION FOUR HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(w) 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 treatment of breast and cervical cancer pursuant to paragraph (v) of subdivision four of section three hundred sixty-six of the social services law, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) up to four hundred fifty thousand dollars for the period January first, two thousand two through December thirty-first, two thousand two;

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

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

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

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

(vi) up to two million one hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

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

(viii) up to two million one hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million one hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to five hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xi) up to two million one hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XII) UP TO TWO MILLION ONE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(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) forty-eight million seven hundred twenty-one thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

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

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.

(z) 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 residential health care facility rate increases for recruitment and retention of health care workers pursuant to paragraph (a) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-one 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-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;

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

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

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

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

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

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

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

(aa) 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 residential health care facilities for recruitment and retention of health care workers pursuant to paragraph (b) of subdivision eighteen of section twenty-eight hundred eight of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) seven 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) 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;

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

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

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

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

(viii) one million three hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine.

(bb)(i) Funds shall be deposited by the commissioner, within amounts appropriated, and subject to the availability of federal financial participation, 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 the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which include a city with a population of over one million persons and computed and distributed in accordance with memorandums of understanding to be entered into between the state of New York and such local social service districts for the purpose of supporting the recruitment and retention of personal care service workers or any worker with direct patient care responsibility, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

(A) forty-four million dollars, on an annualized basis, for the period April first, two thousand two through December thirty-first, two thousand two;

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

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

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

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

(F) one hundred thirty-six million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(G) one hundred thirty-six million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

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

(I) one hundred thirty-six million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(J) thirty-four million dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(K) up to one hundred thirty-six million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(L) UP TO ONE HUNDRED THIRTY-SIX MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN THROUGH APRIL FIRST, TWO THOUSAND SEVENTEEN.

(ii) Adjustments to Medicaid rates made pursuant to this paragraph shall not, in aggregate, exceed the following amounts for the following periods:

(A) for the period April first, two thousand two through December thirty-first, two thousand two, one hundred ten million dollars;

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

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

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

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

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

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

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

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

(J) for the period January first, two thousand eleven through March thirty-first, two thousand eleven, eighty-five million dollars; [and]

(K) for each state fiscal year within the period April first, two thousand eleven through March thirty-first, two thousand fourteen, three hundred forty million dollars[.]; AND

(L) FOR EACH STATE FISCAL YEAR WITHIN THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, THREE HUNDRED FORTY MILLION DOLLARS.

(iii) Personal care service providers which have their rates adjusted pursuant to this paragraph shall use such funds for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility only and are prohibited from using such funds for any other purpose. Each such personal care services provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. The commissioner is author-

ized to audit each such provider to ensure compliance with the written certification required by this subdivision and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory personal care services workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

(cc) 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 the purpose of supporting the state share of adjustments to Medicaid rates of payment for personal care services provided pursuant to paragraph (e) of subdivision two of section three hundred sixty-five-a of the social services law, for local social service districts which shall not include a city with a population of over one million persons for the purpose of supporting the personal care services worker recruitment and retention program as established pursuant to section three hundred sixty-seven-q of the social services law, from the tobacco control and insurance initiatives pool established for the following periods and the following amounts:

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

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

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

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

(v) ten million eight hundred thousand dollars, on an annualized basis, for the period January first, two thousand six through December thirty-first, two thousand six;

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

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

(viii) eleven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) eleven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

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

(xi) up to eleven million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XII) UP TO ELEVEN MILLION TWO HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(dd) 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 purposes of funding the state share of Medicaid expenditures for physician services from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

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

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

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

(x) twenty-one million three hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) eighty-five million two hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ee) 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 purposes of funding the state share of the free-standing diagnostic and treatment center rate increases for recruitment and retention of health care workers pursuant to subdivision seventeen of section twenty-eight hundred seven of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

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

(viii) two million four hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

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

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

(ff) 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 purposes of funding the state share of Medicaid expenditures for disabled persons as authorized pursuant to FORMER subparagraphs twelve and thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

(viii) fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

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

(x) three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XII) FIFTEEN MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(gg) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (c) 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) up to one million three hundred thousand dollars on an annualized basis for the period January first, two thousand two through December thirty-first, two thousand two;

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

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

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

(v) up to eight million six hundred thousand dollars on an annualized basis for the period January first, two thousand six through December thirty-first, two thousand six;

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

(vii) up to two million six hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(viii) up to two million six hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to two million six hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(x) up to six hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(hh) 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 special revenue fund - other, HCRA transfer fund, medical assistance account for purposes of providing financial assistance to residential health care facilities pursuant to subdivisions nineteen and twenty-one of section twenty-eight hundred eight of this article, from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

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

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

(viii) up to fifteen million dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) up to fifteen million dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(x) up to three million seven hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; and

(xi) fifteen million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(ii) 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 the purpose of supporting the state share of Medicaid expenditures for disabled persons as authorized by sections 1619 (a) and (b) of the federal social security act pursuant to the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) six million four hundred thousand dollars for the period April first, two thousand two through December thirty-first, two thousand two;

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

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

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

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

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

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

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

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

(x) two million one hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(xi) eight million five hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(XII) EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

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

(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 Medical Assistance Program expenditures 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) within amounts appropriated on and after January first, two thousand nine.

(ll) 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 expenditures related to the city of New York from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

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

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

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

(vi) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

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

(viii) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(ix) one hundred twenty-four million seven hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

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

(xi) one hundred twenty-four million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen.

(mm) 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 specified percentages of the state share of services and expenses related to the family health plus program in accordance with the following schedule:

(i) (A) for the period January first, two thousand three through December thirty-first, two thousand four, one hundred percent of the state share;

(B) for the period January first, two thousand five through December thirty-first, two thousand five, seventy-five percent of the state share; and,

(C) for periods beginning on and after January first, two thousand six, fifty percent of the state share.

(ii) Funding for the family health plus program will include up to five million dollars annually for the period January first, two thousand three through December thirty-first, two thousand six, up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, up to seven million two hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, up to seven million two hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, up to seven million two hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, up to one million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, up to six million forty-nine thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, up to six million two hundred eighty-nine thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, and up to six million four hundred sixty-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, for administration and marketing costs associated with such program established pursuant to clauses (A) and (B) of subparagraph (v) of paragraph (a) of subdivision two of section three hundred sixty-nine-ee of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(B) three hundred seventy-four million dollars for the period January first, two thousand four through December thirty-first, two thousand four;

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

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

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

(F) five hundred seventy million twenty-five thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

(G) six hundred ten million seven hundred twenty-five thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

(H) six hundred twenty-seven million two hundred seventy-five thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten;

(I) one hundred fifty-seven million eight hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(J) six hundred twenty-eight million four hundred thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(K) six hundred fifty million four hundred thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen; [and]

(L) six hundred fifty million four hundred thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen[.]; AND

(M) UP TO THREE HUNDRED TEN MILLION FIVE HUNDRED NINETY-FIVE THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN.

(nn) 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, health care services account, or any successor fund or account, for purposes related to adult home initiatives for medicaid eligible residents of residential facilities licensed pursuant to section four hundred sixty-b of the social services law from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

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

(iii) up to eight million dollars for the period January first, two thousand five through December thirty-first, two thousand five, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(iv) up to eight million dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(v) up to eight million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that up to five million two hundred fifty thousand dollars of such funds shall be received by the comptroller and deposited to the credit of the special revenue fund - other / aid to localities, HCRA transfer fund - 061, enhanced community services account - 05, or any successor fund or account, for the purposes set forth in this paragraph;

(vi) up to two million seven hundred fifty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

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

(viii) up to two million seven hundred fifty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten; and

(ix) up to six hundred eighty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(oo) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of grants to non-public general hospitals pursuant to paragraph (e) of subdivision twenty-five 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) up to five million dollars on an annualized basis for the period January first, two thousand four through December thirty-first, two thousand four;

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

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

(iv) up to five million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven; [and]

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

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

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

(viii) up to one million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(pp) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the provision of tax credits for long term care insurance pursuant to subdivision one of section one hundred ninety of the tax law, paragraph (a) of subdivision twenty-five-a of section two hundred ten of such law, subsection (aa) of section six hundred six of such law, paragraph one of subsection (k) of section fourteen hundred fifty-six of such law and paragraph one of subdivision (m) of section fifteen hundred eleven of such law, in the following amounts:

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

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

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

(iv) five million dollars for the period January first, two thousand seven through June thirtieth, two thousand seven.

(qq) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting the long-term care insurance education and outreach program established pursuant to section two hundred seventeen-a of the elder law for the following periods in the following amounts:

(i) up to five million dollars for the period January first, two thousand four through December thirty-first, two thousand four; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(ii) up to five million dollars for the period January first, two thousand five through December thirty-first, two thousand five; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be deposited by the commissioner, within amounts appropriated, and the comptroller is hereby authorized and directed to receive for deposit to the credit of the special revenue funds - other, HCRA transfer fund, long term care insurance resource center account of the state office for the aging or any future account designated for the purpose of implementing the long term care insurance education and outreach program and providing the long term care insurance resource centers with the necessary resources to carry out their operations;

(iii) up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

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

(v) up to five million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight; of such funds one million nine hundred fifty thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long term care insurance education and outreach program and three million fifty thousand dollars shall be made available to the office for the aging for the purpose of providing the long term care insurance resource centers with the necessary resources to carry out their operations;

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

(vii) up to four hundred eighty-eight thousand dollars for the period January first, two thousand ten through March thirty-first, two thousand ten; of such funds four hundred eighty-eight thousand dollars shall be made available to the department for the purpose of developing, implementing and administering the long-term care insurance education and outreach program.

(rr) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and shall be available, including income from invested funds, for the purpose of supporting expenses related to implementation of the provisions of title III of article twenty-nine-D of this chapter, for the following periods and in the following amounts:

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

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

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

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

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

(vi) up to two million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven.

(ss) Funds shall be reserved and accumulated from the tobacco control and insurance initiatives pool and used for a health care stabilization program established by the commissioner for the purposes of stabilizing critical health care providers and health care programs whose ability to continue to provide appropriate services are threatened by financial or other challenges, in the amount of up to twenty-eight million dollars for the period July first, two thousand four through June thirtieth, two thousand five. 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 paragraph may be allocated and distributed by the commissioner, or the state comptroller as applicable without a competitive bid or request for proposal process. Considerations relied upon by the commissioner in determining the allocation and distribution of these funds shall include, but not be limited to, the following: (i) the importance of the provider or program in meeting critical health care needs in the community in which it operates; (ii) the provider or program provision of care to under-served populations; (iii) the quality of the care or services the provider or program delivers; (iv) the ability of the provider or program to continue to deliver an appropriate level of care or services if additional funding is made available; (v) the ability of the provider or program to access, in a timely manner, alternative sources of funding, including other sources of government

funding; (vi) the ability of other providers or programs in the community to meet the community health care needs; (vii) whether the provider or program has an appropriate plan to improve its financial condition; and (viii) whether additional funding would permit the provider or program to consolidate, relocate, or close programs or services where such actions would result in greater stability and efficiency in the delivery of needed health care services or programs.

(tt) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for purposes of providing grants for two long term care demonstration projects designed to test new models for the delivery of long term care services established pursuant to section twenty-eight hundred seven-x of this chapter, for the following periods and in the following amounts:

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

(ii) up to five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five;

(iii) up to five hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six;

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

(v) up to two hundred fifty thousand dollars for the period January first, two thousand eight through March thirty-first, two thousand eight.

(uu) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for the purpose of supporting disease management and telemedicine demonstration programs authorized pursuant to section twenty-one hundred eleven of this chapter for the following periods in the following amounts:

(i) five million dollars for the period January first, two thousand four through December thirty-first, two thousand four, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

(ii) five million dollars for the period January first, two thousand five through December thirty-first, two thousand five, of which three million dollars shall be available for disease management demonstration programs and two million dollars shall be available for telemedicine demonstration programs;

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

(iv) nine million five hundred thousand dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, of which seven million five hundred thousand dollars shall be available for disease management demonstration programs and one million dollars shall be available for telemedicine demonstration programs;

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

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

(ww) 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 recruitment and retention of health care workers pursuant to paragraph (e) 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) sixty million five hundred thousand dollars for the period January first, two thousand five through December thirty-first, two thousand five; and

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

(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 two hundred eight thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(yy) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated and notwithstanding section one hundred twelve of the state finance law and any other contrary provision of law, for the purpose of supporting grants not to exceed five million dollars to be made by the commissioner without a competitive bid or request for proposal process, in support of the

delivery of critically needed health care services, to health care providers located in the counties of Erie and Niagara which executed a memorandum of closing and conducted a merger closing in escrow on November twenty-fourth, nineteen hundred ninety-seven and which entered into a settlement dated December thirtieth, two thousand four for a loss on disposal of assets under the provisions of title XVIII of the federal social security act applicable to mergers occurring prior to December first, nineteen hundred ninety-seven.

(zz) Funds shall be reserved and accumulated from year to year and shall be available, within amounts appropriated, for the purpose of supporting expenditures authorized pursuant to section twenty-eight hundred eighteen of this article from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

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

(ii) one hundred eight million three hundred thousand dollars for the period January first, two thousand six through December thirty-first, two thousand six, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

(iii) one hundred seventy-one million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven, provided, however, that within amounts appropriated in the two thousand six through two thousand seven state fiscal year, a portion of such funds may be transferred to the Roswell Park Cancer Institute Corporation to fund capital costs;

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

(v) one hundred twenty-eight million seven hundred fifty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine;

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

(vii) thirty-four million two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(viii) four hundred thirty-three million three hundred sixty-six thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;

(ix) one hundred fifty million eight hundred six thousand dollars for the period April first, two thousand twelve through March thirty-first, two thousand thirteen; [and]

(x) seventy-eight million seventy-one thousand dollars for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen.

(aaa) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, for services and expenses related to school based health centers, in an amount up to three million five hundred thousand dollars for the period April first, two thousand six through March thirty-first, two thousand seven, up to three million five hundred thousand dollars for the period April first,

two thousand seven through March thirty-first, two thousand eight, up to three million five hundred thousand dollars for the period April first, two thousand eight through March thirty-first, two thousand nine, up to three million five hundred thousand dollars for the period April first, two thousand nine through March thirty-first, two thousand ten, up to three million five hundred thousand dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven, [and] up to two million eight hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO TWO MILLION SIX HUNDRED FORTY-FOUR THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN. The total amount of funds provided herein shall be distributed as grants based on the ratio of each provider's total enrollment for all sites to the total enrollment of all providers. This formula shall be applied to the total amount provided herein.

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

(ccc) 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 increases in the rates for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs and managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter for recruitment and retention of health care workers pursuant to subdivisions nine and ten of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following periods in the following amounts:

(i) twenty-five million dollars for the period June first, two thousand six through December thirty-first, two thousand six;

(ii) fifty million dollars for the period January first, two thousand seven through December thirty-first, two thousand seven;

(iii) fifty million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight;

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

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

(vi) twelve million five hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven; [and]

(vii) up to fifty million dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen[.]; AND

(VIII) UP TO FIFTY MILLION DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

(ddd) 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 increases in the medical assistance rates for providers for purposes of enhancing the provision, quality and/or efficiency of home care services pursuant to subdivision eleven of section thirty-six hundred fourteen of this chapter from the tobacco control and insurance initiatives pool established for the following period in the amount of eight million dollars for the period April first, two thousand six through December thirty-first, two thousand six.

(eee) Funds shall be reserved and accumulated from year to year and shall be available, including income from invested funds, to the Center for Functional Genomics at the State University of New York at Albany, for the purposes of the Adirondack network for cancer education and research in rural communities grant program to improve access to health care and shall be made available from the tobacco control and insurance initiatives pool established for the following period in the amount of up to five million dollars for the period January first, two thousand six through December thirty-first, two thousand six.

(fff) Funds shall be made available to the empire state stem cell fund established by section ninety-nine-p of the state finance law within amounts appropriated up to fifty million dollars annually and shall not exceed five hundred million dollars in total.

(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) fourteen million seven hundred thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(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 two hundred ninety-two thousand dollars for the period January first, two thousand nine through November thirtieth, two thousand nine.

(iii) Funds shall be reserved and set aside and accumulated from year to year and shall be made available, including income from investment funds, for the purpose of supporting the New York state medical indemnity fund as authorized pursuant to title four of article twenty-nine-D of this chapter, for the following periods and in the following amounts, provided, however, that the commissioner is authorized to seek waiver authority from the federal centers for medicare and Medicaid for the purpose of securing Medicaid federal financial participation for such program, in which case the funding authorized pursuant to this paragraph shall be utilized as the non-federal share for such payments:

Thirty million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve.

2. (a) For periods prior to January first, two thousand five, the commissioner is authorized to contract with the article forty-three insurance law plans, or such other contractors as the commissioner shall designate, to receive and distribute funds from the tobacco control and insurance initiatives pool established pursuant to this section. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of such funds. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis five hundred thousand dollars, for collection and distribution of funds pursuant to this section shall be paid from such funds.

(b) Notwithstanding any inconsistent provision of section one hundred twelve or one hundred sixty-three of the state finance law or any other law, at the discretion of the commissioner without a competitive bid or request for proposal process, contracts in effect for administration of pools established pursuant to sections twenty-eight hundred seven-k, twenty-eight hundred seven-l and twenty-eight hundred seven-m of this article for the period January first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine may be extended to provide for administration pursuant to this section and may be amended as may be necessary.

S 9. Subdivisions 5-a and 7 of section 2807-m of the public health law, as added by section 75-c of part C of chapter 58 of the laws of 2008, the paragraph heading of paragraph (b) and the second undesignated paragraph of paragraph (b) of subdivision 5-a as amended by section 4 of part B of chapter 109 of the laws of 2010, the opening paragraph of paragraph (b), subparagraphs (C), (D) and (G) of paragraph (b), and paragraphs (c), (f) and (g) of subdivision 5-a as amended by section 26 of part C of chapter 59 of the laws of 2011, subparagraph (H) of para-

graph (b) of subdivision 5-a as added by section 60 of part D of chapter 56 of the laws of 2012, paragraphs (d) and (e) of subdivision 5-a as amended by section 53 of part D of chapter 56 of the laws of 2012 and paragraph (e-1) of subdivision 5-a as added by section 54 of part D of chapter 56 of the laws of 2012, and subdivision 7 as amended by section 26-a of part C of chapter 59 of the laws of 2011, are amended to read as follows:

5-a. Graduate medical education innovations pool. (a) Supplemental distributions. (i) Thirty-one million dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, 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 pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York as in effect on January first, two thousand eight; provided, however, for purposes of funding the empire clinical research investigation program (ECRIP) in accordance with paragraph eight of subdivision (e) and paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York, distributions shall be made using two regions defined as New York city and the rest of the state and the dollar amount set forth in subparagraph (i) of paragraph two of subdivision (f) of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be increased from sixty thousand dollars to seventy-five thousand dollars.

(ii) For periods on and after January first, two thousand nine, supplemental distributions pursuant to subdivision five of this section and in accordance with section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall no longer be made and the provisions of section 86-1.89 of title 10 of the codes, rules and regulations of the state of New York shall be null and void.

(b) Empire clinical research investigator program (ECRIP). Nine million one hundred twenty thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, and two million two hundred eighty thousand dollars for the period January first, two thousand eleven, [and] THROUGH MARCH THIRTY-FIRST, TWO THOUSAND ELEVEN, nine million one hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, [through March thirty-first, two thousand eleven,] AND UP TO EIGHT MILLION SIX HUNDRED TWELVE THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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:

Distributions shall first be made to consortia and teaching general hospitals for the empire clinical research investigator program (ECRIP) to help secure federal funding for biomedical research, train clinical researchers, recruit national leaders as faculty to act as mentors, and train residents and fellows in biomedical research skills based on hospital-specific data submitted to the commissioner by consortia and teaching general hospitals in accordance with clause (G) of this subpar-

agraph. Such distributions shall be made in accordance with the following methodology:

(A) The greatest number of clinical research positions for which a consortium or teaching general hospital may be funded pursuant to this subparagraph shall be one percent of the total number of residents training at the consortium or teaching general hospital on July first, two thousand eight for the period January first, two thousand nine through December thirty-first, two thousand nine rounded up to the nearest one position.

(B) Distributions made to a consortium or teaching general hospital shall equal the product of the total number of clinical research positions submitted by a consortium or teaching general hospital and accepted by the commissioner as meeting the criteria set forth in paragraph (b) of subdivision one of this section, subject to the reduction calculation set forth in clause (C) of this subparagraph, times one hundred ten thousand dollars.

(C) If the dollar amount for the total number of clinical research positions in the region calculated pursuant to clause (B) of this subparagraph exceeds the total amount appropriated for purposes of this paragraph, including clinical research positions that continue from and were funded in prior distribution periods, the commissioner shall eliminate one-half of the clinical research positions submitted by each consortium or teaching general hospital rounded down to the nearest one position. Such reduction shall be repeated until the dollar amount for the total number of clinical research positions in the region does not exceed the total amount appropriated for purposes of this paragraph. If the repeated reduction of the total number of clinical research positions in the region by one-half does not render a total funding amount that is equal to or less than the total amount reserved for that region within the appropriation, the funding for each clinical research position in that region shall be reduced proportionally in one thousand dollar increments until the total dollar amount for the total number of clinical research positions in that region does not exceed the total amount reserved for that region within the appropriation. Any reduction in funding will be effective for the duration of the award. No clinical research positions that continue from and were funded in prior distribution periods shall be eliminated or reduced by such methodology.

(D) Each consortium or teaching general hospital shall receive its annual distribution amount in accordance with the following:

(I) Each consortium or teaching general hospital with a one-year ECRIP award shall receive its annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching general hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(II) Each consortium or teaching general hospital with a two-year ECRIP award shall receive its first annual distribution amount in full upon completion of the requirements set forth in items (I) and (II) of clause (G) of this subparagraph. Each consortium or teaching general hospital will receive its second annual distribution amount in full upon completion of the requirements set forth in item (III) of clause (G) of this subparagraph. The requirements set forth in items (IV) and (V) of clause (G) of this subparagraph must be completed by the consortium or teaching general hospital in order for the consortium or teaching gener-

al hospital to be eligible to apply for ECRIP funding in any subsequent funding cycle.

(E) Each consortium or teaching general hospital receiving distributions pursuant to this subparagraph shall reserve seventy-five thousand dollars to primarily fund salary and fringe benefits of the clinical research position with the remainder going to fund the development of faculty who are involved in biomedical research, training and clinical care.

(F) Undistributed or returned funds available to fund clinical research positions pursuant to this paragraph for a distribution period shall be available to fund clinical research positions in a subsequent distribution period.

(G) In order to be eligible for distributions pursuant to this subparagraph, each consortium and teaching general hospital shall provide to the commissioner by July first of each distribution period, the following data and information on a hospital-specific basis. Such data and information shall be certified as to accuracy and completeness by the chief executive officer, chief financial officer or chair of the consortium governing body of each consortium or teaching general hospital and shall be maintained by each consortium and teaching general hospital for five years from the date of submission:

(I) For each clinical research position, information on the type, scope, training objectives, institutional support, clinical research experience of the sponsor-mentor, plans for submitting research outcomes to peer reviewed journals and at scientific meetings, including a meeting sponsored by the department, the name of a principal contact person responsible for tracking the career development of researchers placed in clinical research positions, as defined in paragraph (c) of subdivision one of this section, and who is authorized to certify to the commissioner that all the requirements of the clinical research training objectives set forth in this subparagraph shall be met. Such certification shall be provided by July first of each distribution period;

(II) For each clinical research position, information on the name, citizenship status, medical education and training, and medical license number of the researcher, if applicable, shall be provided by December thirty-first of the calendar year following the distribution period;

(III) Information on the status of the clinical research plan, accomplishments, changes in research activities, progress, and performance of the researcher shall be provided upon completion of one-half of the award term;

(IV) A final report detailing training experiences, accomplishments, activities and performance of the clinical researcher, and data, methods, results and analyses of the clinical research plan shall be provided three months after the clinical research position ends; and

(V) Tracking information concerning past researchers, including but not limited to (A) background information, (B) employment history, (C) research status, (D) current research activities, (E) publications and presentations, (F) research support, and (G) any other information necessary to track the researcher; and

(VI) Any other data or information required by the commissioner to implement this subparagraph.

(H) Notwithstanding any inconsistent provision of this subdivision, for periods on and after April first, two thousand thirteen, ECRIP grant awards shall be made in accordance with rules and regulations promulgated by the commissioner. Such regulations shall, at a minimum:

(1) provide that ECRIP grant awards shall be made with the objective of securing federal funding for biomedical research, training clinical researchers, recruiting national leaders as faculty to act as mentors, and training residents and fellows in biomedical research skills;

(2) provide that ECRIP grant applicants may include interdisciplinary research teams comprised of teaching general hospitals acting in collaboration with entities including but not limited to medical centers, hospitals, universities and local health departments;

(3) provide that applications for ECRIP grant awards shall be based on such information requested by the commissioner, which shall include but not be limited to hospital-specific data;

(4) establish the qualifications for investigators and other staff required for grant projects eligible for ECRIP grant awards; and

(5) establish a methodology for the distribution of funds under ECRIP grant awards.

(c) Ambulatory care training. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, four million nine hundred thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO FOUR MILLION SIXTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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.

(d) Physician loan repayment program. One million nine hundred sixty thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, one million nine hundred sixty thousand dollars for the period January first, two thousand nine through December thirty-first, two thousand nine, one million nine hundred sixty thousand dollars for the period January first, two thousand ten through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO ONE MILLION SEVEN HUNDRED FIVE THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, 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 without a competitive bid or request for proposal process as follows:

(i) Funding shall first be awarded to repay loans of up to twenty-five physicians who train in primary care or specialty tracks in teaching general hospitals, and who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to repay loans of physicians who enter and remain in primary care or specialty practices in underserved communities, as determined by the commissioner, including but not limited to physicians working in general hospitals, or other health care facilities.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed in accordance with subparagraphs (i) and (ii) of this paragraph to physicians identified by general hospitals.

(e) Physician practice support. Four million nine hundred thousand dollars for the period January first, two thousand eight through December thirty-first, two thousand eight, four million nine hundred thousand dollars annually for the period January first, two thousand nine through December thirty-first, two thousand ten, one million two hundred twenty-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] four million three hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO FOUR MILLION THREE HUNDRED SIXTY THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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. Notwithstanding any contrary provision of this section, sections one hundred twelve and one hundred sixty-three of the state finance law, or any other contrary provision of law, 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 without a competitive bid or request for proposal process as follows:

(i) Preference in funding shall first be accorded to teaching general hospitals for up to twenty-five awards, to support costs incurred by physicians trained in primary or specialty tracks who thereafter establish or join practices in underserved communities, as determined by the commissioner.

(ii) After distributions in accordance with subparagraph (i) of this paragraph, all remaining funds shall be awarded to physicians to support the cost of establishing or joining practices in underserved communities, as determined by the commissioner, and to hospitals and other

health care providers to recruit new physicians to provide services in underserved communities, as determined by the commissioner.

(iii) In no case shall less than fifty percent of the funds available pursuant to this paragraph be distributed to general hospitals in accordance with subparagraphs (i) and (ii) of this paragraph.

(e-1) Work group. For funding available pursuant to paragraphs (d) and (e) of this subdivision:

(i) The department shall appoint a work group from recommendations made by associations representing physicians, general hospitals and other health care facilities to develop a streamlined application process by June first, two thousand twelve.

(ii) Subject to available funding, applications shall be accepted on a continuous basis. The department shall provide technical assistance to applicants to facilitate their completion of applications. An applicant shall be notified in writing by the department within ten days of receipt of an application as to whether the application is complete and if the application is incomplete, what information is outstanding. The department shall act on an application within thirty days of receipt of a complete application.

(f) Study on physician workforce. Five hundred ninety thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, one hundred forty-eight thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] five hundred sixteen thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO FOUR HUNDRED EIGHTY-SEVEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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, one million nine hundred sixty thousand dollars annually for the period January first, two thousand eight through December thirty-first, two thousand ten, four hundred ninety thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] one million seven hundred thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO ONE MILLION SIX HUNDRED FIVE THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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.

(h) In the event there are undistributed funds within amounts made available for distributions pursuant to this subdivision, such funds may be reallocated and distributed in current or subsequent distribution periods in a manner determined by the commissioner for any purpose set forth in this subdivision.

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 eight, one million five hundred thousand dollars annually for the periods January first, two thousand nine through December thirty-first, two thousand ten, three hundred seventy-five thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, [and] one million three hundred twenty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, AND UP TO TWO MILLION SEVENTY-SEVEN THOUSAND DOLLARS EACH STATE FISCAL YEAR FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, 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, two hundred fifty thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven, and eight hundred eighty thousand dollars each state fiscal year for the period April first, two thousand eleven through March thirty-first, two thousand fourteen, 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 10. Paragraph (a) of subdivision 12 of section 367-b of the social services law, as amended by section 10 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

(a) For the purpose of regulating cash flow for general hospitals, the department shall develop and implement a payment methodology to provide for timely payments for inpatient hospital services eligible for case based payments per discharge based on diagnosis-related groups provided during the period January first, nineteen hundred eighty-eight through March thirty-first two thousand [fourteen] SEVENTEEN, by such hospitals which elect to participate in the system.

S 11. Section 2 of chapter 600 of the laws of 1986 amending the public health law relating to the development of pilot reimbursement programs for ambulatory care services, as amended by section 11 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

S 2. This act shall take effect immediately, except that this act shall expire and be of no further force and effect on and after April 1, [2014] 2017; provided, however, that the commissioner of health shall submit a report to the governor and the legislature detailing the objective, impact, design and computation of any pilot reimbursement program established pursuant to this act, on or before March 31, 1994 and annually thereafter. Such report shall include an assessment of the financial impact of such payment system on providers, as well as the impact of such system on access to care.

S 12. Paragraph (i) of subdivision (b) of section 1 of chapter 520 of the laws of 1978, relating to providing for a comprehensive survey of health care financing, education and illness prevention and creating councils for the conduct thereof, as amended by section 12 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

(i) oversight and evaluation of the inpatient financing system in place for 1988 through March 31, [2014] 2017, and the appropriateness and effectiveness of the bad debt and charity care financing provisions;

S 13. Paragraph (i) of subdivision 9 of section 3614 of the public health law, as added by section 23 of part C of chapter 59 of the laws of 2011, is amended and three new paragraphs (j), (k) and (l) are added to read as follows:

(i) for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, up to one hundred million dollars[.];

(J) FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, UP TO ONE HUNDRED MILLION DOLLARS;

(K) FOR THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN, UP TO ONE HUNDRED MILLION DOLLARS;

(L) FOR THE PERIOD APRIL FIRST, TWO THOUSAND SIXTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, UP TO ONE HUNDRED MILLION DOLLARS.

S 14. Paragraphs (l) and (m) of subdivision 1 of section 367-q of the social services law, as amended by section 35 of part D of chapter 56 of the laws of 2012, are amended and three new paragraphs (n), (o) and (p) are added to read as follows:

(l) for the period April first, two thousand twelve through March thirty-first, two thousand thirteen, up to twenty-eight million five hundred thousand dollars; [and]

(m) for the period April first, two thousand thirteen through March thirty-first, two thousand fourteen, up to twenty-eight million five hundred thousand dollars[.];

(N) FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, UP TO TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS;

(O) FOR THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN, UP TO TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS; AND

(P) FOR THE PERIOD APRIL FIRST, TWO THOUSAND SIXTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, UP TO TWENTY-EIGHT MILLION FIVE HUNDRED THOUSAND DOLLARS.

S 15. Subdivision 6 of section 2807-t of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

6. Prospective adjustments. (A) The commissioner shall annually reconcile the sum of the actual payments made to the commissioner or the commissioner's designee for each region pursuant to section twenty-eight hundred seven-s of this article and pursuant to this section for the prior year with the regional allocation of the gross annual statewide

amount specified in subdivision six of section twenty-eight hundred seven-s of this article for such prior year. The difference between the actual amount raised for a region and the regional allocation of the specified gross annual amount for such prior year shall be applied as a prospective adjustment to the regional allocation of the specified gross annual payment amount for such region for the year next following the calculation of the reconciliation. The authorized dollar value of the adjustments shall be the same as if calculated retrospectively.

(B) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION, FOR COVERED LIVES ASSESSMENT RATE PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND SEVENTEEN, FOR AMOUNTS COLLECTED IN THE AGGREGATE IN EXCESS OF ONE BILLION FORTY-FIVE MILLION DOLLARS ON AN ANNUAL BASIS, PROSPECTIVE ADJUSTMENTS SHALL BE SUSPENDED IF THE ANNUAL RECONCILIATION CALCULATION FROM THE PRIOR YEAR WOULD OTHERWISE RESULT IN A DECREASE TO THE REGIONAL ALLOCATION OF THE SPECIFIED GROSS ANNUAL PAYMENT AMOUNT FOR THAT REGION, PROVIDED, HOWEVER, THAT SUCH SUSPENSION SHALL BE LIFTED UPON A DETERMINATION BY THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, THAT SIXTY-FIVE MILLION DOLLARS IN AGGREGATE COLLECTIONS ON AN ANNUAL BASIS OVER AND ABOVE ONE BILLION FORTY-FIVE MILLION DOLLARS ON AN ANNUAL BASIS HAVE BEEN RESERVED AND SET ASIDE FOR DEPOSIT IN THE HCRA RESOURCES FUND. ANY AMOUNTS COLLECTED IN THE AGGREGATE AT OR BELOW ONE BILLION FORTY-FIVE MILLION DOLLARS ON AN ANNUAL BASIS, SHALL BE SUBJECT TO REGIONAL ADJUSTMENTS RECONCILING ANY DECREASES OR INCREASES TO THE REGIONAL ALLOCATION IN ACCORDANCE WITH PARAGRAPH (A) OF THIS SUBDIVISION.

S 16. Subdivision 4-c of section 2807-p of the public health law, as amended by section 27 of part C of chapter 59 of the laws of 2011, 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, 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, for the period January first, two thousand eleven though December thirty-first, two thousand eleven, seven million five hundred thousand dollars, for the period January first, two thousand twelve through December thirty-first, two thousand twelve, seven million five hundred thousand dollars, for the period January first, two thousand thirteen through December thirty-first, two thousand thirteen, seven million five hundred thousand dollars, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND FOURTEEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND FOURTEEN, SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS, FOR THE PERIOD JANUARY FIRST, TWO THOUSAND FIFTEEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN, SEVEN MILLION FIVE HUNDRED THOUSAND DOLLARS, FOR THE PERIOD JANUARY FIRST TWO THOUSAND SIXTEEN THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND SIXTEEN, SEVEN MILLION FIVE HUNDRED

THOUSAND DOLLARS, and for the period January first, two thousand [fourteen] SEVENTEEN through March thirty-first, two thousand [fourteen] SEVENTEEN, in the amount of one million [eight hundred seventy-five] SIX HUNDRED 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 17. Subdivision 9 of section 2807-k of the public health law, as added by chapter 639 of the laws of 1996, is amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must implement minimum collection policies and procedures approved by the commissioner [and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article].

S 17-a. Paragraph (d) of subdivision 16 of section 2807-c of the public health law, as amended by chapter 731 of the laws of 1993, is amended to read as follows:

(d) In order for a general hospital to participate in the distribution of funds from the pools, the general hospital must implement collection policies and procedures approved by the commissioner [and must be in compliance with bad debt and charity care reporting requirements established pursuant to this article].

S 18. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 15 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

(a) The superintendent of insurance and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of insurance for purposes of providing equivalent excess

coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013 [and], between July 1, 2013 and June 30, 2014, AND BETWEEN JULY 1, 2014 AND JUNE 30, 2015 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013 [and], between July 1, 2013 and June 30, 2014, AND BETWEEN JULY 1, 2014 AND JUNE 30, 2015 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of insurance during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of

two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

S 19. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 16 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

(3)(a) The superintendent of insurance shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, AND BETWEEN JULY 1, 2014 AND JUNE 30, 2015 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of insurance shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1,

1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, [and] between July 1, 2013 and June 30, 2014, AND BETWEEN JULY 1, 2014 AND JUNE 30, 2015 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of insurance shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and June 30, 2013, [and] to the period July 1, 2013 and June 30, 2014, AND TO THE PERIOD JULY 1, 2014 AND JUNE 30, 2015.

S 20. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 17 of part C of chapter 59 of the laws of 2011, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant

to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, [and] during the period July 1, 2013 to June 30, 2014, AND DURING THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, OR COVERING THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of insurance.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, OR COVERING THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of insurance pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of insurance and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, OR COVERING THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, AND TO THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, AND COVERING THE PERIOD JULY 1, 2014 TO JUNE 30, 2015 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

S 21. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 18 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

S 40. The superintendent of insurance shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2014] 2015; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor

whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2014] 2015, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2014] 2015 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

S 22. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 20 of the laws of 2001 amending the military law and other laws relating to making appropriations for the support of government, as amended by section 20 of part C of chapter 59 of the laws of 2011, are amended to read as follows:

S 5. The superintendent of insurance and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, [and] June 15, 2014, AND JUNE 15, 2015 the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, OR JULY 1, 2014 TO JUNE 30, 2015, as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of insurance and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, OR JULY 1, 2014 TO JUNE 30, 2015, as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of insurance for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, [and] June 15, 2014, AND JUNE 15, 2015, as applicable.

S 23. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand fourteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand fourteen; provided, however, if the total number of physicians or dentists for

whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand fourteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand fourteen, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand fourteen, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand fourteen and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess coverage for the coverage period beginning the first of July, two thousand fourteen.

S 24. 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 25. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 26. 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 27. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2014, provided that:

(a) 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;

(b) this act shall not be construed to alter, change, affect, impair or defeat any right, obligations, duties or interests accrued, incurred or conferred prior to the effective date of this act;

(c) the commissioner of health and the superintendent of financial services and any appropriate council may take any steps necessary to implement this act prior to its effective date;

(d) 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 financial services 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;

(e) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act;

(f) the amendments to sections 2807-s and 2807-j of the public health law made by sections three, four and five, respectively, of this act shall not affect the expiration of such sections and shall expire therewith;

(g) the amendments to paragraph (i-l) of subdivision 1 of section 2807-v of the public health law made by section eight of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith; and

(h) the amendments to subdivision 6 of section 2807-t of the public health law made by section fifteen of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART C

Section 1. Notwithstanding any provision of law to the contrary, the department of health is directed to consult with all interested stakeholders, for the purpose of developing a new methodology of reimbursement for pharmacies. The department of health shall develop a transparent methodology that provides an adequate level of reimbursement for pharmacies.

S 2. Subparagraphs (i) and (ii) of paragraph (b) of subdivision 9 of section 367-a of the social services law, as amended by section 10 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) if the drug dispensed is a multiple source prescription drug for which an upper limit has been set by the federal centers for medicare and medicaid services, the lower of: (A) an amount equal to the specific upper limit set by such federal agency for the multiple source prescription drug; (B) the estimated acquisition cost of such drug to pharmacies which, for purposes of this subparagraph, shall mean the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof; (C) the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, PROVIDED THAT THE METHODOLOGY USED BY THE DEPARTMENT TO ESTABLISH A MAXIMUM ACQUISITION COST SHALL NOT INCLUDE AVERAGE ACQUISITION COST AS DETERMINED BY DEPARTMENT SURVEYS; OR (D) the dispensing pharmacy's usual and customary price charged to the general public; [or (E) the average acquisition cost if available;] and

(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies[, the average acquisition cost if available] or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less seventeen percent thereof or the wholesale acquisition cost of a prescription drug based upon package size dispensed from, as reported by the prescription drug pricing service used by the department, minus zero and forty-one

hundredths percent thereof, and updated monthly by the department. For multiple source generic drugs, estimated acquisition cost means the lower of [the average acquisition cost,] the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, PROVIDED THAT THE METHODOLOGY USED BY THE DEPARTMENT TO ESTABLISH A MAXIMUM ACQUISITION COST SHALL NOT INCLUDE AVERAGE ACQUISITION COST AS DETERMINED BY DEPARTMENT SURVEYS.

S 3. Paragraph (f) of subdivision 9 of section 367-a of the social services law, as added by section 10-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

[(f) Notwithstanding any inconsistent provision of law or regulation to the contrary, the commissioner shall have the authority to establish the amount of payments and dispensing fees under this title for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title. The commissioner shall not change the amounts of or method for such payments or dispensing fees on or after April first, two thousand eleven unless notice is given sixty days in advance of such change to the chairs of the committees on senate finance, assembly ways and means, senate health, and assembly health.]

S 4. Intentionally omitted.

S 5. Paragraph (g-1) of subdivision 2 of section 365-a of the social services law, as amended by section 23 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when [less than seventy-five percent of the previously dispensed amount per fill should have been used] MORE THAN A TEN DAY SUPPLY OF THE PREVIOUSLY DISPENSED AMOUNT SHOULD REMAIN were the product used as normally indicated; provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period in accordance with section two hundred seventy-three of the public health law; medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established

by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

S 6. Paragraph (i) of subdivision 9 of section 367-a of the social services law is REPEALED.

S 7. Section 365-h of the social services law is amended by adding a new subdivision 5 to read as follows:

5. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER OF HEALTH SHALL MAKE ADJUSTMENTS TO PAYMENTS UNDER THIS SECTION, FOR THE PURPOSES OF PROVIDING INCREASED ACCESS TO MEDICAID NON-EMERGENCY TRANSPORTATION IN RURAL COMMUNITIES. UP TO TWO MILLION DOLLARS SHALL BE AVAILABLE FOR SUCH PURPOSES.

S 8. The opening paragraph of subdivision 1 and subdivision 3 of section 367-s of the social services law, as amended by section 38 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

Notwithstanding any provision of law to the contrary, a supplemental medical assistance payment shall be made on an annual basis to providers of emergency medical transportation services in an aggregate amount not to exceed four million dollars for two thousand six, six million dollars for two thousand seven [and], six million dollars for two thousand eight, AND SIX MILLION DOLLARS FOR THE PERIOD MAY FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN pursuant to the following methodology:

3. If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed two million dollars for two thousand six, three million dollars for two thousand seven [and], three million dollars for two thousand eight AND THREE MILLION DOLLARS FOR THE PERIOD MAY FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be two million dollars or three million dollars as applicable to the annual period.

S 9. Subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law, as amended by section 47 of part C of chapter 58 of the laws of 2009, 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 OR, FOR MANAGED CARE PROVIDERS OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE, FOR EACH BRAND NAME PRESCRIPTION DRUG ON A MANAGED CARE PROVIDER'S FORMULARY THAT SUCH PROVIDER HAS DESIGNATED AS A PREFERRED DRUG, 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 10. Notwithstanding any inconsistent provision of law to the contrary, funds shall be made available to the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, in consultation with the commissioner of health and approved by the director of the budget, and pursuant to appropriations made therefor in an amount equal to the savings achieved

by the reductions described herein, to implement allocation plans developed by such commissioners, in consultation with the voluntary agencies providing behavioral health services and local governmental units, as defined in section 41.03 of the mental hygiene law, of the areas impacted by reductions of inpatient behavioral health services, and which shall describe behavioral health services, including mental health and substance use disorder services, that are designed to amend service needs resulting from the reduction of inpatient behavioral health services provided under the Medicaid program by programs licensed pursuant to article 31 or 32 of the mental hygiene law. Such programs may include programs that are licensed pursuant to both article 31 of the mental hygiene law and article 28 of the public health law, or certified under both article 32 of the mental hygiene law and article 28 of the public health law. The commissioner of health shall include details regarding the implementation of reinvestment allocation plans pursuant to reductions of inpatient behavioral health services in the annual report required under section 45-c of part A of chapter 56 of the laws of 2013.

S 11. Section 365-m of the social services law is amended by adding a new subdivision 5 to read as follows:

5. PURSUANT TO APPROPRIATIONS, THE DEPARTMENT OF HEALTH SHALL REINVEST FUNDS ALLOCATED FOR BEHAVIORAL HEALTH SERVICES, WHICH ARE GENERAL FUND SAVINGS DIRECTLY RELATED TO SAVINGS REALIZED THROUGH THE TRANSITION OF POPULATIONS COVERED BY THIS SECTION FROM THE APPLICABLE MEDICAID FEE-FOR-SERVICE SYSTEM TO A MANAGED CARE MODEL, INCLUDING SAVINGS RESULTING FROM THE REDUCTION OF INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED UNDER THE MEDICAID PROGRAMS LICENSED OR CERTIFIED PURSUANT TO ARTICLE THIRTY-ONE OR THIRTY-TWO OF THE MENTAL HYGIENE LAW, OR PROGRAMS THAT ARE LICENSED PURSUANT TO BOTH ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW AND ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, OR CERTIFIED UNDER BOTH ARTICLE THIRTY-TWO OF THE MENTAL HYGIENE LAW AND ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, FOR THE PURPOSE OF INCREASING INVESTMENT IN COMMUNITY BASED BEHAVIORAL HEALTH SERVICES, INCLUDING RESIDENTIAL SERVICES CERTIFIED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES. THE METHODOLOGIES USED TO CALCULATE THE SAVINGS SHALL BE DEVELOPED BY THE COMMISSIONER OF HEALTH AND THE DIRECTOR OF THE BUDGET IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES. IN NO EVENT SHALL THE FULL ANNUAL VALUE OF THE COMMUNITY BASED BEHAVIORAL HEALTH SERVICE REINVESTMENT SAVINGS ATTRIBUTABLE TO THE TRANSITION TO MANAGED CARE EXCEED THE TWELVE MONTH VALUE OF THE DEPARTMENT OF HEALTH GENERAL FUND REDUCTIONS RESULTING FROM SUCH TRANSITION. WITHIN ANY FISCAL YEAR WHERE APPROPRIATION INCREASES ARE RECOMMENDED FOR REINVESTMENT, INSOFAR AS MANAGED CARE TRANSITION SAVINGS DO NOT OCCUR AS ESTIMATED, AND GENERAL FUND SAVINGS DO NOT RESULT, THEN SPENDING FOR SUCH REINVESTMENT MAY BE REDUCED IN THE NEXT YEAR'S ANNUAL BUDGET ITEMIZATION. THE COMMISSIONER OF HEALTH SHALL PROMULGATE REGULATIONS, AND PRIOR TO OCTOBER FIRST, TWO THOUSAND FIFTEEN, MAY PROMULGATE EMERGENCY REGULATIONS AS REQUIRED TO DISTRIBUTE FUNDS PURSUANT TO THIS SUBDIVISION; PROVIDED, HOWEVER, THAT ANY EMERGENCY REGULATIONS PROMULGATED PURSUANT TO THIS SECTION SHALL EXPIRE NO LATER THAN DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN. THE COMMISSIONER SHALL INCLUDE DETAILED DESCRIPTIONS OF THE METHODOLOGY USED TO CALCULATE SAVINGS FOR REINVESTMENT, THE RESULTS OF APPLYING SUCH METHODOLOGIES, THE DETAILS REGARDING IMPLEMENTATION OF SUCH REINVESTMENT PURSUANT TO THIS SECTION, AND ANY REGULATIONS PROMULGATED UNDER THIS SUBDIVISION, IN THE ANNUAL

REPORT REQUIRED UNDER SECTION FORTY-FIVE-C OF PART A OF CHAPTER FIFTY-SIX OF THE LAWS OF TWO THOUSAND THIRTEEN.

S 12. Notwithstanding any law, rule, or regulation to the contrary, the commissioner of health, in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, is authorized to establish an evidence-based, collaborative care clinical delivery model in clinics licensed under article 28 of the public health law, for the purpose of improving the detection of depression and other diagnosed mental or substance use disorders and the treatment of individuals with such conditions in an integrated manner. Such commissioner shall be authorized to develop criteria for the designation of clinics to be providers of collaborative care services. At a minimum, such designated clinics shall provide screening for depression and substance use disorders, medical diagnosis of patients who screen positive, evidence-based depression care and substance use disorder referrals, ongoing tracking of patient progress, care management, and a designated behavioral health practitioner who consults with the care manager and primary care physician. The rates of payment and billing rules for this service will be developed by the commissioner of health, in consultation with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, and with the approval of the director of the budget. Such commissioners are authorized to waive any duplicative regulatory requirements as may be necessary to allow this service to function in an effective and efficient manner; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulation be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project, or such shorter time period as the authorizing commissioner may determine. The commissioner of health shall include details regarding the implementation of the collaborative care clinical delivery model, including any regulations waived and the frequency and rationale for such waivers, in the annual report under section 45-c of part A of chapter 56 of the laws of 2013.

S 12-a. Paragraph (c) of subdivision 2 of section 365-a of the social services law, as amended by section 24 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(c) out-patient hospital or clinic services in facilities operated in compliance with applicable provisions of this chapter, the public health law, the mental hygiene law and other laws, including any provisions thereof requiring an operating certificate or license, including facilities authorized by the appropriate licensing authority to provide integrated mental health services, and/or alcoholism and substance abuse services, and/or physical health services, and/or services to persons with developmental disabilities, when such services are provided at a single location or service site, or where such facilities are not conveniently accessible, in any hospital located [without] WITHIN the state and care and services in a day treatment program operated by the department of mental hygiene or by a voluntary agency under an agreement with such department in that part of a public institution operated and approved pursuant to law as an intermediate care facility for persons with developmental disabilities; AND PROVIDED, THAT THE COMMISSIONERS OF HEALTH, MENTAL HEALTH, ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY ISSUE REGULATIONS, INCLUDING EMERGENCY REGULATIONS PROMULGATED PRIOR TO OCTOBER FIRST, TWO THOUSAND FIFTEEN THAT ARE REQUIRED TO FACILITATE THE ESTABLISHMENT OF INTEGRATED SERVICES CLINICS. ANY SUCH REGULATIONS PROMULGATED UNDER THIS

PARAGRAPH SHALL BE DESCRIBED IN THE ANNUAL REPORT REQUIRED PURSUANT TO SECTION FORTY-FIVE-C OF PART A OF CHAPTER FIFTY-SIX OF THE LAWS OF TWO THOUSAND THIRTEEN;

S 13. Section 48-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, is amended to read as follows:

S 48-a. Notwithstanding any contrary provision of law, the [commissioner] COMMISSIONERS OF THE OFFICE of alcoholism and substance abuse services [is] AND THE OFFICE OF MENTAL HEALTH ARE authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing [hospital-based and free-standing chemical dependence outpatient and opioid treatment clinics] PROVIDERS licensed pursuant to article 28 of the public health law or article 31 OR 32 of the mental hygiene law for [chemical dependency] AMBULATORY BEHAVIORAL HEALTH services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services AND THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health [or by], the office of alcoholism and substance abuse services, OR THE OFFICE OF MENTAL HEALTH for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services AND THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, be greater than the increased funds made available pursuant to this section. THE INCREASE OF SUCH AMBULATORY BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH DECEMBER 31, 2016 FOR PATIENTS IN THE CITY OF NEW YORK, FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH JUNE 30, 2017 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF SUCH CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH DECEMBER 31, 2017 FOR ALL SERVICES PROVIDED TO PERSONS UNDER THE AGE OF TWENTY-ONE; PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED ABOVE, SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services AND THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH, promulgate regulations, including emergency regulations PROMULGATED PRIOR TO OCTOBER 1, 2015 TO ESTABLISH RATES FOR AMBULATORY BEHAVIORAL HEALTH SERVICES, as are necessary to implement the provisions of this section. RATES PROMULGATED UNDER THIS

SECTION SHALL BE INCLUDED IN THE REPORT REQUIRED UNDER SECTION 45-C OF PART A OF THIS CHAPTER.

S 14. Subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, is amended to read as follows:

8. section forty-eight-a of this act shall expire and be deemed repealed [March 31, 2016] JANUARY 1, 2018;

S 15. Section 1 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, is amended to read as follows:

Section 1. Notwithstanding any contrary provision of law, the [commissioner] COMMISSIONERS of mental health [is] AND ALCOHOLISM AND SUBSTANCE ABUSE SERVICES ARE authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing [hospital-based and free-standing clinics] PROVIDERS licensed pursuant to article 28 of the public health law, OR pursuant to article 31 OR ARTICLE 32 of the mental hygiene law [or pursuant to both such provisions of law for outpatient mental health services] FOR AMBULATORY BEHAVIORAL HEALTH SERVICES, as determined by the commissioner of health in consultation with the commissioner of mental health AND COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health OR OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the [commissioner] COMMISSIONERS of mental health AND ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, be greater than the increased funds made available pursuant to this section. THE INCREASE OF SUCH BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH DECEMBER 31, 2016 FOR PATIENTS IN THE CITY OF NEW YORK, FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH JUNE 30, 2017 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION THROUGH DECEMBER 31, 2017 FOR ALL SERVICES PROVIDED TO PERSONS UNDER THE AGE OF TWENTY-ONE; PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED, SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED. The commissioner of health may, in consultation with the [commissioner] COMMISSIONERS of mental health AND ALCOHOLISM AND

SUBSTANCE ABUSE SERVICES, promulgate regulations, including emergency regulations PROMULGATED PRIOR TO OCTOBER 1, 2013 THAT ESTABLISH RATES FOR BEHAVIORAL HEALTH SERVICES, as are necessary to implement the provisions of this section. RATES PROMULGATED UNDER THIS SECTION SHALL BE INCLUDED IN THE REPORT REQUIRED UNDER SECTION 45-C OF PART A OF CHAPTER 56 OF THE LAWS OF 2013.

S 16. Section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 49 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, and shall expire on [March 31, 2016] JANUARY 1, 2018.

S 16-a. Section 45-c of part A of chapter 56 of the laws of 2013, relating to the report on the transition of behavioral health services as a managed care benefit in the medical assistance program, is amended to read as follows:

S 45-c. The commissioner of health in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse SERVICES shall prepare a report on the transition of behavioral health services as a managed care benefit in the medical assistance program. Such report shall examine (i) the adequacy of rates; (ii) the ability of managed care plans to arrange and manage covered services for eligible enrollees; (iii) the ability of managed care plans to provide an adequate network of providers to meet the needs of enrollees; (iv) the use of evidence based tools or guidelines by managed care plans when determining the appropriate level of care or coverage for enrollees; (v) the ability of managed care plans to provide eligible enrollees with both the appropriate amount and type of services; (vi) the quality assurance mechanisms used by managed care plans, including processes to ensure enrollee satisfaction; (vii) the manner in which managed care plans address the cultural and linguistic needs of enrollees; [and] (viii) any other quality of care criteria deemed appropriate by the commissioners to ensure the adequacy of rates, continuity of care and the quality of life, health, and safety of enrollees during the transition of the behavioral health benefit; (IX) DETAILS REGARDING THE IMPLEMENTATION OF REINVESTMENT ALLOCATION PLANS PURSUANT TO REDUCTIONS OF INPATIENT BEHAVIORAL HEALTH SERVICES INCLUDING, BUT NOT LIMITED, TO THE LOCATION AND SCOPE OF SERVICE REDUCTIONS RESULTING FROM THE REDUCTION OR CLOSURE OF PROGRAMS LICENSED PURSUANT TO ARTICLE 31 OR 32 OF THE MENTAL HYGIENE LAW AND A DESCRIPTION OF SERVICES TO BE FUNDED PURSUANT TO ALLOCATION PLANS; (X) DETAILED DESCRIPTIONS OF THE METHODOLOGY USED TO CALCULATE THE AMOUNT OF SAVINGS RESULTING FROM THE TRANSITION OF INDIVIDUALS INTO MANAGED CARE REALIZED UNDER SUBDIVISION 5 OF SECTION 365-M OF THE SOCIAL SERVICES LAW, AND THE MANNER IN WHICH THE REINVESTMENT WILL ADDRESS THE SERVICE NEEDS; (XI) DETAILS REGARDING THE IMPLEMENTATION OF THE COLLABORATIVE CARE CLINICAL DELIVERY MODEL; (XII) A DESCRIPTION OF, AND RATIONALE FOR, ANY WAIVER OF EXISTING REGULATIONS OR ANY PROMULGATION OF EMERGENCY REGULATIONS PURSUANT TO THE BEHAVIORAL HEALTH SERVICES TRANSITION AUTHORIZED BY SECTIONS 10 THROUGH 17 OF PART C OF A CHAPTER OF THE LAWS OF 2014 WHICH AMENDED THIS SECTION, RELATING TO THE IMPLEMENTATION OF THE HEALTH AND MENTAL HYGIENE BUDGET; (XIII) IMPLEMENTATION OF INFRASTRUCTURE AND ORGANIZATIONAL MODIFICATIONS AND INVESTMENTS IN HEALTH INFORMATION TECHNOLOGY AND TRAINING AND TECHNICAL ASSISTANCE; AND (XIV) DETAILS REGARDING THE

IMPLEMENTATION OF THE PLAN TO TRANSITION ADULT AND CHILDREN'S BEHAVIORAL HEALTH PROVIDERS AND SERVICES INTO MANAGED CARE. [The report shall be submitted no later than April first, two thousand sixteen to the governor, the temporary president of the senate, the speaker of the assembly, the minority leader of the senate, and the minority leader of the assembly.] THE REPORT SHALL BE SUBMITTED ON AN ANNUAL BASIS TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE MINORITY LEADER OF THE SENATE, THE MINORITY LEADER OF THE ASSEMBLY, AND THE BEHAVIORAL HEALTH SUBCOMMITTEE OF THE MEDICAID REDESIGN TEAM, NO LATER THAN JANUARY FIRST OF EACH YEAR.

S 16-b. Section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to state health mental hygiene budget for the 2013-14 state fiscal year, is amended by adding a new subdivision 7-a to read as follows:

7-A. SECTION FORTY-FIVE-C OF THIS ACT SHALL EXPIRE AND BE DEEMED REPEALED JANUARY 1, 2018;

S 17. Subject to the availability of federal financial participation, the commissioner of health is authorized, within amounts appropriated, to distribute funds to local governmental units, as defined in section 41.03 of the mental hygiene law, to Medicaid managed care plans certified by the department of health, health homes designated by such department, and individual behavioral health providers and consortiums of such providers licensed or certified by the office of mental health or the office of alcoholism and substance abuse services to prepare for the transition of adult and children's behavioral health providers and services into managed care. The use of such funds may include, but not be limited to, infrastructure and organizational modifications and investments in health information technology and training and technical assistance. Such funds shall be distributed pursuant to a plan to be developed by the commissioner of health, in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse services. In developing such plan, such commissioners may take into account the size and scope of a grantee's operations as a factor relevant to eligibility for, and the amount of, such funds. The commissioner of health is authorized to audit recipients of funds under this section to ensure compliance and to recoup any funds determined to have been used for purposes other than as described herein or otherwise approved by such commissioners. The commissioners shall include details regarding the implementation of the plan to transition adult and children's behavioral health providers and services into managed care in the annual report required under section 45-c of part A of chapter 56 of the laws of 2013.

S 18. The commissioner of health is authorized to establish a disability clinician advisory group of experienced clinicians and clinic administrators who have an understanding of the comprehensive needs of people with disabilities. Such group shall provide the commissioner and the department of health with information and data on the effect of policies, including proposed regulations or statutes, and of fiscal proposals, including rate setting and appropriations, on the delivery of supports and services for individuals with disabilities including but not limited to the role of specialty services.

S 19. Paragraph (i) of subdivision 38 of section 2 of the social services law, as added by section 63 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) "Participating provider" means a certified home health agency, long term home health agency or personal care provider with total medi-

caid reimbursements, INCLUDING REIMBURSEMENTS THROUGH THE MANAGED CARE PROGRAM ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS CHAPTER, exceeding fifteen million dollars per calendar year.

S 20. The opening paragraph of section 363-e of the social services law, as added by section 64 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

THE DEPARTMENT OF HEALTH AND THE OFFICE OF THE MEDICAID INSPECTOR GENERAL SHALL JOINTLY DEVELOP REQUIREMENTS FOR PRECLAIM REVIEW. Every service or item within a claim OR ENCOUNTER submitted by a participating provider shall be reviewed and verified by a verification organization prior to submission of a claim OR ENCOUNTER to the department of health OR TO A MANAGED CARE PROVIDER AS DEFINED IN PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE. The verification organization shall declare each service or item to be verified or unverified. Each participating provider shall receive and maintain reports from the verification organization which shall contain data on:

S 21. The opening paragraph of subdivision 1 of section 20-c of the social services law, as added by section 151 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

(A) Except as otherwise specified in the appropriation for system support and information services program in the office of temporary disability assistance within the department of family assistance, OR AS AUTHORIZED BY SUBDIVISION TWO-A OF SECTION TWENTY-TWO OF THIS ARTICLE, the department shall not enter into any contract with a private entity under which that entity would perform any of the public assistance and care eligibility determination functions, duties or obligations of the department as set forth in this chapter.

S 22. Section 22 of the social services law is amended by adding a new subdivision 2-a to read as follows:

2-A. WITH REGARD TO FAIR HEARINGS HELD IN CONNECTION WITH APPEALS UNDER THE FULLY INTEGRATED DUALS ADVANTAGE DEMONSTRATION PROGRAM, THE COMMISSIONER MAY CONTRACT FOR THE SOLE PURPOSE OF ASSISTING STAFF OF THE OFFICE FOR SUCH PURPOSE.

S 23. Subdivision 2-c of section 2808 of the public health law is amended by adding a new paragraph (e) to read as follows:

(E) WITH THE EXCEPTION OF THOSE ENROLLEES COVERED UNDER A PAYMENT RATE METHODOLOGY AGREEMENT NEGOTIATED WITH A RESIDENTIAL HEALTH CARE FACILITY, PAYMENTS FOR INPATIENT RESIDENTIAL HEALTH CARE FACILITY SERVICES PROVIDED TO PATIENTS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW MADE BY ORGANIZATIONS 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, SHALL BE THE RATES OF PAYMENT THAT WOULD BE PAID FOR SUCH PATIENTS UNDER THE MEDICAL ASSISTANCE PROGRAM AS DETERMINED PURSUANT TO THIS SECTION AND SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-D OF THIS ARTICLE AND AS IN EFFECT AT THE TIME SUCH SERVICES WERE PROVIDED. THE PROVISIONS OF THIS PARAGRAPH SHALL NOT APPLY TO PAYMENTS FOR PATIENTS WHOSE PLACEMENT IN A RESIDENTIAL HEALTH CARE FACILITY IS FOR THE PURPOSE OF RECEIVING TIME-LIMITED REHABILITATION, TO BE FOLLOWED BY DISCHARGE FROM THE FACILITY, DURING THE PERIOD SUCH TIME-LIMITED SERVICES ARE PROVIDED.

S 24. Section 365-f of the social services law is amended by adding a new subdivision 9 to read as follows:

9. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER IS AUTHORIZED

TO MAKE TEMPORARY PERIODIC LUMP-SUM MEDICAID PAYMENTS TO FISCAL INTERMEDIARIES PRINCIPALLY ENGAGED IN PROVIDING CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES TO MEDICAID PATIENTS, IN ACCORDANCE WITH THE FOLLOWING:

(A) ELIGIBLE FISCAL INTERMEDIARIES SHALL INCLUDE:

(I) PROVIDERS UNDERGOING CLOSURE OR SUBSTANTIAL REDUCTION IN THE VOLUME OF CARE;

(II) PROVIDERS IMPACTED BY THE CLOSURE OF OTHER HEALTH CARE PROVIDERS;

(III) PROVIDERS SUBJECT TO MERGERS, ACQUISITIONS, CONSOLIDATIONS OR RESTRUCTURING;

(IV) PROVIDERS IMPACTED BY THE MERGER, ACQUISITION, CONSOLIDATION OR RESTRUCTURING OF OTHER HEALTH CARE PROVIDERS;

(V) PROVIDERS SEEKING TO ENSURE THAT ACCESS TO CARE IS MAINTAINED OR INCREASED; OR

(VI) ON OR AFTER JANUARY FIRST, TWO THOUSAND FIFTEEN, PROVIDERS IMPACTED BY CHANGES TO THE FAIR LABOR STANDARDS ACT REQUIRING OVERTIME PAY FOR PERSONAL ASSISTANTS WORKING IN EXCESS OF FORTY HOURS PER WEEK.

(B) PROVIDERS SEEKING MEDICAID PAYMENTS UNDER THIS SUBDIVISION SHALL DEMONSTRATE THROUGH SUBMISSION OF A WRITTEN PROPOSAL TO THE COMMISSIONER THAT THE ADDITIONAL RESOURCES PROVIDED BY SUCH MEDICAID PAYMENTS WILL ACHIEVE ONE OR MORE OF THE FOLLOWING:

(I) PROTECT OR ENHANCE ACCESS TO CARE;

(II) PROTECT OR ENHANCE QUALITY OF CARE;

(III) IMPROVE THE COST EFFECTIVENESS OF THE DELIVERY OF HEALTH CARE SERVICES; OR

(IV) OTHERWISE PROTECT OR ENHANCE THE HEALTH CARE DELIVERY SYSTEM, AS DETERMINED BY THE COMMISSIONER.

(C)(I) SUCH WRITTEN PROPOSAL SHALL BE SUBMITTED TO THE COMMISSIONER AT LEAST SIXTY DAYS PRIOR TO THE REQUESTED COMMENCEMENT OF SUCH MEDICAID PAYMENTS AND SHALL INCLUDE A PROPOSED BUDGET TO ACHIEVE THE GOALS OF THE PROPOSAL. ANY MEDICAID PAYMENTS ISSUED PURSUANT TO THIS SUBDIVISION SHALL BE MADE OVER A SPECIFIED PERIOD OF TIME, AS DETERMINED BY THE COMMISSIONER, OF UP TO THREE YEARS. AT THE END OF THE SPECIFIED TIME-FRAME SUCH PAYMENTS SHALL CEASE. THE COMMISSIONER MAY ESTABLISH, AS A CONDITION OF RECEIVING SUCH MEDICAID PAYMENTS, BENCHMARKS AND GOALS TO BE ACHIEVED IN CONFORMITY WITH THE PROVIDER'S WRITTEN PROPOSAL AS APPROVED BY THE COMMISSIONER AND MAY ALSO REQUIRE THAT THE PROVIDER SUBMIT SUCH PERIODIC REPORTS CONCERNING THE ACHIEVEMENT OF SUCH BENCHMARKS AND GOALS AS THE COMMISSIONER DEEMS NECESSARY. FAILURE TO ACHIEVE SATISFACTORY PROGRESS, AS DETERMINED BY THE COMMISSIONER, IN ACCOMPLISHING SUCH BENCHMARKS AND GOALS SHALL BE A BASIS FOR ENDING THE PROVIDER'S MEDICAID PAYMENTS PRIOR TO THE END OF THE SPECIFIED TIMEFRAME.

(II) THE COMMISSIONER MAY REQUIRE THAT APPLICATIONS SUBMITTED PURSUANT TO THIS SUBDIVISION BE SUBMITTED IN RESPONSE TO AND IN ACCORDANCE WITH A REQUEST FOR APPLICATIONS OR A REQUEST FOR PROPOSALS ISSUED BY THE COMMISSIONER.

S 25. Section 3605 of the public health law is amended by adding a new subdivision 14 to read as follows:

14. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER IS AUTHORIZED TO MAKE TEMPORARY PERIODIC LUMP-SUM MEDICAID PAYMENTS TO LICENSED HOME CARE SERVICE AGENCIES ("LHCSA") PRINCIPALLY ENGAGED IN PROVIDING HOME HEALTH SERVICES TO MEDICAID PATIENTS, IN ACCORDANCE WITH THE FOLLOWING:

(A) ELIGIBLE LHCSA PROVIDERS SHALL INCLUDE:

(I) PROVIDERS UNDERGOING CLOSURE;

(II) PROVIDERS IMPACTED BY THE CLOSURE OF OTHER HEALTH CARE PROVIDERS;
(III) PROVIDERS SUBJECT TO MERGERS, ACQUISITIONS, CONSOLIDATIONS OR RESTRUCTURING;
(IV) PROVIDERS IMPACTED BY THE MERGER, ACQUISITION, CONSOLIDATION OR RESTRUCTURING OF OTHER HEALTH CARE PROVIDERS; OR
(V) PROVIDERS SEEKING TO ENSURE THAT ACCESS TO CARE IS MAINTAINED.
(B) PROVIDERS SEEKING MEDICAID PAYMENTS UNDER THIS SUBDIVISION SHALL DEMONSTRATE THROUGH SUBMISSION OF A WRITTEN PROPOSAL TO THE COMMISSIONER THAT THE ADDITIONAL RESOURCES PROVIDED BY SUCH MEDICAID PAYMENTS WILL ACHIEVE ONE OR MORE OF THE FOLLOWING:
(I) PROTECT OR ENHANCE ACCESS TO CARE;
(II) PROTECT OR ENHANCE QUALITY OF CARE;
(III) IMPROVE THE COST EFFECTIVENESS OF THE DELIVERY OF HEALTH CARE SERVICES; OR
(IV) OTHERWISE PROTECT OR ENHANCE THE HEALTH CARE DELIVERY SYSTEM, AS DETERMINED BY THE COMMISSIONER.
(C) (I) SUCH WRITTEN PROPOSAL SHALL BE SUBMITTED TO THE COMMISSIONER AT LEAST SIXTY DAYS PRIOR TO THE REQUESTED COMMENCEMENT OF SUCH MEDICAID PAYMENTS AND SHALL INCLUDE A PROPOSED BUDGET TO ACHIEVE THE GOALS OF THE PROPOSAL. ANY MEDICAID PAYMENTS ISSUED PURSUANT TO THIS SUBDIVISION SHALL BE MADE OVER A SPECIFIED PERIOD OF TIME, AS DETERMINED BY THE COMMISSIONER, OF UP TO THREE YEARS. AT THE END OF THE SPECIFIED TIME-FRAME SUCH PAYMENTS SHALL CEASE. THE COMMISSIONER MAY ESTABLISH, AS A CONDITION OF RECEIVING SUCH MEDICAID PAYMENTS, BENCHMARKS AND GOALS TO BE ACHIEVED IN CONFORMITY WITH THE PROVIDER'S WRITTEN PROPOSAL AS APPROVED BY THE COMMISSIONER AND MAY ALSO REQUIRE THAT THE PROVIDER SUBMIT SUCH PERIODIC REPORTS CONCERNING THE ACHIEVEMENT OF SUCH BENCH-MARKS AND GOALS AS THE COMMISSIONER DEEMS NECESSARY. FAILURE TO ACHIEVE SATISFACTORY PROGRESS, AS DETERMINED BY THE COMMISSIONER, IN ACCOMPLISH-ING SUCH BENCHMARKS AND GOALS SHALL BE A BASIS FOR ENDING THE PROVIDER'S MEDICAID PAYMENTS PRIOR TO THE END OF THE SPECIFIED TIMEFRAME.
(II) THE COMMISSIONER MAY REQUIRE THAT APPLICATIONS SUBMITTED PURSUANT TO THIS SUBDIVISION BE SUBMITTED IN RESPONSE TO AND IN ACCORDANCE WITH A REQUEST FOR APPLICATIONS OR A REQUEST FOR PROPOSALS ISSUED BY THE COMMISSIONER.

S 26. Section 3614 of the public health law is amended by adding a new subdivision 14 to read as follows:

14. (A) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND FOURTEEN THE COMMISSIONER SHALL ADJUST MEDICAID RATES OF PAYMENT FOR SERVICES PROVIDED BY CERTIFIED HOME HEALTH AGENCIES TO ADDRESS COST INCREASES STEMMING FROM THE WAGE INCREASES REQUIRED BY IMPLEMENTATION OF THE PROVISIONS OF SECTION THIRTY-SIX HUNDRED FOURTEEN-C OF THIS ARTICLE. SUCH RATE ADJUSTMENTS SHALL BE BASED ON A COMPARISON, AS DETERMINED BY THE COMMISSIONER, OF THE HOURLY COMPENSATION LEVELS FOR HOME HEALTH AIDES AND PERSONAL CARE AIDES AS REFLECTED IN THE EXISTING MEDICAID RATES FOR CERTIFIED HOME HEALTH AGEN-CIES TO THE HOURLY COMPENSATION LEVELS INCURRED AS A RESULT OF COMPLYING WITH THE PROVISIONS OF SECTION THIRTY-SIX HUNDRED FOURTEEN-C OF THIS ARTICLE.
(B) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER MARCH FIRST, TWO THOUSAND FOURTEEN THE COMMISSIONER SHALL ADJUST MEDICAID RATES OF PAYMENT FOR SERVICES PROVIDED BY LONG TERM HOME HEALTH CARE PROGRAMS TO ADDRESS COST INCREASES STEMMING FROM THE WAGE INCREASES REQUIRED BY IMPLEMENTATION OF THE PROVISIONS OF SECTION THIRTY-SIX

HUNDRED FOURTEEN-C OF THIS ARTICLE. SUCH RATE ADJUSTMENTS SHALL BE BASED ON A COMPARISON, AS DETERMINED BY THE COMMISSIONER, OF THE HOURLY COMPENSATION LEVELS FOR HOME HEALTH AIDES AND PERSONAL CARE AIDES AS REFLECTED IN THE EXISTING MEDICAID RATES FOR LONG TERM HOME HEALTH CARE PROGRAMS TO THE HOURLY COMPENSATION LEVELS INCURRED AS A RESULT OF COMPLYING WITH THE PROVISIONS OF SECTION THIRTY-SIX HUNDRED FOURTEEN-C OF THIS ARTICLE.

S 26-a. Paragraph (d) of subdivision 2-c of section 2808 of the public health law, as added by section 95 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(d) The commissioner shall promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this subdivision. Such regulations shall be developed in consultation with the nursing home industry and advocates for residential health care facility residents and, further, the commissioner shall provide notification concerning such regulations to the chairs of the senate and assembly health committees, the chair of the senate finance committee and the chair of the assembly ways and means committee. Such regulations shall include provisions for rate adjustments or payment enhancements to facilitate a minimum four-year transition of facilities to the rate-setting methodology established by this subdivision and may also include, but not be limited to, provisions for facilitating quality improvements in residential health care facilities. FOR PURPOSES OF FACILITATING QUALITY IMPROVEMENTS THROUGH THE ESTABLISHMENT OF A NURSING HOME QUALITY POOL, THOSE FACILITIES THAT CONTRIBUTE TO THE QUALITY POOL, BUT ARE DEEMED INELIGIBLE FOR QUALITY POOL PAYMENTS DUE EXCLUSIVELY TO A SPECIFIC CASE OF EMPLOYEE MISCONDUCT, SHALL NEVERTHELESS BE ELIGIBLE FOR A QUALITY POOL PAYMENT IF THE FACILITY PROPERLY REPORTED THE INCIDENT, DID NOT RECEIVE A SURVEY CITATION FROM THE COMMISSIONER OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES ESTABLISHING THE FACILITY'S CULPABILITY WITH REGARD TO SUCH MISCONDUCT AND, BUT FOR THE SPECIFIC CASE OF EMPLOYEE MISCONDUCT, THE FACILITY WOULD HAVE OTHERWISE RECEIVED A QUALITY POOL PAYMENT. REGULATIONS PERTAINING TO THE FACILITATION OF QUALITY IMPROVEMENT MAY BE MADE EFFECTIVE FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN.

S 27. The public health law is amended by adding a new section 2826 to read as follows:

S 2826. TEMPORARY ADJUSTMENT TO REIMBURSEMENT RATES. (A) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, WITHIN FUNDS APPROPRIATED AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER MAY GRANT APPROVAL OF A TEMPORARY ADJUSTMENT TO THE NON-CAPITAL COMPONENTS OF RATES, OR MAKE TEMPORARY LUMP-SUM MEDICAID PAYMENTS, TO ELIGIBLE GENERAL HOSPITALS, SKILLED NURSING FACILITIES, CLINICS AND HOME CARE PROVIDERS, PROVIDED HOWEVER, THAT SHOULD FEDERAL FINANCIAL PARTICIPATION NOT BE AVAILABLE FOR ANY ELIGIBLE PROVIDER, THEN PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS GRANTS AND SHALL NOT BE DEEMED TO BE MEDICAL ASSISTANCE PAYMENTS.

(B) ELIGIBLE PROVIDERS SHALL INCLUDE:

(I) PROVIDERS UNDERGOING CLOSURE;

(II) PROVIDERS IMPACTED BY THE CLOSURE OF OTHER HEALTH CARE PROVIDERS;

(III) PROVIDERS SUBJECT TO MERGERS, ACQUISITIONS, CONSOLIDATIONS OR RESTRUCTURING; OR

(IV) PROVIDERS IMPACTED BY THE MERGER, ACQUISITION, CONSOLIDATION OR RESTRUCTURING OF OTHER HEALTH CARE PROVIDERS.

(C) PROVIDERS SEEKING TEMPORARY RATE ADJUSTMENTS UNDER THIS SECTION SHALL DEMONSTRATE THROUGH SUBMISSION OF A WRITTEN PROPOSAL TO THE

COMMISSIONER THAT THE ADDITIONAL RESOURCES PROVIDED BY A TEMPORARY RATE ADJUSTMENT WILL ACHIEVE ONE OR MORE OF THE FOLLOWING:

(I) PROTECT OR ENHANCE ACCESS TO CARE;

(II) PROTECT OR ENHANCE QUALITY OF CARE;

(III) IMPROVE THE COST EFFECTIVENESS OF THE DELIVERY OF HEALTH CARE SERVICES; OR

(IV) OTHERWISE PROTECT OR ENHANCE THE HEALTH CARE DELIVERY SYSTEM, AS DETERMINED BY THE COMMISSIONER.

(D) (I) SUCH WRITTEN PROPOSAL SHALL BE SUBMITTED TO THE COMMISSIONER AT LEAST SIXTY DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE OF THE TEMPORARY RATE ADJUSTMENT, AND SHALL INCLUDE A PROPOSED BUDGET TO ACHIEVE THE GOALS OF THE PROPOSAL. ANY MEDICAID PAYMENT ISSUED PURSUANT TO THIS SECTION SHALL BE IN EFFECT FOR A SPECIFIED PERIOD OF TIME AS DETERMINED BY THE COMMISSIONER, OF UP TO THREE YEARS. AT THE END OF THE SPECIFIED TIMEFRAME SUCH PAYMENTS OR ADJUSTMENTS TO THE NON-CAPITAL COMPONENT OF RATES SHALL CEASE, AND THE PROVIDER SHALL BE REIMBURSED IN ACCORDANCE WITH THE OTHERWISE APPLICABLE RATE-SETTING METHODOLOGY AS SET FORTH IN APPLICABLE STATUTES AND REGULATIONS. THE COMMISSIONER MAY ESTABLISH, AS A CONDITION OF RECEIVING SUCH TEMPORARY RATE ADJUSTMENTS OR GRANTS, BENCHMARKS AND GOALS TO BE ACHIEVED IN CONFORMITY WITH THE PROVIDER'S WRITTEN PROPOSAL AS APPROVED BY THE COMMISSIONER AND MAY ALSO REQUIRE THAT THE FACILITY SUBMIT SUCH PERIODIC REPORTS CONCERNING THE ACHIEVEMENT OF SUCH BENCHMARKS AND GOALS AS THE COMMISSIONER DEEMS NECESSARY. FAILURE TO ACHIEVE SATISFACTORY PROGRESS, AS DETERMINED BY THE COMMISSIONER, IN ACCOMPLISHING SUCH BENCHMARKS AND GOALS SHALL BE A BASIS FOR ENDING THE FACILITY'S TEMPORARY RATE ADJUSTMENT OR GRANT PRIOR TO THE END OF THE SPECIFIED TIMEFRAME. (II) THE COMMISSIONER MAY REQUIRE THAT APPLICATIONS SUBMITTED PURSUANT TO THIS SECTION BE SUBMITTED IN RESPONSE TO AND IN ACCORDANCE WITH A REQUEST FOR APPLICATIONS OR A REQUEST FOR PROPOSALS ISSUED BY THE COMMISSIONER.

(E) NOTWITHSTANDING ANY LAW TO THE CONTRARY, GENERAL HOSPITALS DEFINED AS CRITICAL ACCESS HOSPITALS PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE ALLOCATED NO LESS THAN FIVE MILLION DOLLARS ANNUALLY PURSUANT TO THIS SECTION. THE DEPARTMENT OF HEALTH SHALL PROVIDE A REPORT TO THE GOVERNOR AND LEGISLATURE NO LATER THAN DECEMBER FIRST, TWO THOUSAND FOURTEEN PROVIDING RECOMMENDATIONS ON HOW TO ENSURE THE FINANCIAL STABILITY OF, AND PRESERVE PATIENT ACCESS TO, CRITICAL ACCESS HOSPITALS.

S 27-a. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (bb) to read as follows:

(BB) SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, SERVICES AND SUPPORTS AUTHORIZED BY THE FEDERAL REGULATIONS GOVERNING THE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS STATE PLAN OPTION (COMMUNITY FIRST CHOICE) PURSUANT TO 42 U.S.C. S 1396N(K).

S 27-b. Section 365-f of the social services law is amended by adding a new subdivision 8 to read as follows:

8. SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE PROVISIONS OF THIS SECTION GOVERNING CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES SHALL ALSO APPLY TO SUCH SERVICES WHEN OFFERED UNDER THE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS STATE PLAN OPTION (COMMUNITY FIRST CHOICE) PURSUANT TO 42 U.S.C. S 1396N(K).

S 27-c. Subparagraph (iii) of paragraph a of subdivision 1 of section 6908 of the education law, as amended by chapter 160 of the laws of 2003, is amended to read as follows:

(iii) the providing of care by a person acting in the place of a person exempt under clause (i) of this paragraph, but who does hold

himself or herself out as one who accepts employment for performing such care, where nursing services are under the instruction of a licensed nurse, or under the instruction of a patient or family or household member determined by a registered professional nurse to be self-directing and capable of providing such instruction, and [any remuneration is] SERVICES ARE provided under section three hundred sixty-five-f of the social services law; or

S 27-d. Intentionally omitted.

S 27-e. Intentionally omitted.

S 27-f. Intentionally omitted.

S 27-h. Section 57-c of part A of chapter 56 of the laws of 2013, relating to establishing the home and community-based care work group, is amended to read as follows:

S 57-c. Home and community based care workgroup. The commissioner of health shall convene a home and community based care workgroup to examine and make recommendations on issues which include, but are not limited to:

a. State and federal regulatory requirements and related policy guidelines (including the applicability of the federal conditions of participation);

b. Efficient home and community based care delivery, including telehealth and hospice services; [and]

c. Alignment of functions between managed care entities and home and community based providers[.]; AND

D. BEST PRACTICE FOR CLEAN CLAIMS AND RELATED DISPUTE RESOLUTION.

The workgroup shall be 11 members. The members of the workgroup shall including providers, plans and representatives of consumers and direct caregivers with relevant expertise.

The commissioner of health, or his or her designee shall chair the workgroup and department of health and other executive agencies and offices shall provide relevant data and other information as is necessary for the group to perform its duties.

The commissioner of health shall convene this workgroup by May 15, [2013] 2014 and the group shall issue [a report] PERIODIC REPORTS with recommendations by March 1, 2014, SEPTEMBER 1, 2014 AND FEBRUARY 28, 2015.

S 28. Subdivision 35 of section 2807-c of the public health law is amended by adding a new paragraph (j) to read as follows:

(J) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, WITH REGARD TO INPATIENT AND OUTPATIENT MEDICAID RATES OF PAYMENT FOR GENERAL HOSPITAL SERVICES, THE COMMISSIONER MAY MAKE SUCH ADJUSTMENTS TO SUCH RATES AND TO THE METHODOLOGY FOR COMPUTING SUCH RATES AS IS NECESSARY TO ACHIEVE NO AGGREGATE, NET INCREASE OR DECREASE IN OVERALL MEDICAID EXPENDITURES RELATED TO THE IMPLEMENTATION OF THE INTERNATIONAL CLASSIFICATION OF DISEASES VERSION 10 (ICD-10) CODING SYSTEM ON OR ABOUT OCTOBER FIRST, TWO THOUSAND FOURTEEN, AS COMPARED TO SUCH AGGREGATE EXPENDITURES FROM THE TWELVE-MONTH PERIOD IMMEDIATELY PRIOR TO SUCH IMPLEMENTATION.

S 29. Subparagraph (i) of paragraph (e-1) of subdivision 4 of section 2807-c of the public health law, as amended by section 41 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(i) For rate periods on and after April first, two thousand ten, the commissioner, in consultation with the commissioner of the office of mental health, shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for determining the operating cost components of rates of payments for services described in this paragraph. Such regulations shall utilize two thousand five operating

costs as submitted to the department prior to July first, two thousand nine and shall provide for methodologies establishing per diem inpatient rates that utilize case mix adjustment mechanisms. Such regulations shall contain criteria for adjustments based on length of stay AND MAY ALSO PROVIDE FOR A BASE YEAR UPDATE, PROVIDED, HOWEVER, THAT SUCH BASE YEAR UPDATE SHALL TAKE EFFECT NO EARLIER THAN APRIL FIRST, TWO THOUSAND FIFTEEN, AND PROVIDED FURTHER, HOWEVER, THAT THE COMMISSIONER MAY MAKE SUCH ADJUSTMENTS TO SUCH UTILIZATION AND TO THE METHODOLOGY FOR COMPUTING SUCH RATES AS IS NECESSARY TO ACHIEVE NO AGGREGATE, NET GROWTH IN OVERALL MEDICAID EXPENDITURES RELATED TO SUCH RATES, AS COMPARED TO SUCH AGGREGATE EXPENDITURES FROM THE PRIOR YEAR. IN DETERMINING THE UPDATED BASE YEAR TO BE UTILIZED PURSUANT TO THIS SUBPARAGRAPH, THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE BASE YEAR DETERMINED IN ACCORDANCE WITH PARAGRAPH (C) OF SUBDIVISION THIRTY-FIVE OF THIS SECTION.

S 30. Subparagraph (vii) of paragraph (e-2) of subdivision 4 of section 2807-c of the public health law, as added by section 13 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(vii) The commissioner may promulgate regulations, including emergency regulations, implementing the provisions of this paragraph, AND, FURTHER, SUCH REGULATIONS MAY PROVIDE FOR AN UPDATE OF THE BASE YEAR COSTS AND STATISTICS USED TO COMPUTE SUCH RATES, PROVIDED, HOWEVER, THAT SUCH BASE YEAR UPDATE SHALL TAKE EFFECT NO EARLIER THAN APRIL FIRST, TWO THOUSAND FIFTEEN, AND PROVIDED FURTHER, HOWEVER, THAT THE COMMISSIONER MAY MAKE SUCH ADJUSTMENTS TO SUCH UTILIZATION AND TO THE METHODOLOGY FOR COMPUTING SUCH RATES AS IS NECESSARY TO ACHIEVE NO AGGREGATE, NET GROWTH IN OVERALL MEDICAID EXPENDITURES RELATED TO SUCH RATES, AS COMPARED TO SUCH AGGREGATE EXPENDITURES FROM THE PRIOR YEAR. IN DETERMINING THE UPDATED BASE YEAR TO BE UTILIZED PURSUANT TO THIS SUBPARAGRAPH, THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE BASE YEAR DETERMINED IN ACCORDANCE WITH PARAGRAPH (C) OF SUBDIVISION THIRTY-FIVE OF THIS SECTION.

S 31. Paragraph (l) of subdivision 4 of section 2807-c of the public health law is amended by adding a new subparagraph (v) to read as follows:

(V) THE COMMISSIONER MAY PROMULGATE REGULATIONS, INCLUDING EMERGENCY REGULATIONS, PROVIDING FOR AN UPDATE OF THE BASE YEAR COSTS AND STATISTICS USED TO COMPUTE RATES OF PAYMENT PURSUANT TO THIS PARAGRAPH, PROVIDED, HOWEVER, THAT SUCH BASE YEAR UPDATE SHALL TAKE EFFECT NO EARLIER THAN APRIL FIRST, TWO THOUSAND FIFTEEN, AND PROVIDED FURTHER, HOWEVER, THAT THE COMMISSIONER MAY MAKE SUCH ADJUSTMENTS TO SUCH UTILIZATION AND TO THE METHODOLOGY FOR COMPUTING SUCH RATES AS IS NECESSARY TO ACHIEVE NO AGGREGATE, NET GROWTH IN OVERALL MEDICAID EXPENDITURES RELATED TO SUCH RATES, AS COMPARED TO SUCH AGGREGATE EXPENDITURES FROM THE PRIOR YEAR. IN DETERMINING THE UPDATED BASE YEAR TO BE UTILIZED PURSUANT TO THIS SUBPARAGRAPH, THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE BASE YEAR DETERMINED IN ACCORDANCE WITH PARAGRAPH (C) OF SUBDIVISION THIRTY-FIVE OF THIS SECTION.

S 32. Paragraph (c) of subdivision 35 of section 2807-c of the public health law, as amended by section 26 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(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 provided, however, that the first updated base period shall

begin on [January] OR AFTER APRIL first, two thousand fourteen, BUT NO LATER THAN JULY FIRST, TWO THOUSAND FOURTEEN.

S 32-a. Notwithstanding any contrary provision of law, the commissioner of health shall establish a workgroup to review and investigate Medicaid inpatient rate-setting methodologies with regard to hospitals whose rates are governed by paragraphs (e-1), (e-2) and (l) of subdivision 4 of section 2807-c of the public health law and with particular regard to the impact of the utilization of updated base years in the computation of such rates. The workgroup shall contain designated staff of the department of health, representatives of hospital associations and such other interested stakeholders as determined by the commissioner. The commissioner shall consider the recommendations of such workgroup in determining proposed revised rates reflecting the utilization of such updated base years and shall make such proposed revised rates available to the chairs of the senate and assembly health committees no less than thirty days prior to the effective date for such rates. Such updated base years shall be implemented for rate periods commending no earlier than April 1, 2015.

S 33. Subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, as amended by section 3 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

1. For state fiscal years 2011-12 through [2014-15] 2015-16, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

S 33-a. Subdivision 5 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, as amended by section 3 of part A of chapter 56 of the laws of 2013, is amended and three new subdivisions 6, 7, and 8 are added to read as follows:

5. The [department of health] COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF BUDGET, shall prepare a monthly report that sets forth:

(a) known and projected department of health medicaid expenditures as described in subdivision one of this section, and factors that could result in medicaid disbursements for the relevant state fiscal year to exceed the projected department of health state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, including spending increases or decreases due to: enrollment fluctuations, rate changes, utilization changes, MRT investments, and shift of beneficiaries to managed care; and variations in offline medicaid payments; [and]

(b) the actions taken to implement any medicaid savings allocation plan implemented pursuant to subdivision four of this section, including information concerning the impact of such actions on each category of service and each geographic region of the state. [Each such monthly report shall be provided to the chairs of the senate finance and the assembly ways and means committees and shall be posted on the department of health's website in a timely manner.]

(C) THE PRICE, TO INCLUDE THE BASE RATE PLUS ANY UPCOMING RATE ADJUSTMENT; UTILIZATION, TO INCLUDE CURRENT ENROLLMENT, PROJECTED ENROLLMENT CHANGES AND ACUITY; AND MEDICAID REDESIGN TEAM INITIATIVES, ONE-TIME INITIATIVES AND OTHER INITIATIVES DESCRIBING THE PROPOSED BUDGET ACTION IMPACT, ANY PRIOR YEAR INITIATIVE WITH CURRENT AND FUTURE YEAR IMPACTS FOR THE FOLLOWING CATEGORIES OF SPENDING:

(I) INPATIENT;
(II) OUTPATIENT;
(III) EMERGENCY ROOM;
(IV) CLINIC;
(V) NURSING HOMES;
(VI) OTHER LONG TERM CARE;
(VII) MEDICAID MANAGED CARE;
(VIII) FAMILY HEALTH PLUS;
(IX) PHARMACY;
(X) TRANSPORTATION;
(XI) DENTAL;
(XII) NON-INSTITUTIONAL AND ALL OTHER CATEGORIES;
(XIII) AFFORDABLE HOUSING;
(XIV) VITAL ACCESS PROVIDER SERVICES;
(XV) BEHAVIORAL HEALTH VITAL ACCESS PROVIDER SERVICES;
(XVI) HEALTH HOME ESTABLISHMENT GRANTS;
(XVII) GRANTS FOR FACILITATING TRANSITION OF BEHAVIORAL HEALTH SERVICE TO MANAGED CARE;
(XVIII) FINGER LAKES HEALTH SERVICES AGENCY;
(XIX) THE TRANSITION OF VULNERABLE POPULATIONS TO MANAGED CARE;
(XX) AUDIT RECOVERIES AND SETTLEMENTS; AND

(D) WHERE PRICE AND UTILIZATION ARE NOT APPLICABLE, DETAIL SHALL BE PROVIDED ON SPENDING, TO INCLUDE BUT NOT BE LIMITED TO:

(I) DEMOGRAPHIC INFORMATION OF TARGETED RECIPIENTS;
(II) NUMBER OF RECIPIENTS;
(III) AWARD AMOUNTS;
(IV) TIMING OF AWARDS; AND
(V) THE IMPACT OF MEDICAID REDESIGN TEAM AND/OR ONE-TIME INITIATIVES.

INFORMATION REQUIRED BY PARAGRAPHS (A) AND (B) OF THIS SUBDIVISION SHALL BE PROVIDED TO THE CHAIRS OF THE SENATE FINANCE AND THE ASSEMBLY

WAYS AND MEANS COMMITTEES, AND SHALL BE POSTED ON THE DEPARTMENT OF HEALTH'S WEBSITE IN THE TIMELY MANNER.

(E) BEGINNING ON JULY 1, 2014, ADDITIONAL INFORMATION REQUIRED BY PARAGRAPHS (C) AND (D) OF THIS SUBDIVISION SHALL BE PROVIDED TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES.

(F) ANY PROJECTED MEDICAID SAVINGS DETERMINED BY THE COMMISSIONER OF HEALTH PURSUANT TO SECTION 34 OF PART C OF A CHAPTER OF THE LAWS OF 2014, RELATING TO THE IMPLEMENTATION OF THE HEALTH AND MENTAL HYGIENE BUDGET, AND THE PROPOSED ALLOCATION PLAN WITH REGARD TO SUCH SAVINGS.

6. THE COMMISSIONER OF HEALTH AND THE DIRECTOR OF THE BUDGET SHALL MAKE APPROPRIATE STAFF AVAILABLE TO MEET WITH THE CHAIRS OF THE HEALTH COMMITTEES OF THE NEW YORK STATE SENATE AND THE NEW YORK STATE ASSEMBLY, OR THEIR DESIGNEES, UPON THEIR REQUEST AND WITH REASONABLE NOTICE, TO REVIEW EACH MONTHLY REPORT, AS DESCRIBED IN THIS SUBDIVISION.

7. THE COMMISSIONER OF HEALTH SHALL MAKE TRAINING AVAILABLE TO DESIGNATED LEGISLATIVE STAFF WITH REGARD TO THE SKILLS AND TECHNIQUES NEEDED TO EFFECTIVELY ACCESS AND REVIEW RELEVANT MEDICAID DATA BASES UNDER THE CONTROL OF THE DEPARTMENT OF HEALTH, UPON THEIR REQUEST AND WITH REASONABLE NOTICE.

8. THE MONTHLY REPORTS AS DESCRIBED IN SUBDIVISION FIVE OF THIS SECTION AND RELATED DOCUMENTS PROVIDED TO THE NEW YORK STATE LEGISLATURE SHALL BE POSTED ON THE WEBSITE MAINTAINED BY THE DEPARTMENT OF HEALTH.

S 34. Notwithstanding any contrary provision of law and subject to the availability of federal financial participation, for state fiscal years beginning on and after April 1, 2014, the commissioner of health, in consultation with the director of the budget, shall, prior to January first of each year, determine the extent of savings that have been achieved as a result of the application of the provisions of sections 91 and 92 of part H of chapter 59 of the laws of 2011, as amended, and shall further determine the availability of such savings for distribution during the last quarter of such state fiscal year. In determining such savings the commissioner of health, in consultation with the director of the budget, may exempt the medical assistance administration program from distributions under this section. The commissioner of health, in consultation with the director of the budget, may distribute funds up to an amount equal to such available savings in accordance with an allocation plan that utilizes a methodology that distributes such funds proportionately among providers and plans in New York's Medicaid program. In developing such allocation plan the commissioner of health shall seek the input of the legislature, as well as organizations representing health care providers, consumers, businesses, workers, health care insurers and others with relevant expertise. Such allocation plan shall utilize three years of the most recently available system-wide expenditure data reflecting both MMIS and managed care encounters. Distributions to managed care plans shall be based on the administrative outlays stemming from participation in the Medicaid program. The commissioner of health may impose minimum threshold amounts in determining provider eligibility for distributions pursuant to this section. No less than fifty percent of the amount available for distribution shall be made available for the purpose of assisting eligible providers utilizing the methodology outlined above. The remainder of the distributions pursuant to this section shall be made available for the purposes of ensuring a minimum level of assistance to financially distressed and

critically needed providers as identified by the commissioner. The commissioner of health shall post the Medicaid savings allocation plan on the department of health's website and shall provide written copies of such plan to the chairs of the senate finance and the assembly ways and means committees at least 30 days before the date on which implementation is expected to begin. The commissioner of health is authorized to seek such federal approvals as may be required to effectuate the provisions of this section, including, but not limited to, to permit payment of such distributions as lumps sums and to secure waivers from otherwise applicable federal upper payment limit restrictions on such payments. The provisions of this section are subject to the reporting requirements set forth in paragraph (e) of subdivision 5 of section 92 of part H of chapter 59 of the laws of 2011, as amended by section 33-a of part C of a chapter of the laws of 2014, relating to implementation of the health and mental hygiene budget.

S 34-a. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (u) to read as follows:

(U) THE COMMISSIONER SHALL PROVIDE A WRITTEN OR ELECTRONIC COPY OF ANY STATE PLAN AMENDMENT SUBMITTED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE, NO LATER THAN FIVE BUSINESS DAYS FROM THE DATE OF MAILING OR SUBMISSION.

S 35. Subdivision 9 of section 365-l of the social services law, as added by section 6 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

9. [Any] THE contract [or contracts] entered into by the commissioner of health prior to January first, two thousand thirteen pursuant to subdivision eight of this section may be amended or modified without the need for a competitive bid or request for proposal process, and without regard to the provisions of sections one hundred twelve and one hundred sixty-three of the state finance law, section one hundred forty-two of the economic development law, or any other provision of law, to allow the purchase of additional personnel and services, subject to available funding, for the limited purpose of assisting the department of health with implementing the Balancing Incentive Program, the Fully Integrated Duals Advantage Program, the Vital Access Provider Program, the Medicaid waiver amendment associated with the public hospital transformation, the addition of behavioral health services as a managed care plan benefit, THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PLAN, ACTIVITIES TO FACILITATE THE TRANSITION OF VULNERABLE POPULATIONS TO MANAGED CARE and/or any workgroups required to be established by the chapter of the laws of two thousand thirteen that added this subdivision.

S 36. Section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, is amended by adding a new subdivision 6 to read as follows:

6. THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIVISION OF THE BUDGET SHALL, UPON SUBMISSION OF THE EXECUTIVE BUDGET TO THE LEGISLATURE, PROVIDE A DETAILED ACCOUNTING OF THE STATE MEDICAID GLOBAL CAP ON THE CLOSE OUT OF THE PRIOR YEAR, A CURRENT YEAR RE-ESTIMATE, THE PROSPECTIVE TWO-YEAR ESTIMATE AND ANY OTHER INFORMATION DEEMED NECESSARY AND APPROPRIATE.

S 37. Notwithstanding any provision of law to the contrary, the department of health and its designees, in consultation with the assembly and the senate health committees and their designees, and the division of budget and its designees, shall explore the feasibility and

efficacy of codifying in consolidated law the provisions of section 92 of part H of chapter 59 of the laws of 2011, and other such related laws and shall make such recommendations regarding codification by no later than June 1, 2014.

S 38. Subdivision (a) of section 90 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, as amended by section 1 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(a) (1) Notwithstanding any other provision of law to the contrary, for the state fiscal years beginning April 1, 2011 and ending on March 31, [2015] 2014, all Medicaid payments made for services provided on and after April 1, 2011, shall, except as hereinafter provided, be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry including but not limited to, a uniform reduction in Medicaid rates of payments or other reductions provided that any method selected achieves up to $345,000,000 in Medicaid state share savings in state fiscal year 2011-12 and up to $357,000,000 annually in state fiscal years 2012-13[,] AND 2013-14 [and 2014-15] except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, [2015] 2014. Any alternative methods to achieve the reduction must be provided in writing and shall be filed with the senate finance committee and the assembly ways and means committee not less than thirty days before the date on which implementation is expected to begin. Nothing in this section shall be deemed to prevent all or part of such alternative reduction plan from taking effect retroactively, to the extent permitted by the federal centers for medicare and medicaid services.

(2) ALTERNATIVE METHODS OF COST CONTAINMENT AS AUTHORIZED AND IMPLEMENTED PURSUANT TO PARAGRAPH ONE OF THIS SUBDIVISION SHALL CONTINUE TO BE APPLIED AND MAINTAINED FOR PERIODS ON AND AFTER APRIL 1, 2014, PROVIDED, HOWEVER, THAT THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, IS AUTHORIZED TO TERMINATE SUCH ALTERNATIVE METHODS UPON A FINDING THAT THEY ARE NO LONGER NECESSARY TO MAINTAIN ESSENTIAL COST SAVINGS.

S 39. Subdivisions (a) and (b) of section 364-jj of the social services law, as amended by section 80-a of part A of chapter 56 of the laws of 2013, are amended to read as follows:

(a) There is hereby established a special advisory review panel on Medicaid managed care. The panel shall consist of [twelve] SIXTEEN members who shall be appointed as follows: [four] SIX by the governor, one of which shall serve as the chair; [three] FOUR each by the temporary president of the senate and the speaker of the assembly; and one each by the minority leader of the senate and the minority leader of the assembly. At least three members of such panel shall be members of the joint advisory panel established under section 13.40 of the mental hygiene law. THE PANEL SHALL INCLUDE A CONSUMER REPRESENTATIVE FOR INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS, A CONSUMER REPRESENTATIVE FOR INDIVIDUALS WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID, A REPRESENTATIVE OF ENTITIES THAT PROVIDE OR ARRANGE FOR THE PROVISION OF SERVICES TO INDIVIDUALS WITH BEHAVIORAL HEALTH NEEDS, AND A REPRESENTATIVE OF ENTITIES THAT PROVIDE OR ARRANGE FOR THE PROVISION OF SERVICES TO INDIVIDUALS WHO ARE DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID.

Members shall serve without compensation but shall be reimbursed for appropriate expenses. The department shall provide technical assistance and access to data as is required for the panel to effectuate the mission and purposes established herein.

(b) The panel shall:

(i) determine whether there is sufficient managed care provider participation in the Medicaid managed care program;

(ii) determine whether managed care providers meet proper enrollment targets that permit as many Medicaid recipients as possible to make their own health plan decisions, thus minimizing the number of automatic assignments;

(iii) review the phase-in schedule for enrollment, of managed care providers under both the voluntary and mandatory programs;

(iv) assess the impact of managed care provider marketing and enrollment strategies, and the public education campaign conducted in New York city, on enrollees participation in Medicaid managed care plans;

(v) evaluate the adequacy of managed care provider capacity by reviewing established capacity measurements and monitoring actual access to plan practitioners;

(vi) examine the cost implications of populations excluded and exempted from Medicaid managed care;

(vii) EVALUATE THE ADEQUACY AND APPROPRIATENESS OF PROGRAM MATERIALS;

(VIII) EXAMINE TRENDS IN SERVICE DENIALS;

(IX) ASSESS THE ACCESS TO CARE FOR PEOPLE WITH DISABILITIES;

(X) in accordance with the recommendations of the joint advisory council established pursuant to section 13.40 of the mental hygiene law, advise the commissioners of health and developmental disabilities with respect to the oversight of DISCOs and of health maintenance organizations and managed long term care plans providing services authorized, funded, approved or certified by the office for people with developmental disabilities, and review all managed care options provided to persons with developmental disabilities, including: the adequacy of support for habilitation services; the record of compliance with requirements for person-centered planning, person-centered services and community integration; the adequacy of rates paid to providers in accordance with the provisions of paragraph 1 of subdivision four of section forty-four hundred three of the public health law, paragraph (a-2) of subdivision eight of section forty-four hundred three of the public health law or paragraph (a-2) of subdivision twelve of section forty-four hundred three-f of the public health law; and the quality of life, health, safety and community integration of persons with developmental disabilities enrolled in managed care; and

[(viii)] (XI) examine other issues as it deems appropriate.

S 40. Subdivision 6 of section 368-d of the social services law, as amended by section 37 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

6. The commissioner shall evaluate the results of the study conducted pursuant to subdivision four of this section to determine, after identification of actual direct and indirect costs incurred by public school districts [and state operated and state supported schools for blind and deaf students], whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district results in a decrease in the state share of annual

expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision five of section three hundred sixty-eight-e of this title exceeds one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal [year 2012-13 or any fiscal year thereafter] YEARS 2013-14 AND 2014-15, the excess amount shall be transferred to such public school districts [and state operated and state supported schools for blind and deaf students] in amounts proportional to their percentage contribution to the statewide savings; AN AMOUNT EQUAL TO THIRTEEN AND FIVE HUNDREDTHS PERCENT OF ANY DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES PURSUANT TO THIS SECTION FOR SUCH RECIPIENTS IN STATE FISCAL YEAR 2015-16 AND ANY FISCAL YEAR THEREAFTER SHALL BE TRANSFERRED TO SUCH PUBLIC SCHOOL DISTRICTS IN AMOUNTS PROPORTIONAL TO THEIR PERCENTAGE CONTRIBUTION TO THE STATEWIDE SAVINGS. Any [such excess] amount transferred PURSUANT TO THIS SECTION shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

S 41. Subdivision 5 of section 368-e of the social services law, as amended by section 38 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

5. The commissioner shall evaluate the results of the study conducted pursuant to subdivision three of this section to determine, after identification of actual direct and indirect costs incurred by counties for medical care, services, and supplies furnished to pre-school children with handicapping conditions, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision six of section three hundred sixty-eight-d of this title exceeds one hundred fifty million dollars for the period April 1, 2011 through March 31, 2013, or exceeds one hundred million dollars in state fiscal [year 2012-13 or any fiscal year thereafter] YEARS 2013-14 AND 2014-15, the excess amount shall be transferred to such counties in amounts proportional to their percentage contribution to the statewide savings; AN AMOUNT EQUAL TO THIRTEEN AND FIVE HUNDREDTHS PERCENT OF ANY DECREASE IN THE STATE SHARE OF ANNUAL EXPENDITURES PURSUANT TO THIS SECTION FOR SUCH RECIPIENTS IN STATE FISCAL YEAR 2015-16 AND ANY FISCAL YEAR THEREAFTER SHALL BE TRANSFERRED TO SUCH COUNTIES IN AMOUNTS PROPORTIONAL TO THEIR PERCENTAGE CONTRIBUTION TO THE STATEWIDE SAVINGS. Any [such excess] amount transferred PURSUANT TO THIS SECTION shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

S 42. Subdivision 8 of section 365-a of the social services law, as added by section 46-a of part B of chapter 58 of the laws of 2009, is amended 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, WITHOUT REGARD TO EXPIRATION OF THE PRIOR SERVICE AUTHORIZATION.

S 43. Subparagraph (ii) of paragraph (a) of subdivision 7 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation, AND SUBJECT TO THE PROVISIONS OF SUBDIVISION EIGHT OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW.

S 44. The social services law is amended by adding a new section 398-b to read as follows:

S 398-B. TRANSITION TO MANAGED CARE. 1. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW TO THE CONTRARY AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO MAKE GRANTS FROM A GROSS AMOUNT OF FIVE MILLION DOLLARS TO FACILITATE THE TRANSITION OF FOSTER CARE CHILDREN PLACED WITH VOLUNTARY FOSTER CARE AGENCIES TO MANAGED CARE. THE USE OF SUCH FUNDS MAY INCLUDE PROVIDING TRAINING AND CONSULTING SERVICES TO VOLUNTARY AGENCIES TO ACCESS READINESS AND MAKE NECESSARY INFRASTRUCTURE AND ORGANIZATIONAL MODIFICATIONS, COLLECTING SERVICE UTILIZATION AND OTHER DATA FROM VOLUNTARY AGENCIES AND OTHER ENTITIES, AND MAKING INVESTMENTS IN HEALTH INFORMATION TECHNOLOGY, INCLUDING THE INFRASTRUCTURE NECESSARY TO ESTABLISH AND MAINTAIN ELECTRONIC HEALTH RECORDS. SUCH FUNDS SHALL BE DISTRIBUTED PURSUANT TO A FORMULA TO BE DEVELOPED BY THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE OF FAMILY AND CHILD SERVICES. IN DEVELOPING SUCH FORMULA THE COMMISSIONERS MAY TAKE INTO ACCOUNT SIZE AND SCOPE OF PROVIDER OPERATIONS AS A FACTOR RELEVANT TO ELIGIBILITY FOR SUCH FUNDS. EACH RECIPIENT OF SUCH FUNDS SHALL BE REQUIRED TO DOCUMENT AND DEMONSTRATE THE EFFECTIVE USE OF FUNDS DISTRIBUTED HEREIN.

2. DATA PROVIDED BY VOLUNTARY FOSTER CARE AGENCIES SHALL BE COMPLIANT WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, AND SHALL BE TRANSMITTED SECURELY USING EMEDS OR OTHER MECHANISM TO BE DETERMINED BY THE DEPARTMENT OF HEALTH. SUCH DATA MAY BE USED BY THE DEPARTMENT OF HEALTH TO ESTABLISH RATES OF PAYMENT FOR MANAGED CARE ORGANIZATIONS FOR SERVICES PROVIDED TO CHILDREN IN FOSTER CARE. IN ESTABLISHING SUCH RATES

THE COMMISSIONER OF HEALTH SHALL ALSO TAKE INTO ACCOUNT CARE COORDINATION SERVICES THAT WILL CONTINUE TO BE PROVIDED BY THE VOLUNTARY FOSTER CARE AGENCIES.

3. THE COMMISSIONER OF HEALTH SHALL ISSUE A REPORT TO BE MADE PUBLIC ON THE DEPARTMENT OF HEALTH'S WEBSITE. SUCH REPORT SHALL CONFORM TO THE REQUIREMENTS OF SUBDIVISION FIVE OF SECTION NINETY-TWO OF PART H OF CHAPTER FIFTY-NINE OF THE LAWS OF TWO THOUSAND ELEVEN.

S 45. Subdivision 3 of section 365-n of the social services law, as added by section 6 of part F of chapter 56 of the laws of 2012, is amended to read as follows:

3. Notwithstanding sections sixty-one, sixty-three, seventy, seventy-eight, seventy-nine, eighty-one and [eight-one-a] EIGHTY-ONE-A of the civil service law or any provisions to the contrary contained in any general, special, or local laws, all lawful appointees of a county performing the functions established in subdivision two of this section as of the effective date of this section OR ANY SUCH APPOINTEES WHO MEET THE OPEN COMPETITIVE QUALIFICATIONS FOR POSITIONS ESTABLISHED TO PERFORM THESE FUNCTIONS will be eligible for voluntary transfer to appropriate positions, in the department, that are classified to perform such functions without further examination, qualification, or probationary period; and, upon such transfer, will have all the rights and privileges of the jurisdictional classification to which such positions are allocated in the classified service of the state.

S 46. Section 365-n of the social services law is amended by adding a new subdivision 5-a to read as follows:

5-A. (A) THE COMMISSIONER MAY TAKE NECESSARY ACTION TO REVIEW THE ACCURACY OF DETERMINATIONS OF INITIAL AND ONGOING ELIGIBILITY UNDER THE MEDICAL ASSISTANCE PROGRAM, AND TO IDENTIFY AND ELIMINATE INAPPROPRIATE INSTANCES OF CONCURRENT OR DUPLICATE BENEFITS AND AUTHORIZATIONS. THE COMMISSIONER IS AUTHORIZED TO CONTRACT WITH ONE OR MORE ENTITIES TO ASSIST THE STATE IN IMPLEMENTING THE PROVISIONS OF THIS SUBDIVISION.

(B) NOTWITHSTANDING THE PROVISIONS OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY CONTRARY PROVISION OF LAW, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER PARAGRAPH (A) OF THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, PROVIDED, HOWEVER, THAT:

(I) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(1) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(2) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(3) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(4) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(II) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER; AND

(III) THE COMMISSIONER SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION; AND

(IV) NO CONTRACT ENTERED PURSUANT TO THIS PARAGRAPH SHALL HAVE A TERM THAT ENDS LATER THAN MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

S 47. Subparagraph (iv) of paragraph (e-2) of subdivision 4 of section 2807-c of the public health law is amended by adding a new clause (E) to read as follows:

(E) FOR FACILITIES SUBJECT TO THE PROVISIONS OF THIS SUBPARAGRAPH, THE DEPARTMENT SHALL EXAMINE THE FEASIBILITY OF REIMBURSING SUCH FACILITIES FOR SERVICES PROVIDED TO CHILDREN ELIGIBLE FOR MEDICAL ASSISTANCE ON A NON-FEE-FOR-SERVICE BASIS. FOR PURPOSES OF THIS CLAUSE, "NON-FEE-FOR-SERVICE" SHALL BE DEFINED AS AN ALTERNATIVE PAYMENT METHOD TO BUNDLE CERTAIN SERVICES RENDERED BY SUCH FACILITY, INCLUDING INPATIENT, OUTPATIENT, SPECIALTY OUTPATIENT AND PHYSICIAN SERVICES, IN AMOUNTS DETERMINED BY THE COMMISSIONER. THE DEPARTMENT SHALL EXAMINE:

(A) WHAT SERVICES COULD BE PROVIDED PURSUANT TO THE NON-FEE-FOR-SERVICE BASIS;

(B) HOW TO ENSURE, FOR CHILDREN ENROLLED IN MEDICAID MANAGED CARE, THAT THEIR HEALTH PLANS CAN CONTINUE TO ASSIST IN THE COORDINATION OF THEIR CARE, PARTICULARLY UPON DISCHARGE FROM INPATIENT, OUTPATIENT OR SPECIALTY OUTPATIENT SERVICES; AND

(C) WHETHER INCENTIVES SHOULD BE INCORPORATED FOR MEETING QUALITY BENCHMARKS OR ACHIEVING EFFICIENCIES IN THE DELIVERY AND COORDINATION OF CARE OR WHETHER OTHER MEANS SHOULD BE CONSIDERED TO ACHIEVE THESE OBJECTIVES.

THE DEPARTMENT SHALL PROVIDE A REPORT OF ITS FINDINGS AND RECOMMENDATIONS TO THE GOVERNOR AND LEGISLATURE NO LATER THAN MARCH FIRST, TWO THOUSAND FIFTEEN.

S 48. Notwithstanding sections 112 and 163 of the state finance law, or any other contrary provision of law, the commissioner of health is authorized to negotiate an extension of the terms of the contract executed by the department of health for actuarial and consulting services, on September 18, 2009, without a competitive bid or request for proposal process; provided, however, such extension shall not extend beyond December 31, 2016.

S 49. Section 364-j of the social services law is amended by adding a new subdivision 29 to read as follows:

29. IN THE EVENT THAT THE DEPARTMENT RECEIVES APPROVAL FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES TO AMEND ITS 1115 WAIVER KNOWN AS THE PARTNERSHIP PLAN OR RECEIVES APPROVAL FOR A NEW 1115 WAIVER FOR THE PURPOSE OF REINVESTING SAVINGS RESULTING FROM THE REDESIGN OF THE MEDICAL ASSISTANCE PROGRAM, THE COMMISSIONER IS AUTHORIZED TO ENTER INTO CONTRACTS, AND/OR TO AMEND THE TERMS OF CONTRACTS AWARDED PRIOR TO THE EFFECTIVE DATE OF THIS SUBDIVISION, FOR THE PURPOSE OF ASSISTING THE DEPARTMENT OF HEALTH WITH IMPLEMENTING PROJECTS AUTHORIZED UNDER SUCH WAIVER APPROVAL. NOTWITHSTANDING THE PROVISIONS OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTIONS ONE HUNDRED FORTY-TWO AND ONE HUNDRED FORTY-THREE OF THE ECONOMIC DEVELOPMENT LAW, OR ANY CONTRARY PROVISION OF LAW, CONTRACTS MAY BE ENTERED OR CONTRACT AMENDMENTS MAY BE MADE PURSUANT TO THIS SUBDIVISION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS IF THE TERM OF ANY SUCH CONTRACT OR CONTRACT AMENDMENT DOES NOT EXTEND BEYOND MARCH THIRTY-FIRST, TWO THOUSAND NINETEEN; PROVIDED, HOWEVER, IN THE CASE OF A CONTRACT ENTERED INTO AFTER THE EFFECTIVE DATE OF THIS SUBDIVISION, THAT:

(A) THE DEPARTMENT OF HEALTH SHALL POST ON ITS WEBSITE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(II) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SELECTION, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SEEK SUCH SELECTION, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH; AND

(C) THE COMMISSIONER OF HEALTH SHALL SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN HIS OR HER DISCRETION, ARE BEST SUITED TO SERVE THE PURPOSES OF THIS SECTION.

S 50. Subdivision 1 of section 366 of the social services law is amended by adding a new paragraph (g) to read as follows:

(G) COVERAGE OF CERTAIN NONCITIZENS. (1) APPLICANTS AND RECIPIENTS WHO ARE LAWFULLY ADMITTED FOR PERMANENT RESIDENCE, OR WHO ARE PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW; WHO ARE MAGI ELIGIBLE PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION; AND WHO WOULD BE INELIGIBLE FOR MEDICAL ASSISTANCE COVERAGE UNDER SUBDIVISIONS ONE AND TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE SOLELY DUE TO THEIR IMMIGRATION STATUS IF THE PROVISIONS OF SECTION ONE HUNDRED TWENTY-TWO OF THIS CHAPTER WERE APPLIED, SHALL ONLY BE ELIGIBLE FOR ASSISTANCE UNDER THIS TITLE IF ENROLLED IN A STANDARD HEALTH PLAN OFFERED BY A BASIC HEALTH PROGRAM ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-NINE-GG OF THIS ARTICLE IF SUCH PROGRAM IS ESTABLISHED AND OPERATING.

(2) WITH RESPECT TO A PERSON DESCRIBED IN SUBPARAGRAPH ONE OF THIS PARAGRAPH WHO IS ENROLLED IN A STANDARD HEALTH PLAN, MEDICAL ASSISTANCE COVERAGE SHALL MEAN:

(I) PAYMENT OF REQUIRED PREMIUMS AND OTHER COST-SHARING OBLIGATIONS UNDER THE STANDARD HEALTH PLAN THAT EXCEED THE PERSON'S CO-PAYMENT OBLIGATION UNDER SUBDIVISION SIX OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THIS TITLE; AND

(II) PAYMENT FOR SERVICES AND SUPPLIES DESCRIBED IN SUBDIVISION ONE OR TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE, AS APPLICABLE, BUT ONLY TO THE EXTENT THAT SUCH SERVICES AND SUPPLIES ARE NOT COVERED BY THE STANDARD HEALTH PLAN.

(3) NOTHING IN THIS SUBDIVISION SHALL PREVENT A PERSON DESCRIBED IN SUBPARAGRAPH ONE OF THIS PARAGRAPH FROM QUALIFYING FOR OR RECEIVING MEDICAL ASSISTANCE WHILE HIS OR HER ENROLLMENT IN A STANDARD HEALTH PLAN IS PENDING, IN ACCORDANCE WITH APPLICABLE PROVISIONS OF THIS TITLE.

S 51. The social services law is amended by adding a new section 369-gg to read as follows:

S 369-GG. BASIC HEALTH PROGRAM. 1. DEFINITIONS. FOR PURPOSES OF THIS SECTION:

(A) "ELIGIBLE ORGANIZATION" MEANS AN INSURER LICENSED PURSUANT TO ARTICLE THIRTY-TWO OR FORTY-TWO OF THE INSURANCE LAW, A CORPORATION OR AN ORGANIZATION UNDER ARTICLE FORTY-THREE OF THE INSURANCE LAW, OR AN ORGANIZATION CERTIFIED UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, INCLUDING PROVIDERS CERTIFIED UNDER SECTION FORTY-FOUR HUNDRED THREE-E OF THE PUBLIC HEALTH LAW;

(B) "APPROVED ORGANIZATION" MEANS AN ELIGIBLE ORGANIZATION APPROVED BY THE COMMISSIONER TO UNDERWRITE A BASIC HEALTH INSURANCE PLAN PURSUANT TO THIS TITLE;

(C) "HEALTH CARE SERVICES" MEANS THE SERVICES AND SUPPLIES AS DEFINED BY THE COMMISSIONER IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, AND SHALL BE CONSISTENT WITH AND SUBJECT TO THE ESSENTIAL

HEALTH BENEFITS AS DEFINED BY THE COMMISSIONER IN ACCORDANCE WITH THE PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148) AND CONSISTENT WITH THE BENEFITS PROVIDED BY THE REFERENCE PLAN SELECTED BY THE COMMISSIONER FOR THE PURPOSES OF DEFINING SUCH BENEFITS;

(D) "QUALIFIED HEALTH PLAN" MEANS A HEALTH PLAN THAT MEETS THE CRITERIA FOR CERTIFICATION DESCRIBED IN S 1311(C) OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AND IS OFFERED TO INDIVIDUALS THROUGH THE HEALTH INSURANCE EXCHANGE MARKETPLACE; AND

(E) "BASIC HEALTH INSURANCE PLAN" MEANS A STANDARD HEALTH PLAN, SEPARATE AND APART FROM QUALIFIED HEALTH PLANS, THAT IS ISSUED BY AN APPROVED ORGANIZATION AND CERTIFIED IN ACCORDANCE WITH THIS SECTION.

2. AUTHORIZATION. IF IT IS IN THE FINANCIAL INTEREST OF THE STATE TO DO SO, THE COMMISSIONER OF HEALTH IS AUTHORIZED, WITH THE APPROVAL OF THE DIRECTOR OF THE BUDGET, TO ESTABLISH A BASIC HEALTH PROGRAM. THE COMMISSIONER'S AUTHORITY PURSUANT TO THIS SECTION IS CONTINGENT UPON OBTAINING AND MAINTAINING ALL NECESSARY APPROVALS FROM THE SECRETARY OF HEALTH AND HUMAN SERVICES TO OFFER A BASIC HEALTH PROGRAM IN ACCORDANCE WITH 42 U.S.C. 18051. THE COMMISSIONER MAY TAKE ANY AND ALL ACTIONS NECESSARY TO OBTAIN SUCH APPROVALS.

3. ELIGIBILITY. A PERSON IS ELIGIBLE TO RECEIVE COVERAGE FOR HEALTH CARE SERVICES PURSUANT TO THIS TITLE IF HE OR SHE:

(A) RESIDES IN NEW YORK STATE AND IS UNDER SIXTY-FIVE YEARS OF AGE;

(B) IS NOT ELIGIBLE FOR MEDICAL ASSISTANCE UNDER TITLE ELEVEN OF THIS ARTICLE OR FOR THE CHILD HEALTH INSURANCE PLAN DESCRIBED IN TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW;

(C) IS NOT ELIGIBLE FOR MINIMUM ESSENTIAL COVERAGE, AS DEFINED IN SECTION 5000A(F) OF THE INTERNAL REVENUE SERVICE CODE OF 1986, OR IS ELIGIBLE FOR AN EMPLOYER-SPONSORED PLAN THAT IS NOT AFFORDABLE, IN ACCORDANCE WITH SECTION 5000A OF SUCH CODE; AND

(D) (I) HAS HOUSEHOLD INCOME AT OR BELOW TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A HOUSEHOLD OF THE SAME SIZE; AND (II) HAS HOUSEHOLD INCOME THAT EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A HOUSEHOLD OF THE SAME SIZE; HOWEVER, MAGI ELIGIBLE ALIENS LAWFULLY PRESENT IN THE UNITED STATES WITH HOUSEHOLD INCOMES AT OR BELOW ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE SHALL BE ELIGIBLE TO RECEIVE COVERAGE FOR HEALTH CARE SERVICES PURSUANT TO THE PROVISIONS OF THIS TITLE IF SUCH ALIEN WOULD BE INELIGIBLE FOR MEDICAL ASSISTANCE UNDER TITLE ELEVEN OF THIS ARTICLE DUE TO HIS OR HER IMMIGRATION STATUS.

AN APPLICANT WHO FAILS TO MAKE AN APPLICABLE PREMIUM PAYMENT SHALL LOSE ELIGIBILITY TO RECEIVE COVERAGE FOR HEALTH CARE SERVICES IN ACCORDANCE WITH TIME FRAMES AND PROCEDURES DETERMINED BY THE COMMISSIONER.

4. ENROLLMENT. (A) SUBJECT TO FEDERAL APPROVAL, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH AN APPLICATION AND ENROLLMENT PROCEDURE FOR PROSPECTIVE ENROLLEES. SUCH PROCEDURE SHALL INCLUDE A VERIFICATION SYSTEM FOR APPLICANTS, WHICH SHALL BE CONSISTENT WITH 42 USC S 1320B-7.

(B) SUCH PROCEDURE SHALL ALLOW FOR CONTINUOUS ENROLLMENT FOR ENROLLEES TO THE BASIC HEALTH PROGRAM WHERE AN INDIVIDUAL MAY APPLY AND ENROLL FOR COVERAGE AT ANY POINT.

(C) UPON AN APPLICANT'S ENROLLMENT IN A BASIC HEALTH INSURANCE PLAN, COVERAGE FOR HEALTH CARE SERVICES PURSUANT TO THE PROVISIONS OF THIS TITLE SHALL BE PROSPECTIVE. COVERAGE SHALL BEGIN IN A MANNER CONSISTENT WITH THE REQUIREMENTS FOR QUALIFIED HEALTH PLANS OFFERED THROUGH THE

HEALTH INSURANCE EXCHANGE MARKETPLACE, AS DELINEATED IN FEDERAL REGULATION AT 42 CFR 155.420(B)(1) OR ANY SUCCESSOR REGULATION THEREOF.

(D) A PERSON WHO HAS ENROLLED FOR COVERAGE PURSUANT TO THIS TITLE, AND WHO LOSES ELIGIBILITY TO ENROLL IN THE BASIC HEALTH PROGRAM FOR A REASON OTHER THAN CITIZENSHIP STATUS, LACK OF STATE RESIDENCE, FAILURE TO PROVIDE A VALID SOCIAL SECURITY NUMBER, PROVIDING INACCURATE INFORMATION THAT WOULD AFFECT ELIGIBILITY WHEN REQUESTING OR RENEWING HEALTH COVERAGE PURSUANT TO THIS TITLE, OR FAILURE TO MAKE AN APPLICABLE PREMIUM PAYMENT, BEFORE THE END OF A TWELVE MONTH PERIOD BEGINNING ON THE EFFECTIVE DATE OF THE PERSON'S INITIAL ELIGIBILITY FOR COVERAGE, OR BEFORE THE END OF A TWELVE MONTH PERIOD BEGINNING ON THE DATE OF ANY SUBSEQUENT DETERMINATION OF ELIGIBILITY, SHALL HAVE HIS OR HER ELIGIBILITY FOR COVERAGE CONTINUED UNTIL THE END OF SUCH TWELVE MONTH PERIOD, PROVIDED THAT THE STATE RECEIVES FEDERAL APPROVAL FOR USING FUNDS FROM THE BASIC HEALTH PROGRAM TRUST FUND, ESTABLISHED UNDER SECTION 97-OOOO OF THE STATE FINANCE LAW, FOR THE COSTS ASSOCIATED WITH SUCH ASSISTANCE.

5. PREMIUMS AND COST SHARING. (A) SUBJECT TO FEDERAL APPROVAL, THE COMMISSIONER SHALL ESTABLISH PREMIUM PAYMENTS ENROLLEES SHALL PAY TO APPROVED ORGANIZATIONS FOR COVERAGE OF HEALTH CARE SERVICES PURSUANT TO THIS TITLE. SUCH PREMIUM PAYMENTS SHALL BE ESTABLISHED IN THE FOLLOWING MANNER:

(I) UP TO TWENTY DOLLARS MONTHLY FOR AN INDIVIDUAL WITH A HOUSEHOLD INCOME ABOVE ONE HUNDRED AND FIFTY PERCENT OF THE FEDERAL POVERTY LINE BUT AT OR BELOW TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A HOUSEHOLD OF THE SAME SIZE; AND

(II) NO PAYMENT IS REQUIRED FOR INDIVIDUALS WITH A HOUSEHOLD INCOME AT OR BELOW ONE HUNDRED AND FIFTY PERCENT OF THE FEDERAL POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR A HOUSEHOLD OF THE SAME SIZE.

(B) THE COMMISSIONER SHALL ESTABLISH COST SHARING OBLIGATIONS FOR ENROLLEES, SUBJECT TO FEDERAL APPROVAL.

6. ANY FUNDS TRANSFERRED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES TO THE STATE PURSUANT TO 42 U.S.C. 18051(D) SHALL BE DEPOSITED IN TRUST. FUNDS FROM THE TRUST SHALL BE USED FOR PROVIDING HEALTH BENEFITS THROUGH AN APPROVED ORGANIZATION, WHICH, AT A MINIMUM, SHALL INCLUDE ESSENTIAL HEALTH BENEFITS AS DEFINED IN 42 U.S.C. 18022(B); TO REDUCE THE PREMIUMS AND COST SHARING OF PARTICIPANTS IN THE BASIC HEALTH PROGRAM; OR FOR SUCH OTHER PURPOSES AS MAY BE ALLOWED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES. HEALTH BENEFITS AVAILABLE THROUGH THE BASIC HEALTH PROGRAM SHALL BE PROVIDED BY ONE OR MORE APPROVED ORGANIZATIONS PURSUANT TO AN AGREEMENT WITH THE DEPARTMENT OF HEALTH AND SHALL MEET THE REQUIREMENTS OF APPLICABLE FEDERAL AND STATE LAWS AND REGULATIONS.

7. AN INDIVIDUAL WHO IS LAWFULLY ADMITTED FOR PERMANENT RESIDENCE OR PERMANENTLY RESIDING IN THE UNITED STATES UNDER COLOR OF LAW, AND WHO WOULD BE INELIGIBLE FOR MEDICAL ASSISTANCE UNDER TITLE ELEVEN OF THIS ARTICLE DUE TO HIS OR HER IMMIGRATION STATUS IF THE PROVISIONS OF SECTION ONE HUNDRED TWENTY-TWO OF THIS CHAPTER WERE APPLIED, SHALL BE CONSIDERED TO BE INELIGIBLE FOR MEDICAL ASSISTANCE FOR PURPOSES OF PARAGRAPHS (B) AND (C) OF SUBDIVISION THREE OF THIS SECTION.

S 52. Subparagraph 2 of paragraph (e) of subdivision 3 of section 367-a of the social services law, as added by section 16 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(2) Payment pursuant to this paragraph shall be for premium obligations of the individual under the qualified health plan and shall continue only if and for so long as the individual's MAGI household

income exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size, OR, IF EARLIER, UNTIL THE INDIVIDUAL IS ELIGIBLE FOR ENROLLMENT IN A STANDARD HEALTH PLAN PURSUANT TO SECTION THREE HUNDRED SIXTY-NINE-GG OF THIS ARTICLE.

S 53. The state finance law is amended by adding a new section 97-oooo to read as follows:

S 97-OOOO. BASIC HEALTH PROGRAM TRUST FUND. 1. THERE IS HEREBY ESTABLISHED IN THE JOINT CUSTODY OF THE COMPTROLLER AND THE COMMISSIONER OF TAXATION AND FINANCE A FUND, TO BE KNOWN AS THE "BASIC HEALTH PROGRAM TRUST FUND".

2. SUCH FUND SHALL CONSIST OF MONEYS TRANSFERRED FROM THE FEDERAL GOVERNMENT PURSUANT TO 42 U.S.C. S 18051(D) FOR THE PURPOSE OF REDUCING THE PREMIUMS AND COST-SHARING OF, OR PROVIDING BENEFITS FOR, ELIGIBLE INDIVIDUALS ENROLLED IN THE BASIC HEALTH PROGRAM, ESTABLISHED PURSUANT TO SECTION THREE HUNDRED SIXTY-NINE-GG OF THE SOCIAL SERVICES LAW.

3. UPON FEDERAL APPROVAL, ALL MONIES IN SUCH FUND SHALL BE USED TO IMPLEMENT AND OPERATE THE BASIC HEALTH PLAN, PURSUANT TO SECTION THREE HUNDRED SIXTY-NINE-GG OF THE SOCIAL SERVICES LAW, EXCEPT TO THE EXTENT THAT THE PROVISIONS OF SUCH SECTION CONFLICT OR ARE INCONSISTENT WITH FEDERAL LAW, IN WHICH CASE THE PROVISIONS OF SUCH FEDERAL LAW SHALL SUPERSEDE SUCH STATE LAW PROVISIONS.

S 54. The state finance law is amended by adding a new section 97-xxxx to read as follows:

S 97-XXXX. STATE HEALTH INNOVATION PLAN ACCOUNT. 1. THERE IS HEREBY ESTABLISHED IN THE JOINT CUSTODY OF THE STATE COMPTROLLER AND THE COMMISSIONER OF THE DEPARTMENT OF HEALTH AN ACCOUNT OF THE MISCELLANEOUS SPECIAL REVENUE FUND TO BE KNOWN AS THE STATE HEALTH INNOVATION PLAN ACCOUNT.

2. NOTWITHSTANDING ANY OTHER LAW, RULE OR REGULATION TO THE CONTRARY, THE STATE COMPTROLLER IS HEREBY AUTHORIZED AND DIRECTED TO RECEIVE FOR DEPOSIT TO THE CREDIT OF THE STATE HEALTH INNOVATION PLAN ACCOUNT, MONIES RECEIVED PURSUANT TO THE STATE INNOVATION MODEL INITIATIVE FROM THE CENTERS FOR MEDICARE AND MEDICAID INNOVATION.

3. MONEYS OF THIS ACCOUNT, FOLLOWING APPROPRIATION BY THE LEGISLATURE, SHALL BE AVAILABLE TO THE DEPARTMENT OF HEALTH FOR SERVICES AND EXPENSES OF THE STATE HEALTH INNOVATION PLAN.

S 55. Section 364-i of the social services law is amended by adding a new subdivision 8 to read as follows:

8. (A) THE FOLLOWING INDIVIDUALS SHALL BE PRESUMED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE BEGINNING ON THE DATE THAT A QUALIFIED HOSPITAL, AS DEFINED IN PARAGRAPH (B) OF THIS SUBDIVISION, DETERMINES, ON THE BASIS OF PRELIMINARY INFORMATION, THAT:

(1) A CHILD HAS MAGI HOUSEHOLD INCOME THAT DOES NOT EXCEED THE APPLICABLE LEVEL FOR ELIGIBILITY AS PROVIDED FOR PURSUANT TO SUBPARAGRAPH TWO OR THREE OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(2) A PREGNANT WOMAN HAS MAGI HOUSEHOLD INCOME THAT DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE;

(3) A PARENT OR CARETAKER RELATIVE HAS MAGI HOUSEHOLD INCOME THAT DOES NOT EXCEED THE MAGI-EQUIVALENT 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, OR HAS NET AVAILABLE INCOME, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE

RELATIVES, THAT DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(4) AN INDIVIDUAL IN NEED OF TREATMENT OF BREAST, CERVICAL, COLON, OR PROSTATE CANCER MEETS THE REQUIREMENTS OF PARAGRAPH (D) OR (E) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(5) AN INDIVIDUAL AGE NINETEEN OR OLDER AND UNDER AGE SIXTY-FIVE MEETS THE REQUIREMENTS OF SUBPARAGRAPH ONE OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(6) AN INDIVIDUAL UNDER TWENTY-SIX YEARS OF AGE MEETS THE REQUIREMENTS OF SUBPARAGRAPH NINE OF PARAGRAPH (C) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE; AND

(7) AN INDIVIDUAL HAS INCOME THAT DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, AND THE INDIVIDUAL MEETS THE REQUIREMENTS OF SUBPARAGRAPH SIX OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE; COVERAGE PURSUANT TO THIS SUBPARAGRAPH SHALL BE LIMITED TO FAMILY PLANNING SERVICES REIMBURSED BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT.

(B) FOR THE PURPOSES OF THIS SUBDIVISION, "QUALIFIED HOSPITAL" MEANS A HOSPITAL THAT:

(1) IS LICENSED AS A GENERAL HOSPITAL UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW;

(2) IS ENROLLED AS A PROVIDER IN THE PROGRAM OF MEDICAL ASSISTANCE UNDER THIS TITLE;

(3) HAS NOTIFIED THE DEPARTMENT OF HEALTH OF ITS ELECTION TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS UNDER THIS SUBDIVISION, AND AGREES TO MAKE SUCH DETERMINATIONS IN ACCORDANCE WITH POLICIES AND PROCEDURES ESTABLISHED BY THE DEPARTMENT;

(4) HAS BEEN DESIGNATED BY THE DEPARTMENT OF HEALTH AS A CERTIFIED APPLICATION COUNSELOR TO PROVIDE INFORMATION TO INDIVIDUALS CONCERNING QUALIFIED HEALTH PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE AND OTHER INSURANCE AFFORDABILITY PROGRAMS, ASSIST INDIVIDUALS TO APPLY FOR COVERAGE THROUGH A QUALIFIED HEALTH PLAN OR INSURANCE AFFORDABILITY PROGRAM, AND HELP FACILITATE THE ENROLLMENT OF ELIGIBLE INDIVIDUALS IN SUCH PLANS OR PROGRAMS; AND

(5) HAS NOT BEEN DISQUALIFIED BY THE DEPARTMENT OF HEALTH PURSUANT TO PARAGRAPH (C) OF THIS SUBDIVISION.

(C) THE DEPARTMENT OF HEALTH MAY DISQUALIFY A HOSPITAL AS A QUALIFIED HOSPITAL IF THE DEPARTMENT DETERMINES THAT THE HOSPITAL IS NOT:

(1) MAKING, OR IS NOT CAPABLE OF MAKING, PRESUMPTIVE ELIGIBILITY DETERMINATIONS IN ACCORDANCE WITH THE POLICIES AND PROCEDURES ESTABLISHED BY THE DEPARTMENT; OR

(2) MEETING SUCH STANDARDS AS MAY BE ESTABLISHED BY THE DEPARTMENT WITH RESPECT TO THE PROPORTION OF INDIVIDUALS DETERMINED PRESUMPTIVELY ELIGIBLE BY THE HOSPITAL WHO ARE FOUND BY THE MEDICAL ASSISTANCE PROGRAM TO BE ELIGIBLE FOR ONGOING MEDICAL ASSISTANCE AFTER THE END OF THE PRESUMPTIVE ELIGIBILITY PERIOD.

(D) CARE, SERVICES AND SUPPLIES, AS SET FORTH IN SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE, THAT ARE FURNISHED TO AN INDIVIDUAL DURING A PRESUMPTIVE ELIGIBILITY PERIOD UNDER THIS SUBDIVISION BY AN ENTITY THAT IS ELIGIBLE FOR PAYMENTS UNDER THIS TITLE SHALL BE DEEMED TO BE MEDICAL ASSISTANCE FOR PURPOSES OF PAYMENT AND STATE REIMBURSEMENT.

S 56. Subdivision 1 of section 366 of the social services law is amended by adding a new paragraph (f) to read as follows:

(F) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS TITLE, FOR AN INDIVIDUAL WHO HAS INCOME IN EXCESS OF AN APPLICABLE INCOME ELIGIBILITY

STANDARD AND IS ALLOWED TO ACHIEVE ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS TITLE BY INCURRING MEDICAL EXPENSES EQUAL TO THE AMOUNT OF SUCH EXCESS INCOME, THE AMOUNT OF EXCESS INCOME MAY BE CALCULATED BY COMPARING THE INDIVIDUAL'S MAGI HOUSEHOLD INCOME TO THE MAGI-EQUIVALENT OF THE APPLICABLE INCOME ELIGIBILITY STANDARD; PROVIDED, HOWEVER, THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS PARAGRAPH ONLY IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE THEREFOR. THE COMMISSIONER OF HEALTH SHALL MAKE ANY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE, OR APPLY FOR ANY WAIVER OR APPROVAL UNDER THE FEDERAL SOCIAL SECURITY ACT THAT ARE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS PARAGRAPH.

S 56-a. Section 364-j of the social services law is amended by adding a new subdivision 30 to read as follows:

30. NOTWITHSTANDING THE PROVISIONS OF SECTION ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTIONS ONE HUNDRED FORTY-TWO AND ONE HUNDRED FORTY-THREE OF THE ECONOMIC DEVELOPMENT LAW, OR ANY CONTRARY PROVISION OF LAW, IN THE EVENT THAT THE STATE RECEIVES PRIOR APPROVAL AND ENHANCED FINANCIAL PARTICIPATION FROM THE CENTERS FOR MEDICAID AND MEDICARE SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES AND THE FEDERAL FOOD AND NUTRITION SERVICES FOR REIMBURSEMENT PURSUANT TO AN A-87 COST ALLOCATION WAIVER FOR ENHANCED FUNDING FOR INTEGRATED ELIGIBILITY SYSTEMS, THE STATE IS AUTHORIZED TO ENTER INTO CONTRACTS, AND/OR TO AMEND THE TERMS OF CONTRACTS AWARDED PRIOR TO THE EFFECTIVE DATE OF THIS SUBDIVISION, WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, CONSISTENT WITH FEDERAL REQUIREMENTS, FOR THE PURPOSE OF IMPLEMENTING PROJECTS AUTHORIZED UNDER SUCH WAIVER AMENDMENT; PROVIDED, HOWEVER, IN THE CASE OF A CONTRACT ENTERED INTO AFTER THE EFFECTIVE DATE OF THIS SUBDIVISION, THAT:

(A) THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE AND THE OFFICE OF GENERAL SERVICES, OR ANOTHER STATE AGENCY, SHALL POST ON ITS WEBSITE AND CONCURRENTLY PROVIDE TO THE CHAIR OF THE SENATE HEALTH COMMITTEE AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE, FOR A PERIOD OF NO LESS THAN THIRTY DAYS:

(I) A DESCRIPTION OF THE PROPOSED SERVICES TO BE PROVIDED PURSUANT TO THE CONTRACT OR CONTRACTS;

(II) THE CRITERIA FOR SELECTION OF A CONTRACTOR OR CONTRACTORS;

(III) THE PERIOD OF TIME DURING WHICH A PROSPECTIVE CONTRACTOR MAY SUBMIT AN OFFER, WHICH SHALL BE NO LESS THAN THIRTY DAYS AFTER SUCH INFORMATION IS FIRST POSTED ON THE WEBSITE; AND

(IV) THE MANNER BY WHICH A PROSPECTIVE CONTRACTOR MAY SUBMIT AN OFFER, WHICH MAY INCLUDE SUBMISSION BY ELECTRONIC MEANS;

(B) ALL RESPONSIVE AND REASONABLE OFFERS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF TEMPORARY AND DISABILITY ASSISTANCE OR OTHER STATE AGENCY; AND

(C) THE COMMISSIONERS OF THE DEPARTMENT OF HEALTH, THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE AND THE OFFICE OF CHILDREN AND FAMILY SERVICES, WORKING IN COOPERATION WITH THE STATE CHIEF INFORMATION OFFICER AND THE OFFICE OF GENERAL SERVICES, SHALL AWARD SUCH CONTRACT TO THE CONTRACTOR OR CONTRACTORS OFFER THAT PROVIDES THE BEST VALUE AS SUCH TERM IS DEFINED IN SECTION ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, TO THE STATE. AT NOTIFICATION THE COMMISSIONER OF HEALTH SHALL PROVIDE THIS INFORMATION TO THE CHAIR OF THE SENATE STANDING HEALTH COMMITTEE AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE.

(D) ALL DECISIONS MADE AND APPROACHES TAKEN PURSUANT TO THIS SUBDIVISION SHALL BE DOCUMENTED IN A PROCUREMENT RECORD AS DEFINED IN SECTION ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW.

(E) IN ACCORDANCE WITH ALL FEDERAL ADVANCE PLANNING DOCUMENT GUIDANCE AND WITHIN THE PARAMETERS ESTABLISHED BY THE ENHANCED FINANCIAL PARTICIPATION FROM THE CENTERS FOR MEDICAID AND MEDICARE SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES AND THE FEDERAL FOOD AND NUTRITION SERVICES FOR REIMBURSEMENT TO AN A-87 COST ALLOCATION WAIVER FOR ENHANCED FUNDING FOR INTEGRATED ELIGIBILITY SYSTEMS, PHASE 1 WILL INCLUDE FOUNDATIONAL ALLOWABLE SHARED SERVICE COMPONENTS REQUIRED TO SUCCESSFULLY MEET THE REQUIREMENTS FOR NON-MAGI MEDICAID SUCH AS A COMMON CLIENT PORTAL, DOCUMENT MANAGEMENT, RULES ENGINES, WORKFLOW MANAGEMENT TOOLS, CASE MANAGEMENT, NOTICES AND TRAINING.

(F) THE CONTRACT WILL REQUIRE TRAINING TO BE PROVIDED AT NO COST TO THE SOCIAL SERVICES DISTRICTS.

(G) THE CONTRACT SHALL REQUIRE THE COMPLETION OF SHARED SERVICE COMPONENTS BY THE TIMELINES NECESSARY TO RECEIVE THE ENHANCED FINANCIAL PARTICIPATION FROM THE CENTERS FOR MEDICAID AND MEDICARE SERVICES, ADMINISTRATION FOR CHILDREN AND FAMILIES AND THE FEDERAL FOOD AND NUTRITION SERVICES FOR REIMBURSEMENT TO AN A-87 COST ALLOCATION WAIVER.

(H) THE COMMISSIONER SHALL PROVIDE, WITHIN THIRTY DAYS OF AWARD OF SUCH CONTRACT OR CONTRACTS, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE WITH A REPORT OUTLINING THE PROCUREMENT AND AWARDS.

S 57. Subdivision 8 of section 2511 of the public health law is amended by adding a new paragraph (h) to read as follows:

(H) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS TITLE, ARTICLES THIRTY-TWO AND FORTY-THREE OF THE INSURANCE LAW AND SUBSECTION (E) OF SECTION ELEVEN HUNDRED TWENTY OF THE INSURANCE LAW, FOR THE PERIOD APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, SUBSIDY PAYMENTS MADE TO APPROVED ORGANIZATIONS SHALL BE AT AMOUNTS APPROVED PRIOR TO APRIL FIRST, TWO THOUSAND FOURTEEN.

S 58. Article 29-A of the public health law is amended by adding a new title 1-A to read as follows:

TITLE 1-A

RURAL DENTISTRY PILOT PROGRAM

SECTION 2958-A. RURAL DENTISTRY PILOT PROGRAM.

S 2958-A. RURAL DENTISTRY PILOT PROGRAM. 1. THE COMMISSIONER SHALL, WITHIN MONIES APPROPRIATED THEREFORE, ESTABLISH A RURAL DENTISTRY PILOT PROGRAM IN CHAUTAUQUA, ALLEGANY, AND CATTARAUGUS COUNTIES. THE COMMISSIONER SHALL, IN COORDINATION WITH THE UNIVERSITY OF BUFFALO SCHOOL OF DENTISTRY STUDY COST SAVINGS ACHIEVED THROUGH THE PROVISION OF DENTAL SERVICES IN GEOGRAPHICALLY ISOLATED AND UNDERSERVED AREAS. SUCH A STUDY SHALL DETERMINE:

(I) THE QUALITY OF CARE PROVIDED THROUGH A MOBILE DENTAL SYSTEM, INCLUDING MINIMIZING ANY ADVERSE EFFECTS ON DENTAL PRACTICES ALREADY SERVING OR SEEKING TO ENTER RURAL OR UNDERSERVED COMMUNITIES, THE INVOLVEMENT OF DENTAL PRACTICES SERVING RURAL OR UNDERSERVED COMMUNITIES IN SUCH A MOBILE DENTAL SYSTEM, AND THE ESTABLISHMENT OF REFERRAL SYSTEMS AND NETWORKS TO EXISTING DENTAL PRACTICES SERVING RURAL OR UNDERSERVED COMMUNITIES FOR REGULAR ONGOING CARE OF PATIENTS;

(II) COST SAVINGS ACHIEVED THROUGH TARGETED ORAL HEALTH INITIATIVES IN RURAL AREAS;

(III) COROLLARIES BETWEEN PREVENTATIVE DENTAL CARE AND IMPROVED PATIENT OUTCOMES IN RURAL AREAS;

(IV) KNOWLEDGE, ATTITUDE, AND BEHAVIOR OUTCOMES AMONG DENTAL STUDENTS AND RECOMMENDATIONS FOR RURAL DENTAL HEALTH EDUCATION CURRICULUM;

(V) A PROFILE OF THE PARTICIPANTS, THE NUMBER OF PERSONS SERVED, AND HEALTH CARE DISPARITIES;

(VI) A DESCRIPTION OF THE ACTIVITIES OF THE PROGRAM;

(VII) GUIDANCE ON FACILITATED PARTICIPATION IN RURAL AREAS;

(VIII) PROVIDER SHORTAGES IN RURAL AREAS;

(IX) A DESCRIPTION OF THE IMPACT OF THE PROGRAMS ON THE COMMUNITY AND RECOMMENDATIONS FOR REPLICATION/IMPROVEMENT IN OTHER RURAL AREAS; AND

(X) SUCH OTHER ACTIVITIES AS THE COMMISSIONER MAY DEEM NECESSARY AND APPROPRIATE TO THIS SECTION.

2. TWELVE MONTHS AFTER THE APPROVAL OF THE RURAL DENTISTRY PILOT PROGRAM, AND ANNUALLY THEREAFTER, THE PROGRAM SHALL REPORT TO THE COMMISSIONER ON THE PROGRESS OF THE PROGRAM. THE COMMISSIONER SHALL EVALUATE THE FINDINGS OF THE STUDY AND REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE AND THE CHAIR OF THE LEGISLATIVE COMMISSION ON RURAL RESOURCES ON ITS FINDINGS.

3. ADDITIONALLY, TO THE EXTENT OF FUNDS APPROPRIATED THEREFORE, MEDICAL ASSISTANCE FUNDS, INCLUDING ANY FUNDING OR SHARED SAVINGS AS MAY BECOME AVAILABLE THROUGH FEDERAL WAIVERS OR OTHERWISE UNDER TITLES EIGHTEEN AND NINETEEN OF THE FEDERAL SOCIAL SECURITY ACT, MAY BE USED FOR EXPENDITURES IN SUPPORT OF THE DEMONSTRATION PROGRAM.

4. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW TO THE CONTRARY, THE COMMISSIONER IS AUTHORIZED TO WAIVE, MODIFY OR SUSPEND THE PROVISIONS OF RULES AND REGULATIONS PROMULGATED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER IF THE COMMISSIONER DETERMINES THAT SUCH WAIVER, MODIFICATION OR SUSPENSION IS NECESSARY FOR THE SUCCESSFUL IMPLEMENTING OF THE RURAL DENTISTRY PILOT PROGRAM AUTHORIZED PURSUANT TO THIS SECTION AND PROVIDED THAT THE COMMISSIONER DETERMINES THAT THE HEALTH, SAFETY AND GENERAL WELFARE OF PEOPLE RECEIVING HEALTH CARE UNDER SUCH RURAL DENTISTRY PILOT PROGRAM WILL NOT BE IMPAIRED AS A RESULT OF SUCH WAIVER, MODIFICATION, OR SUSPENSION.

S 59. Paragraph (d) of subdivision 2 of section 2511 of the public health law is REPEALED.

S 60. Subparagraphs (iv) and (v) of paragraph (b) of subdivision 9 of section 2511 of the public health law, subparagraph (iv) as amended by section 33 of part D of chapter 56 of the laws of 2013 and subparagraph (v) as amended by chapter 2 of the laws of 1998, are amended to read as follows:

(iv) outstationing of persons who are authorized to provide assistance to families in completing the enrollment application process under this title and title eleven of article five of the social services law, in locations, such as community settings, which are geographically accessible to large numbers of children who may be eligible for benefits under such titles, and at times, including evenings and weekends, when large numbers of children who may be eligible for benefits under such titles are likely to be encountered. Persons outstationed in accordance with this subparagraph shall be authorized to make determinations of presumptive eligibility in accordance with paragraph [(g)] (F) of subdivision two of THIS section [two thousand five hundred and eleven of this title]; and

(v) notice by local social services districts to medical assistance applicants of the availability of benefits under paragraph [(g)] (F) of

subdivision two of THIS section [two thousand five hundred and eleven of this title].

S 61. Subdivisions 3, 4 and 5 of section 47 of chapter 2 of the laws of 1998, amending the public health law and other laws relating to expanding the child health insurance plan, as amended by section 19 of part D of chapter 59 of the laws of 2011, are amended to read as follows:

3. section six of this act shall take effect January 1, 1999; provided, however, that subparagraph (iii) of paragraph (c) of subdivision 9 of section 2510 of the public health law, as added by this act, shall expire on July 1, [2014] 2017;

4. sections two, three, four, seven, eight, nine, fourteen, fifteen, sixteen, eighteen, eighteen-a, [twenty-three,] twenty-four, and twenty-nine of this act shall take effect January 1, 1999 and SECTION EIGHTEEN-A shall expire on July 1, 2014; section twenty-five of this act shall take effect on January 1, 1999 and shall expire on April 1, 2005;

5. section twelve of this act shall take effect January 1, 1999; provided, however, paragraphs (g) and (h) of subdivision 2 of section 2511 of the public health law, as added by such section, shall expire on July 1, [2014] 2017;

S 62. The opening paragraph of subparagraph (ii) of paragraph (a) of subdivision 2 of section 369 of the social services law, as amended by chapter 41 of the laws of 1992, is amended to read as follows:

with respect to the real property of an individual who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, [and] who is not reasonably expected to be discharged from the medical institution and to return home, AND WHO IS REQUIRED, AS A CONDITION OF RECEIVING SERVICES IN SUCH INSTITUTION UNDER THE STATE PLAN FOR MEDICAL ASSISTANCE, TO SPEND FOR COSTS OF MEDICAL CARE ALL BUT A MINIMAL AMOUNT OF HIS OR HER INCOME REQUIRED FOR PERSONAL NEEDS; provided, however, any such lien will dissolve upon the individual's discharge from the medical institution and return home; in addition, no such lien may be imposed on the individual's home if one of the following persons is lawfully residing in the home:

S 62-a. Subparagraph (i) of paragraph (b) of subdivision 2 of section 369 of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

(i) Notwithstanding any inconsistent provision of this chapter or other law, no adjustment or recovery may be made against the property of any individual on account of any medical assistance correctly paid to or on behalf of an individual under this title, except that recoveries must be pursued:

(A) upon the sale of the property subject to a lien imposed on account of medical assistance paid to an individual described in clause (ii) of paragraph (a) of this subdivision, or from the estate of such individual; and

(B) from the estate of an individual who was fifty-five years of age or older when he or she received such assistance, PROVIDED THAT FOR INDIVIDUALS WHOSE ELIGIBILITY FOR MEDICAL ASSISTANCE WAS BASED ON PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE, RECOVERY SHALL BE LIMITED TO MEDICAL ASSISTANCE CONSISTING OF NURSING FACILITY SERVICES, HOME AND COMMUNITY-BASED SERVICES, AND RELATED HOSPITAL AND PRESCRIPTION DRUG SERVICES.

S 63. Section 4 of chapter 779 of the laws of 1986, amending the social services law relating to authorizing services for non-residents

in adult homes, residences for adults and enriched housing programs, as amended by chapter 108 of the laws of 2011, is amended to read as follows:

S 4. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall remain in full force and effect until July 1, [2014] 2017, provided however, that effective immediately, the addition, amendment and/or repeal of any rules or regulations necessary for the implementation of the foregoing sections of this act on its effective date are authorized and directed to be made and completed on or before such effective date.

S 64. Subdivision (i-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, as amended by section 21 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(i-1) section thirty-one-a of this act shall be deemed repealed July 1, [2014] 2017;

S 65. Section 4 of chapter 19 of the laws of 1998, amending the social services law relating to limiting the method of payment for prescription drugs under the medical assistance program, as amended by section 107 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 4. This act shall take effect 120 days after it shall have become a law and shall expire and be deemed repealed March 31, [2014] 2017.

S 66. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 63 of part A of chapter 56 of the laws of 2013, 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, and for the state fiscal year beginning April first, two thousand ten and for the state fiscal year beginning April first, two thousand eleven, and for the state fiscal years beginning April first, two thousand twelve and April first, two thousand thirteen, AND OF UP TO FIVE HUNDRED MILLION DOLLARS IN SUCH AGGREGATE ANNUAL ADDITIONAL PAYMENTS FOR THE STATE FISCAL YEARS BEGINNING APRIL FIRST, TWO THOUSAND FOURTEEN, APRIL FIRST, TWO THOUSAND FIFTEEN AND APRIL FIRST, TWO THOUSAND SIXTEEN. 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, and provided further, however, that, in consultation with impacted providers, of the funds allocated for distribution in the state fiscal year beginning

April first, two thousand thirteen, up to thirty-two million dollars may be allocated in accordance with paragraph (f-1) of this subdivision.

S 67. Paragraph (i) of subdivision 3 of section 461-1 of the social services law, as amended by section 4 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

(i) (A) 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. 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] SEVEN year plan ENDING PRIOR TO JANUARY FIRST, TWO THOUSAND SEVENTEEN.

(B) THE COMMISSIONER OF HEALTH SHALL PROVIDE AN ANNUAL WRITTEN REPORT TO THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE NO LATER THAN JANUARY FIRST OF EACH YEAR. SUCH REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NUMBER OF ASSISTED LIVING PROGRAM BEDS MADE AVAILABLE PURSUANT TO THIS SECTION BY COUNTY, THE TOTAL NUMBER OF ASSISTED LIVING PROGRAM BEDS BY COUNTY, THE NUMBER OF VACANT ASSISTED LIVING PROGRAM BEDS BY COUNTY, AND ANY OTHER INFORMATION DEEMED NECESSARY AND APPROPRIATE.

S 67-a. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 7 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand [fourteen] FIFTEEN, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand [fourteen] FIFTEEN and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [fourteen] FIFTEEN; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [fourteen] FIFTEEN, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable method-

ologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

S 67-b. Paragraph (b) of subdivision 1 of section 76 of chapter 731 of the laws of 1993, amending the public health law and other laws relating to reimbursement, delivery and capital cost of ambulatory health care services and inpatient hospital services, as amended by section 28 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

(b) sections fifteen through nineteen and subdivision 3 of section 2807-e of the public health law as added by section twenty of this act shall expire on July 1, [2014] 2017, and section seventy-four of this act shall expire on July 1, 2007;

S 67-c. Section 18 of chapter 904 the laws of 1984, amending the public health law and the social services law relating to encouraging comprehensive health services, as amended by section 21 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

S 18. This act shall take effect immediately, except that sections six, nine, ten and eleven of this act shall take effect on the sixtieth day after it shall have become a law, sections two, three, four and nine of this act shall expire and be of no further force or effect on or after March 31, [2014] 2017, section two of this act shall take effect on April 1, 1985 or seventy-five days following the submission of the report required by section one of this act, whichever is later, and sections eleven and thirteen of this act shall expire and be of no further force or effect on or after March 31, 1988.

S 68. 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 69. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 70. 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 71. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2014 provided that:

1. sections five, fifty-nine and sixty of this act shall take effect July 1, 2014;

2. section twenty-six of this act shall take effect immediately and be deemed to have been in full force and effect on and after March 1, 2014;

3. section nine of this act shall take effect May 1, 2014; provided, however, that the amendments to subparagraph (iii) of paragraph (c) of subdivision 6 of section 367-a of the social services law made by

section nine of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith;

3-a. amendments made to section 365-h of the social services law made by section seven of this act, shall not affect the repeal of such section and shall be deemed repealed therewith.

3-b. section twenty-six-a of this act shall take effect October 1, 2014;

3-c. sections fifty, fifty-one, fifty-two and fifty-three shall take effect April 1, 2015;

3-d. section fifty-five of this act shall take effect January 1, 2015;

4. the amendments to subdivision 9 of section 2511 of the public health law made by section sixty of this act shall not affect the expiration of such subdivision and shall expire therewith;

4-a. section twenty-two of this act shall take effect April 1, 2014, and shall be deemed expired January 1, 2017;

4-b. the amendments to subdivisions (a) and (b) of section 364-jj of the social services law made by section thirty-nine of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

4-c. the amendments to section 364-j of the social services law made by section forty-nine of this act shall not affect the repeal of such section and shall be deemed to repeal therewith;

4-d. the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section thirteen of this act shall not affect the expiration of such section and shall expire therewith;

4-e. the amendments to section 1 of part H of chapter 111 of the laws of 2010 made by section fifteen of this act shall not affect the expiration of such section and shall expire therewith;

5. 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;

6. 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;

7. the commissioner of health and the superintendent of the department of financial services and any appropriate council may take any steps necessary to implement this act prior to its effective date;

8. 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 the department of financial services 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; and

9. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of the department of financial services or any council to adopt or amend or promulgate regulations implementing this act.

PART D

Section 1. Section 6802 of the education law is amended by adding three new subdivisions 24, 25 and 26 to read as follows:

24. "COMPOUNDING" MEANS THE COMBINING, ADMIXING, MIXING, DILUTING, POOLING, RECONSTITUTING, OR OTHERWISE ALTERING OF A DRUG OR BULK DRUG

SUBSTANCE TO CREATE A DRUG WITH RESPECT TO AN OUTSOURCING FACILITY UNDER SECTION 503B OF THE FEDERAL FOOD, DRUG AND COSMETIC ACT AND FURTHER DEFINED IN THIS SECTION.

25. "OUTSOURCING FACILITY" MEANS A FACILITY THAT:

(A) IS ENGAGED IN THE COMPOUNDING OF STERILE DRUGS;

(B) IS CURRENTLY REGISTERED AS AN OUTSOURCING FACILITY WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES; AND

(C) COMPLIES WITH ALL APPLICABLE REQUIREMENTS OF FEDERAL AND STATE LAW, INCLUDING THE FEDERAL FOOD, DRUG AND COSMETIC ACT.

26. "STERILE DRUG" MEANS A DRUG THAT IS INTENDED FOR PARENTERAL ADMINISTRATION, AN OPHTHALMIC OR ORAL INHALATION DRUG IN AQUEOUS FORMAT, OR A DRUG THAT IS REQUIRED TO BE STERILE UNDER FEDERAL OR STATE LAW.

S 2. Subdivision 1 of section 6808 of the education law, as added by chapter 987 of the laws of 1971, is amended to read as follows:

1. No person, firm, corporation or association shall possess drugs, prescriptions or poisons for the purpose of compounding, dispensing, retailing, wholesaling, or manufacturing, or shall offer drugs, prescriptions or poisons for sale at retail or wholesale unless registered by the department as a pharmacy, [store,] wholesaler, [or] manufacturer OR OUTSOURCING FACILITY.

S 3. Subdivisions 5, 6 and 7 of section 6808 of the education law are renumbered subdivisions 6, 7 and 8 and a new subdivision 5 is added to read as follows:

5. OUTSOURCING FACILITY'S REGISTRATION.

A. OBTAINING A REGISTRATION. AN OUTSOURCING FACILITY SHALL BE REGISTERED AS FOLLOWS:

(1) AN APPLICATION FOR INITIAL REGISTRATION OR RENEWAL OF REGISTRATION SHALL BE MADE ON A FORM PRESCRIBED BY THE DEPARTMENT.

(2) AN APPLICATION FOR INITIAL REGISTRATION SHALL BE ACCOMPANIED BY A FEE OF EIGHT HUNDRED TWENTY-FIVE DOLLARS.

B. RENEWAL OF REGISTRATION. ALL OUTSOURCING FACILITIES' REGISTRATIONS SHALL BE RENEWED ON A DATE SET BY THE DEPARTMENT. THE TRIENNIAL REGISTRATION FEE SHALL BE FIVE HUNDRED TWENTY DOLLARS OR A PRO RATED PORTION THEREOF AS DETERMINED BY THE DEPARTMENT.

C. DISPLAY OF REGISTRATION. THE REGISTRATION SHALL BE DISPLAYED CONSPICUOUSLY IN THE PLACE OF BUSINESS.

D. CHANGE OF LOCATION. IN THE EVENT THAT THE LOCATION OF SUCH PLACE OF BUSINESS SHALL BE CHANGED, THE OWNER SHALL APPLY TO THE DEPARTMENT FOR INSPECTION OF THE NEW LOCATION AND ENDORSEMENT OF THE REGISTRATION FOR THE NEW LOCATION. THE FEE FOR INSPECTION AND ENDORSEMENT SHALL BE ONE HUNDRED SEVENTY-FIVE DOLLARS, UNLESS IT APPEARS TO THE SATISFACTION OF THE DEPARTMENT THAT THE CHANGE IN LOCATION IS OF A TEMPORARY NATURE DUE TO FIRE, FLOOD OR OTHER DISASTER.

E. REPORT. UPON INITIALLY REGISTERING AS AN OUTSOURCING FACILITY AND EVERY SIX MONTHS THEREAFTER, EACH OUTSOURCING FACILITY SHALL SUBMIT TO THE EXECUTIVE SECRETARY OF THE STATE BOARD OF PHARMACY A REPORT:

(1) IDENTIFYING THE DRUGS COMPOUNDED BY SUCH OUTSOURCING FACILITY DURING THE PREVIOUS 6-MONTH PERIOD; AND

(2) WITH RESPECT TO EACH DRUG IDENTIFIED UNDER SUBPARAGRAPH ONE OF THIS PARAGRAPH, PROVIDING THE ACTIVE INGREDIENT; THE SOURCE OF SUCH ACTIVE INGREDIENT; THE NATIONAL DRUG CODE NUMBER OF THE SOURCE DRUG OR BULK ACTIVE INGREDIENT, IF AVAILABLE; THE STRENGTH OF THE ACTIVE INGREDIENT PER UNIT; THE DOSAGE FORM AND ROUTE OF ADMINISTRATION; THE PACKAGE DESCRIPTION; THE NUMBER OF INDIVIDUAL UNITS PRODUCED; AND THE NATIONAL DRUG CODE NUMBER OF THE FINAL PRODUCT, IF ASSIGNED.

F. CONDUCT OF OUTSOURCING FACILITY. EVERY OWNER OF AN OUTSOURCING FACILITY IS RESPONSIBLE FOR THE STRENGTH, QUALITY, PURITY AND LABELING THEREOF OF ALL COMPOUNDED DRUGS, SUBJECT TO THE GUARANTY PROVISIONS OF THIS ARTICLE AND THE PUBLIC HEALTH LAW. EVERY OUTSOURCING FACILITY SHALL BE UNDER THE IMMEDIATE SUPERVISION AND MANAGEMENT OF A PHARMACIST LICENSED TO PRACTICE IN NEW YORK STATE.

G. APPLICANT FOR REGISTRATION. AN APPLICANT FOR REGISTRATION OF AN OUTSOURCING FACILITY SHALL BE OF GOOD MORAL CHARACTER, AS DETERMINED BY THE DEPARTMENT. IN THE CASE OF A CORPORATE APPLICANT, THE REQUIREMENT SHALL EXTEND TO ALL OFFICERS AND DIRECTORS AND STAKEHOLDERS HAVING A TEN PERCENT OR GREATER INTEREST IN THE CORPORATION.

S 4. Subdivisions 6 and 7 of section 6808 of the education law, as added by chapter 987 of the laws of 1971, such subdivisions as renumbered by section three of this act, are amended to read as follows:

6. Inspection. The state board of pharmacy and the department of education, and their employees designated by the commissioner, shall have the right to enter any pharmacy, wholesaler, manufacturer, [or registered store,] OUTSOURCING FACILITY or vehicle and to inspect, at reasonable times, such factory, warehouse, establishment or vehicle and all records required by this article, pertinent equipment, finished and unfinished materials, containers, and labels.

7. [Revocation or suspension] PENALTIES. A pharmacy, [store,] wholesaler [or], manufacturer [registration may be revoked or suspended by the committee on professional conduct of the state board of pharmacy in accordance with the provisions of article one hundred thirty] OR OUTSOURCING FACILITY REGISTERED UNDER THIS SECTION SHALL BE UNDER THE SUPERVISION OF THE BOARD OF REGENTS AND SHALL BE SUBJECT TO DISCIPLINARY PROCEEDINGS AND PENALTIES IN ACCORDANCE WITH ARTICLE ONE HUNDRED THIRTY OF THIS CHAPTER IN THE SAME MANNER AND TO THE SAME EXTENT AS INDIVIDUALS AND PROFESSIONAL SERVICE CORPORATIONS WITH RESPECT TO THEIR LICENSES AND REGISTRATIONS, PROVIDED THAT FAILURE TO COMPLY WITH THE REQUIREMENTS OF THIS SECTION SHALL CONSTITUTE PROFESSIONAL MISCONDUCT.

S 5. Subdivision 1 of section 6808-b of the education law, as amended by chapter 567 of the laws of 2002, is amended to read as follows:

1. Definition. The term "nonresident establishment" shall mean any pharmacy, manufacturer [or], wholesaler, OR OUTSOURCING FACILITY located outside of the state that ships, mails or delivers prescription drugs or devices to other establishments, authorized prescribers and/or patients residing in this state. Such establishments shall include, but not be limited to, pharmacies that transact business through the use of the internet.

S 6. Paragraph f of subdivision 4 of section 6808-b of the education law, as amended by chapter 567 of the laws of 2002, is amended to read as follows:

f. The application of establishments to be registered as a manufacturer [or], wholesaler OR OUTSOURCING FACILITY of drugs and/or devices shall be accompanied by a fee as provided in section sixty-eight hundred eight of this article; and

S 7. Section 6810 of the education law is amended by adding a new subdivision 14 to read as follows:

14. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, NO OUTSOURCING FACILITY MAY DISTRIBUTE OR DISPENSE ANY DRUG TO ANY PERSON PURSUANT TO A PRESCRIPTION UNLESS IT IS ALSO REGISTERED AS A PHARMACY IN THIS STATE AND MEETS ALL OTHER APPLICABLE REQUIREMENTS OF FEDERAL AND STATE LAW.

S 8. Section 6811 of the education law is amended by adding a new subdivision 26 to read as follows:

26. ANY OUTSOURCING FACILITY TO SELL OR OFFER TO SELL ANY DRUG THAT IS NOT BOTH COMPOUNDED UNDER THE PERSONAL SUPERVISION OF A LICENSED PHARMACIST AND LABELED WITH THE FULL NAME OF THE OUTSOURCING FACILITY.

S 9. Subdivisions 1 and 2 of section 6811-a of the education law, as added by chapter 729 of the laws of 1981, are amended to read as follows:

1. [No] EXCEPT AS OTHERWISE AUTHORIZED IN THE FEDERAL FOOD, DRUG AND COSMETIC ACT, NO drug for which a prescription is required by the provisions of the Federal Food, Drug and Cosmetic Act or by the commissioner of health may be manufactured or commercially distributed within this state in tablet or capsule form unless it has clearly marked or imprinted on each such tablet or capsule in conformance with the applicable plan required by subdivision three of this section:

(a) an individual symbol, number, company name, words, letters, marking or National Drug Code (hereinafter referred to as N. D. C.) number identifying the manufacturer or distributor of the drug; and

(b) an N. D. C. number, symbol, number, letters, words or marking identifying such drug or combination of drugs.

2. [No] EXCEPT AS OTHERWISE AUTHORIZED IN THE FEDERAL FOOD, DRUG AND COSMETIC ACT, NO drug for which any prescription is required by the provisions of the Federal Food, Drug and Cosmetic Act or by the commissioner of health contained within a bottle, vial, carton or other container, or in any way affixed or appended to or enclosed within a package of any kind, and designed or intended for delivery in such container or package to an ultimate consumer, shall be manufactured or distributed within this state unless such container or package has clearly and permanently marked or imprinted upon it in conformance with the applicable plan required by subdivision three of this section:

(a) an individual symbol, N. D. C. number, company name, number, letters, words or marking identifying the manufacturer or distributor of the drug;

(b) an N. D. C. number, symbol, number, letters, words or marking identifying such drug or combination of drugs; and

(c) whenever the distributor of the prescription drug product does not also manufacture the product the names and places of business of both shall appear on the label in words clearly distinguishing each.

S 10. Subdivision 1 of section 6812 of the education law, as added by chapter 987 of the laws of 1971, is amended to read as follows:

1. Where any pharmacy, MANUFACTURER, WHOLESALER OR OUTSOURCING FACILITY registered by the department is damaged by fire the board shall be notified within a period of forty-eight hours, and the board shall have power to impound all drugs for analysis and condemnation, if found unfit for use. Where a pharmacy is discontinued, the owner of its prescription records shall notify the department as to the disposition of said prescription records, and in no case shall records be sold or given away to a person who does not currently possess a registration to operate a pharmacy.

S 11. Subdivision 1 of section 6817 of the education law, as added by chapter 987 of the laws of 1971, is amended to read as follows:

1. [No] EXCEPT AS OTHERWISE PROVIDED IN THE FEDERAL FOOD, DRUG AND COSMETIC ACT, NO person shall sell, deliver, offer for sale, hold for sale, or give away any new drug, unless:

a. an application with respect thereto has become effective, or in the case of an investigational drug the sponsor has complied with the appli-

cable requirements, under the [federal food, drug, and cosmetic act] FEDERAL FOOD, DRUG, AND COSMETIC ACT, or

b. when not subject to such act, such drug has been tested and has not been found to be unsafe or ineffective for use under the conditions prescribed, recommended or suggested in the labeling thereof, and, prior to selling or offering for sale such drug, there has been filed with the department an application setting forth

(1) full reports of investigations which have been made to show whether or not such drug is safe and effective for use;

(2) a full list of the ingredients used as components of such drug;

(3) a full statement of the composition of such drug;

(4) a full description of the methods used in, and the facilities and controls used for, the manufacture, processing and packing of such drugs;

(5) such samples of such drug and of the ingredients used as components thereof as the board or secretary may require; and

(6) specimens of the labeling proposed to be used for such drug.

S 12. The education law is amended by adding a new section 6831 to read as follows:

S 6831. SPECIAL PROVISIONS RELATING TO OUTSOURCING FACILITIES. 1. REGISTRATION. ANY OUTSOURCING FACILITY THAT IS ENGAGED IN THE COMPOUNDING OF STERILE DRUGS IN THIS STATE SHALL BE REGISTERED AS AN OUTSOURCING FACILITY UNDER THE FEDERAL FOOD, DRUG AND COSMETIC ACT AND BE REGISTERED AS AN OUTSOURCING FACILITY PURSUANT TO THIS ARTICLE.

2. NEW DRUGS. SECTIONS 502(F)(1), 505 AND 582 OF THE FEDERAL FOOD, DRUG AND COSMETIC ACT SHALL NOT APPLY TO A DRUG COMPOUNDED IN AN OUTSOURCING FACILITY REGISTERED UNDER THE FEDERAL FOOD, DRUG AND COSMETIC ACT.

3. PRESCRIPTIONS. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, NO OUTSOURCING FACILITY MAY DISTRIBUTE OR DISPENSE ANY DRUG TO ANY PERSON PURSUANT TO A PRESCRIPTION UNLESS IT IS ALSO REGISTERED AS A PHARMACY IN THIS STATE AND MEETS ALL OTHER APPLICABLE REQUIREMENTS OF FEDERAL AND STATE LAW.

4. RESTRICTIONS. ANY DRUGS COMPOUNDED IN AN OUTSOURCING FACILITY REGISTERED PURSUANT TO THIS ARTICLE SHALL BE COMPOUNDED IN ACCORDANCE WITH ALL APPLICABLE FEDERAL AND STATE LAWS.

5. LABELING. NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, THE LABEL OF ANY DRUG COMPOUNDED BY AN OUTSOURCING FACILITY SHALL INCLUDE, BUT NOT BE LIMITED TO THE FOLLOWING:

(A) A STATEMENT THAT THE DRUG IS A COMPOUNDED DRUG OR A REASONABLE COMPARABLE ALTERNATIVE STATEMENT THAT PROMINENTLY IDENTIFIES THE DRUG AS A COMPOUNDED DRUG;

(B) THE NAME, ADDRESS, AND PHONE NUMBER OF THE APPLICABLE OUTSOURCING FACILITY; AND

(C) WITH RESPECT TO THE DRUG:

(I) THE LOT OR BATCH NUMBER;

(II) THE ESTABLISHED NAME OF THE DRUG;

(III) THE DOSAGE FORM AND STRENGTH;

(IV) THE STATEMENT OF QUANTITY OR VOLUME, AS APPROPRIATE;

(V) THE DATE THAT THE DRUG WAS COMPOUNDED;

(VI) THE EXPIRATION DATE;

(VII) STORAGE AND HANDLING INSTRUCTIONS;

(VIII) THE NATIONAL DRUG CODE NUMBER, IF AVAILABLE;

(IX) THE STATEMENT THAT THE DRUG IS NOT FOR RESALE, AND THE STATEMENT "OFFICE USE ONLY"; AND

(X) A LIST OF THE ACTIVE AND INACTIVE INGREDIENTS, IDENTIFIED BY ESTABLISHED NAME, AND THE QUANTITY OR PROPORTION OF EACH INGREDIENT.

6. CONTAINER. THE CONTAINER FROM WHICH THE INDIVIDUAL UNITS OF THE DRUG ARE REMOVED FOR DISPENSING OR FOR ADMINISTRATION (SUCH AS A PLASTIC BAG CONTAINING INDIVIDUAL PRODUCT SYRINGES) SHALL INCLUDE:

(A) A LIST OF ACTIVE AND INACTIVE INGREDIENTS, IDENTIFIED BY ESTABLISHED NAME, AND THE QUANTITY OR PROPORTION OF EACH INGREDIENT; AND

(B) ANY OTHER INFORMATION REQUIRED BY REGULATIONS PROMULGATED BY THE COMMISSIONER TO FACILITATE ADVERSE EVENT REPORTING IN ACCORDANCE WITH THE REQUIREMENTS ESTABLISHED IN SECTION 310.305 OF TITLE 21 OF THE CODE OF FEDERAL REGULATIONS.

7. BULK DRUGS. A DRUG MAY ONLY BE COMPOUNDED IN AN OUTSOURCING FACILITY THAT DOES NOT COMPOUND USING BULK DRUG SUBSTANCES AS DEFINED IN SECTION 207.3(A)(4) OF TITLE 21 OF THE CODE OF FEDERAL REGULATIONS OR ANY SUCCESSOR REGULATION UNLESS:

(A) THE BULK DRUG SUBSTANCE APPEARS ON A LIST ESTABLISHED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES IDENTIFYING BULK DRUG SUBSTANCES FOR WHICH THERE IS A CLINICAL NEED;

(B) THE DRUG IS COMPOUNDED FROM A BULK DRUG SUBSTANCE THAT APPEARS ON THE FEDERAL DRUG SHORTAGE LIST IN EFFECT AT THE TIME OF COMPOUNDING, DISTRIBUTING, AND DISPENSING;

(C) IF AN APPLICABLE MONOGRAPH EXISTS UNDER THE UNITED STATES PHARMACOPEIA, THE NATIONAL FORMULARY, OR ANOTHER COMPENDIUM OR PHARMACOPEIA RECOGNIZED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES AND THE BULK DRUG SUBSTANCES EACH COMPLY WITH THE MONOGRAPH;

(D) THE BULK DRUG SUBSTANCES ARE EACH MANUFACTURED BY AN ESTABLISHMENT THAT IS REGISTERED WITH THE FEDERAL GOVERNMENT.

8. INGREDIENTS. IF AN OUTSOURCING FACILITY USES INGREDIENTS, OTHER THAN BULK DRUG SUBSTANCES, SUCH INGREDIENTS MUST COMPLY WITH THE STANDARDS OF THE APPLICABLE UNITED STATES PHARMACOPEIA OR NATIONAL FORMULARY MONOGRAPH, IF SUCH MONOGRAPH EXISTS, OR OF ANOTHER COMPENDIUM OR PHARMACOPEIA RECOGNIZED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES FOR PURPOSES OF THIS SUBDIVISION, IF ANY.

9. UNSAFE OR INEFFECTIVE DRUGS. NO OUTSOURCING FACILITY MAY COMPOUND A DRUG THAT APPEARS ON A LIST PUBLISHED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES THAT HAS BEEN WITHDRAWN OR REMOVED FROM THE MARKET BECAUSE SUCH DRUGS OR COMPONENTS OF SUCH DRUGS HAVE BEEN FOUND TO BE UNSAFE OR NOT EFFECTIVE.

10. PROHIBITION ON WHOLESALING. NO COMPOUNDED DRUG WILL BE SOLD OR TRANSFERRED BY ANY ENTITY OTHER THAN THE OUTSOURCING FACILITY THAT COMPOUNDED SUCH DRUG. THIS DOES NOT PROHIBIT THE ADMINISTRATION OF A DRUG IN A HEALTH CARE SETTING OR DISPENSING A DRUG PURSUANT TO A PROPERLY EXECUTED PRESCRIPTION.

11. PROHIBITION AGAINST COPYING AN APPROVED DRUG. NO OUTSOURCING FACILITY MAY COMPOUND A DRUG THAT IS ESSENTIALLY A COPY OF ONE OR MORE APPROVED DRUGS.

12. PROHIBITION AGAINST COMPOUNDING DRUGS PRESENTING DEMONSTRABLE DIFFICULTIES. NO OUTSOURCING FACILITY MAY COMPOUND A DRUG:

I. THAT IS IDENTIFIED, DIRECTLY OR AS PART OF A CATEGORY OF DRUGS, ON A LIST PUBLISHED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES THAT PRESENT DEMONSTRABLE DIFFICULTIES FOR COMPOUNDING THAT ARE REASONABLY LIKELY TO LEAD TO AN ADVERSE EFFECT ON THE SAFETY OR EFFECTIVENESS OF THE DRUG OR CATEGORY OF DRUGS, TAKING INTO ACCOUNT THE RISKS AND BENEFITS TO PATIENTS; OR

II. THAT IS COMPOUNDED IN ACCORDANCE WITH ALL APPLICABLE CONDITIONS IDENTIFIED ON THE DRUG LIST AS CONDITIONS THAT ARE NECESSARY TO PREVENT THE DRUG OR CATEGORY OF DRUGS FROM PRESENTING DEMONSTRABLE DIFFICULTIES.

13. ADVERSE EVENT REPORTS. OUTSOURCING FACILITIES SHALL SUBMIT A COPY OF ALL ADVERSE EVENT REPORTS SUBMITTED TO THE SECRETARY OF HEALTH AND HUMAN SERVICES IN ACCORDANCE WITH THE CONTENT AND FORMAT REQUIREMENTS ESTABLISHED IN SECTION 310.305 OF TITLE 21 OF THE CODE OF FEDERAL REGULATIONS, OR ANY SUCCESSOR REGULATION, TO THE EXECUTIVE SECRETARY FOR THE STATE BOARD OF PHARMACY.

14. REPORTS. THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, SHALL PREPARE AND SUBMIT A REPORT TO THE GOVERNOR AND THE LEGISLATURE, DUE EIGHTEEN MONTHS FROM THE EFFECTIVE DATE OF THIS SECTION, EVALUATING THE EFFECTIVENESS OF THE REGISTRATION AND OVERSIGHT OF OUTSOURCING FACILITIES RELATED TO COMPOUNDING.

S 13. Section 3302 of the public health law is amended by adding two new subdivisions 42 and 43 to read as follows:

42. "COMPOUNDING" MEANS THE COMBINING, ADMIXING, MIXING, DILUTING, POOLING, RECONSTITUTING, OR OTHERWISE ALTERING OF A DRUG OR BULK DRUG SUBSTANCE TO CREATE A DRUG WITH RESPECT TO AN OUTSOURCING FACILITY UNDER SECTION 503B OF THE FEDERAL FOOD, DRUG AND COSMETIC ACT AND FURTHER DEFINED IN THIS SECTION.

43. "OUTSOURCING FACILITY" MEANS A FACILITY THAT:

(A) IS ENGAGED IN THE COMPOUNDING OF STERILE DRUGS AS DEFINED IN SECTION SIXTY-EIGHT HUNDRED TWO OF THE EDUCATION LAW;

(B) IS CURRENTLY REGISTERED AS AN OUTSOURCING FACILITY PURSUANT TO ARTICLE ONE HUNDRED THIRTY-SEVEN OF THE EDUCATION LAW; AND

(C) COMPLIES WITH ALL APPLICABLE REQUIREMENTS OF FEDERAL AND STATE LAW, INCLUDING THE FEDERAL FOOD, DRUG AND COSMETIC ACT.

NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, WHEN AN OUTSOURCING FACILITY DISTRIBUTES OR DISPENSES ANY DRUG TO ANY PERSON PURSUANT TO A PRESCRIPTION, SUCH OUTSOURCING FACILITY SHALL BE DEEMED TO BE PROVIDING PHARMACY SERVICES AND SHALL BE SUBJECT TO ALL LAWS, RULES AND REGULATIONS GOVERNING PHARMACIES AND PHARMACY SERVICES.

S 14. The opening paragraph of subdivision 2 of section 3318 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

No controlled substance contained within a bottle, vial, carton or other container, or in any way affixed or appended to or enclosed within a package of any kind, and designed or intended for delivery in such container or package to an ultimate consumer, shall be manufactured, DELIVERED or distributed within this state unless such container or package has clearly and permanently marked or imprinted upon it:

S 15. Subdivision 1 of section 3320 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

1. Controlled substances may be lawfully distributed within this state only to licensed distributors or manufacturers, practitioners, pharmacists, pharmacies, institutional dispensers, REGISTERED OUTSOURCING FACILITIES, and laboratory, research or instructional facilities authorized by law to possess the particular substance distributed.

S 16. Paragraph (a) of subdivision 1 of section 3321 of the public health law, as added by chapter 878 of the laws of 1972, is amended to read as follows:

(a) the return of controlled substances to a manufacturer, REGISTERED OUTSOURCING FACILITY or distributor by a practitioner or pharmacy;

S 17. Section 3322 of the public health law, as added by chapter 878 of the laws of 1972, subdivision 2 as amended by chapter 108 of the laws of 1975, is amended to read as follows:

S 3322. Reports and records. 1. Persons licensed under this title OR OPERATING A REGISTERED OUTSOURCING FACILITY shall maintain records of all controlled substances manufactured, COMPOUNDED, received, disposed of, DELIVERED or distributed by them. The record shall show the date of receipt or delivery, the name and address, and registration number of the person from whom received or to whom DELIVERED OR distributed, the kind and quantity of substance received and DELIVERED OR distributed, the kind and quantity of substance produced or removed from the process of manufacture and the date thereof.

2. Any person licensed under this title OR OPERATING A REGISTERED OUTSOURCING FACILITY shall prepare and maintain a biennial report setting forth the current inventory of controlled substances, the quantities of controlled substances manufactured, COMPOUNDED, DELIVERED or distributed within the state during the period covered by the report and such other information as the commissioner shall [be] BY regulation prescribe. Maintaining for inspection a biennial inventory of controlled substances prepared and maintained in compliance with federal statutes and regulations shall be deemed in compliance with this section.

3. Any person licensed under this title OR OPERATING A REGISTERED OUTSOURCING FACILITY shall forthwith notify the department of any incident involving the theft, loss or possible diversion of controlled substances manufactured, COMPOUNDED, DELIVERED or distributed by the licensee OR OPERATOR.

4. The records and reports required by this section shall be prepared, preserved, or filed in such manner and detail as the commissioner shall by regulation prescribe.

S 18. Paragraph (c) of subdivision 1 of section 3397 of the public health law, as amended by chapter 547 of the laws of 1981, is amended to read as follows:

(c) falsely assume the title of, or represent himself to be a licensed manufacturer, distributor, pharmacy, pharmacist, practitioner, researcher, approved institutional dispenser, OWNER OR EMPLOYEE OF A REGISTERED OUTSOURCING FACILITY or other authorized person, for the purpose of obtaining a controlled substance;

S 19. This act shall take effect on the ninetieth day after it shall have become a law.

PART E

Section 1. The mental hygiene law is amended by adding a new section 13.41 to read as follows:

S 13.41 INTEGRATED EMPLOYMENT PLAN.

(A) THE COMMISSIONER, IN CONSULTATION WITH THE DEVELOPMENTAL DISABILITIES ADVISORY COUNCIL, SHALL ESTABLISH A PLAN TO INCREASE EMPLOYMENT OPPORTUNITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE PLAN SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) IDENTIFICATION OF STRATEGIES TO INCREASE COMPETITIVE EMPLOYMENT OPPORTUNITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, INCLUDING STUDENTS TRANSITIONING FROM EDUCATIONAL PROGRAMS;

(2) DATA CONCERNING JOB RETENTION AMONG INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND THE IDENTIFICATION OF STRATEGIES TO INCREASE JOB RETENTION;

(3) IDENTIFICATION OF MODELS OF INTEGRATED EMPLOYMENT PROMOTING, TO THE GREATEST EXTENT POSSIBLE, INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES WORKING ALONGSIDE INDIVIDUALS WITHOUT DISABILITIES, INCLUDING CONSIDERATIONS OF ABILITY LEVELS, CRITICAL LIFE TRANSITIONS AND APPROPRIATE OPTIONS;

(4) STRATEGIES FOR ASSISTING INDIVIDUALS IN TRANSITIONING FROM SHELTERED WORKSHOP PROGRAMS TO COMPETITIVE EMPLOYMENT;

(5) PARTNERSHIPS WITH BUSINESS COMMUNITIES AND SENIOR SERVICES TO ASSIST IN INCREASING THE AVAILABILITY OF COMPETITIVE EMPLOYMENT FOR OLDER ADULTS;

(6) IDENTIFICATION OF MEANS TO ASSIST INDIVIDUALS WITH SIGNIFICANT BEHAVIORAL OR MEDICAL NEEDS IN PREPARING FOR AND MOVING TOWARDS INTEGRATED EMPLOYMENT;

(7) TECHNICAL ASSISTANCE, COMPLIANCE AND TRANSITION ASSISTANCE PROCEDURES FOR EXISTING PROVIDERS WHO SEEK TO TRANSITION TO COMPETITIVE AND/OR INTEGRATED EMPLOYMENT MODELS; AND

(8) ASSESSMENTS OF FUNDING AND NECESSARY SUPPORTS FOR INDIVIDUALS AND PROVIDERS.

(B) THE COMMISSIONER, IN CONSULTATION WITH THE DEVELOPMENTAL DISABILITIES ADVISORY COUNCIL, SHALL DEVELOP THE PLAN WITH INPUT FROM STAKEHOLDERS, INCLUDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, PARENTS AND GUARDIANS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, ADVOCATES AND PROVIDERS OF SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

(C) THE PLAN REQUIRED PURSUANT TO THIS SECTION SHALL BE DEVELOPED AND SUBMITTED TO THE TEMPORARY PRESIDENT OF THE SENATE AND SPEAKER OF THE ASSEMBLY AND POSTED ON THE WEBSITE OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES WITHIN ONE HUNDRED EIGHTY DAYS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES' APPROVAL OF THE PLAN TO INCREASE COMPETITIVE EMPLOYMENT OPPORTUNITIES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.

S 2. This act shall take effect immediately.

PART F

Section 1. No later than January 1, 2016, the office for people with developmental disabilities shall issue a report to the governor, the temporary president of the senate and the speaker of the assembly setting forth recommendations for the establishment of a direct support professional credentialing pilot program. Recommendations for the program shall be based on a study to be conducted by the office for people with developmental disabilities and shall include consideration of: (1) national and international models of direct support credentialing; (2) career ladders for direct support professionals and supervisors; (3) current direct support professional salaries and training requirements; (4) classroom and on-the-job training requirements for existing direct support credentialing programs and the impact of these requirements on operations of providers of services; (5) ongoing and continuing professional education requirements for credentialed direct support of professionals; (6) the fiscal impact of a credentialing pilot program; and (7) financial incentives for those who successfully complete the credentialing program.

S 2. This act shall take effect immediately.

PART G

Section 1. Subdivision (e) of section 41.55 of the mental hygiene law, as amended by section 3 of part C of chapter 111 of the laws of 2010, is amended to read as follows:

(e) The amount of community mental health support and workforce reinvestment funds for the office of mental health shall be determined in the annual budget and shall include the amount of actual state operations general fund appropriation reductions, including personal service savings and other than personal service savings directly attributed to each child and adult non-geriatric inpatient bed closure. For the purposes of this section a bed shall be considered to be closed upon the elimination of funding for such beds in the executive budget. The appropriation reductions as a result of inpatient bed closures shall be no less than [seventy] ONE HUNDRED TEN thousand dollars per bed on a full annual basis, as annually recommended by the commissioner, subject to the approval of the director of the budget, in the executive budget request prior to the fiscal year for which the executive budget is being submitted. The methodologies used to calculate the per bed closure savings shall be developed by the commissioner and the director of the budget. In no event shall the full annual value of community mental health support and workforce reinvestment programs attributable to beds closed as a result of net inpatient census decline exceed the twelve month value of the office of mental health state operations general fund reductions resulting from such census decline. Such reinvestment amount shall be made available in the same proportion by which the office of mental health's state operations general fund appropriations are reduced each year as a result of child and adult non-geriatric inpatient bed closures due to census decline.

S 2. Subdivision 2 of section 97-dddd of the state finance law, as added by section 6 of part R2 of chapter 62 of the laws of 2003, is amended to read as follows:

2. The commissioner of the office of mental health shall notify the director of the budget when the number of children's psychiatric center beds or adult, non-geriatric psychiatric center beds closed in any one year exceeds the number of beds projected to be closed by the office of mental health in the executive budget request submitted in the year prior to the fiscal year for which the executive budget is being submitted. Notwithstanding any other law, rule or regulation to the contrary the director of the budget shall then transfer the amount of actual state operations general fund appropriation reductions, including personal service and nonpersonal service, directly attributed to the closure of such beds, to the state comptroller who shall then credit such appropriation reductions to the community mental health support and workforce reinvestment account. The per bed appropriation reduction shall be no less than [seventy] ONE HUNDRED TEN thousand dollars on a full annual basis.

S 3. Section 7 of part R2 of chapter 62 of the laws of 2003, amending the mental hygiene law and the state finance law relating to the community mental health support and workforce reinvestment program, the membership of subcommittees for mental health of community services boards and the duties of such subcommittees and creating the community mental health and workforce reinvestment account, as amended by section 3 of part H of chapter 56 of the laws of 2013, is amended to read as follows:

S 7. This act shall take effect immediately and shall expire March 31, [2015] 2018 when upon such date the provisions of this act shall be deemed repealed.

S 4. This act shall take effect immediately; provided that:

1. the amendments to subdivision (e) of section 41.55 of the mental hygiene law made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

2. the amendments to subdivision 2 of section 97-dddd of the state finance law made by section two of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART H

Section 1. Paragraphs 11, 12, 13, 14, 16 and 17 of subsection (a) of section 3217-a of the insurance law, as added by chapter 705 of the laws of 1996, are amended and four new paragraphs 16-a, 18, 19 and 20 are added to read as follows:

(11) where applicable, notice that an insured enrolled in a managed care product OR IN A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer may obtain a referral [to] OR PREAUTHORIZATION FOR a health care provider outside of the insurer's network or panel when the insurer does not have a health care provider [with] WHO IS GEOGRAPHICALLY ACCESSIBLE TO THE INSURED AND WHO HAS THE appropriate training and experience in the network or panel to meet the particular health care needs of the insured and the procedure by which the insured can obtain such referral OR PREAUTHORIZATION;

(12) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with [(i)] (A) a life-threatening condition or disease, or [(ii)] (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the insured's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that an insured enrolled in a managed care product OR A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS offered by the insurer with [(i)] (A) a life-threatening condition or disease, or [(ii)] (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained;

(16) notice of all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization; [and]

(16-A) WHERE APPLICABLE, NOTICE THAT AN INSURED SHALL HAVE DIRECT ACCESS TO PRIMARY AND PREVENTIVE OBSTETRIC AND GYNECOLOGIC SERVICES, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, FROM A QUALIFIED PROVIDER OF SUCH SERVICES OF HER CHOICE FROM WITHIN THE PLAN OR FOR ANY CARE RELATED TO A PREGNANCY;

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification[.],

LANGUAGES SPOKEN AND ANY AFFILIATIONS WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE INSURER'S WEBSITE AND THE INSURER SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE INSURER'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(18) A DESCRIPTION OF THE METHOD BY WHICH AN INSURED MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES;

(19) WITH RESPECT TO OUT-OF-NETWORK COVERAGE:

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE INSURER TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) THE AMOUNT THAT THE INSURER WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(20) INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN INSURED OR PROSPECTIVE INSURED TO ESTIMATE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE INSURER WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 2. Paragraphs 11 and 12 of subsection (b) of section 3217-a of the insurance law, as added by chapter 705 of the laws of 1996, are amended and two new paragraphs 13 and 14 are added to read as follows:

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the insurer for participation in the insurer's network for a managed care product; [and]

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; AND

(14) WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE APPROXIMATE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE. THE INSURER SHALL ALSO INFORM THE INSURED THROUGH SUCH DISCLOSURE THAT SUCH APPROXIMATION IS NOT BINDING ON THE INSURER AND THAT THE APPROXIMATE DOLLAR AMOUNT THAT THE INSURER WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE MAY CHANGE.

S 3. Section 3217-a of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 4. Section 3217-d of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) AN INSURER THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT

AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 5. Section 3224-a of the insurance law is amended by adding a new subsection (j) to read as follows:

(J) AN INSURER OR AN ORGANIZATION OR CORPORATION LICENSED OR CERTIFIED PURSUANT TO ARTICLE FORTY-THREE OR FORTY-SEVEN OF THIS CHAPTER OR ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER SHALL ACCEPT CLAIMS SUBMITTED BY A POLICYHOLDER OR COVERED PERSON, IN WRITING, INCLUDING THROUGH THE INTERNET, BY ELECTRONIC MAIL OR BY FACSIMILE.

S 6. The insurance law is amended by adding a new section 3241 to read as follows:

S 3241. NETWORK COVERAGE. (A) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER, THAT ISSUES A HEALTH INSURANCE POLICY OR CONTRACT WITH A NETWORK OF HEALTH CARE PROVIDERS SHALL ENSURE THAT THE NETWORK IS ADEQUATE TO MEET THE HEALTH NEEDS OF INSUREDS AND PROVIDE AN APPROPRIATE CHOICE OF PROVIDERS SUFFICIENT TO RENDER THE SERVICES COVERED UNDER THE POLICY OR CONTRACT. THE SUPERINTENDENT SHALL REVIEW THE NETWORK OF HEALTH CARE PROVIDERS FOR ADEQUACY AT THE TIME OF THE SUPERINTENDENT'S INITIAL APPROVAL OF A HEALTH INSURANCE POLICY OR CONTRACT; AT LEAST EVERY THREE YEARS THEREAFTER; AND UPON APPLICATION FOR EXPANSION OF ANY SERVICE AREA ASSOCIATED WITH THE POLICY OR CONTRACT IN CONFORMANCE WITH THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED BY THE COMMISSIONER OF HEALTH TO MEET THE STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE BY THE SUPERINTENDENT.

(B)(1)(A) AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE GROUP OR GROUP REMITTANCE HEALTH INSURANCE POLICY OR CONTRACT THAT COVERS OUT-OF-NETWORK HEALTH CARE SERVICES SHALL MAKE AVAILABLE AND, IF REQUESTED BY THE POLICYHOLDER OR CONTRACTHOLDER, PROVIDE AT LEAST ONE OPTION FOR COVERAGE FOR AT LEAST EIGHTY PERCENT OF THE USUAL AND CUSTOMARY COST OF EACH OUT-OF-NETWORK HEALTH CARE SERVICE AFTER IMPOSITION OF A DEDUCTIBLE OR ANY PERMISSIBLE BENEFIT MAXIMUM.

(B) IF THERE IS NO COVERAGE AVAILABLE PURSUANT TO SUBPARAGRAPH (A) OF THIS PARAGRAPH IN A RATING REGION, THEN THE SUPERINTENDENT MAY REQUIRE AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF

THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER ISSUING A COMPREHENSIVE GROUP OR GROUP REMITTANCE HEALTH INSURANCE POLICY OR CONTRACT IN THE RATING REGION, TO MAKE AVAILABLE AND, IF REQUESTED BY THE POLICYHOLDER OR CONTRACTHOLDER, PROVIDE AT LEAST ONE OPTION FOR COVERAGE OF EIGHTY PERCENT OF THE USUAL AND CUSTOMARY COST OF EACH OUT-OF-NETWORK HEALTH CARE SERVICE AFTER IMPOSITION OF ANY PERMISSIBLE DEDUCTIBLE OR BENEFIT MAXIMUM. THE SUPERINTENDENT MAY, AFTER GIVING CONSIDERATION TO THE PUBLIC INTEREST, PERMIT AN INSURER, A CORPORATION, OR A HEALTH MAINTENANCE ORGANIZATION TO SATISFY THE REQUIREMENTS OF THIS PARAGRAPH ON BEHALF OF ANOTHER INSURER, CORPORATION, OR HEALTH MAINTENANCE ORGANIZATION WITHIN THE SAME HOLDING COMPANY SYSTEM, AS DEFINED IN ARTICLE FIFTEEN OF THIS CHAPTER, INCLUDING A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A LINE OF BUSINESS OF A HEALTH SERVICE CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER. THE SUPERINTENDENT MAY, UPON WRITTEN REQUEST, WAIVE THE REQUIREMENT FOR COVERAGE OF OUT-OF-NETWORK HEALTH CARE SERVICES TO BE MADE AVAILABLE PURSUANT TO THIS SUBPARAGRAPH IF THE SUPERINTENDENT DETERMINES THAT IT WOULD POSE AN UNDUE HARDSHIP UPON AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER.

(2) FOR THE PURPOSES OF THIS SUBSECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER.

(3) THIS SUBSECTION SHALL NOT APPLY TO EMERGENCY CARE SERVICES IN HOSPITAL FACILITIES OR PREHOSPITAL EMERGENCY MEDICAL SERVICES AS DEFINED IN CLAUSE (I) OF SUBPARAGRAPH (E) OF PARAGRAPH TWENTY-FOUR OF SUBSECTION (I) OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN OF THIS ARTICLE, OR CLAUSE (I) OF SUBPARAGRAPH (E) OF PARAGRAPH FIFTEEN OF SUBSECTION (L) OF SECTION THREE THOUSAND TWO HUNDRED TWENTY-ONE OF THIS CHAPTER, OR SUBPARAGRAPH (A) OF PARAGRAPH FIVE OF SUBSECTION (AA) OF SECTION FOUR THOUSAND THREE HUNDRED THREE OF THIS CHAPTER.

(4) NOTHING IN THIS SUBSECTION SHALL LIMIT THE SUPERINTENDENT'S AUTHORITY PURSUANT TO SECTION THREE THOUSAND TWO HUNDRED SEVENTEEN OF THIS ARTICLE TO ESTABLISH MINIMUM STANDARDS FOR THE FORM, CONTENT AND SALE OF ACCIDENT AND HEALTH INSURANCE POLICIES AND SUBSCRIBER CONTRACTS, TO REQUIRE ADDITIONAL COVERAGE OPTIONS FOR OUT-OF-NETWORK SERVICES, OR TO PROVIDE FOR STANDARDIZATION AND SIMPLIFICATION OF COVERAGE.

(C) WHEN AN INSURED OR ENROLLEE UNDER A CONTRACT OR POLICY THAT PROVIDES COVERAGE FOR EMERGENCY SERVICES RECEIVES THE SERVICES FROM A

HEALTH CARE PROVIDER THAT DOES NOT PARTICIPATE IN THE PROVIDER NETWORK OF AN INSURER, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THIS CHAPTER, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER ("HEALTH CARE PLAN"), THE HEALTH CARE PLAN SHALL ENSURE THAT THE INSURED OR ENROLLEE SHALL INCUR NO GREATER OUT-OF-POCKET COSTS FOR THE EMERGENCY SERVICES THAN THE INSURED OR ENROLLEE WOULD HAVE INCURRED WITH A HEALTH CARE PROVIDER THAT PARTICIPATES IN THE HEALTH CARE PLAN'S PROVIDER NETWORK. FOR THE PURPOSE OF THIS SECTION, "EMERGENCY SERVICES" SHALL HAVE THE MEANING SET FORTH IN SUBPARAGRAPH (D) OF PARAGRAPH NINE OF SUBSECTION (I) OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN OF THIS ARTICLE, SUBPARAGRAPH (D) OF PARAGRAPH FOUR OF SUBSECTION (K) OF SECTION THREE THOUSAND TWO HUNDRED TWENTY-ONE OF THIS ARTICLE, AND SUBPARAGRAPH (D) OF PARAGRAPH TWO OF SUBSECTION (A) OF SECTION FOUR THOUSAND THREE HUNDRED THREE OF THIS CHAPTER.

S 7. Section 4306-c of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) A CORPORATION, INCLUDING A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER AND A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER, THAT ISSUES A COMPREHENSIVE POLICY THAT UTILIZES A NETWORK OF PROVIDERS AND IS NOT A MANAGED CARE HEALTH INSURANCE CONTRACT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER, SHALL PROVIDE ACCESS TO OUT-OF-NETWORK SERVICES CONSISTENT WITH THE REQUIREMENTS OF SUBSECTION (A) OF SECTION FOUR THOUSAND EIGHT HUNDRED FOUR OF THIS CHAPTER, SUBSECTIONS (G-6) AND (G-7) OF SECTION FOUR THOUSAND NINE HUNDRED OF THIS CHAPTER, SUBSECTIONS (A-1) AND (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER, PARAGRAPHS THREE AND FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS CHAPTER, AND SUBPARAGRAPHS (C) AND (D) OF PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

S 8. Paragraphs 11, 12, 13, 14, 16-a, 17, and 18 of subsection (a) of section 4324 of the insurance law, paragraphs 11, 12, 13, 14, 17 and 18 as added by chapter 705 of the laws of 1996, paragraph 16-a as added by chapter 554 of the laws of 2002, are amended and three new paragraphs 19, 20 and 21 are added to read as follows:

(11) where applicable, notice that a subscriber enrolled in a managed care product OR IN A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation may obtain a referral [to] OR PREAUTHORIZATION FOR a health care provider outside of the corporation's network or panel when the corporation does not have a health care provider [with] WHO IS GEOGRAPHICALLY ACCESSIBLE TO THE INSURED AND WHO HAS THE appropriate training and experience in the network or panel to meet the particular health care needs of the subscriber and the procedure by which the subscriber can obtain such referral OR PREAUTHORIZATION;

(12) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral;

(13) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with (i) a life-threatening condition or disease, or (ii) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating the subscriber's medical care and the procedure for requesting and obtaining such a specialist;

(14) where applicable, notice that a subscriber enrolled in a managed care product OR A COMPREHENSIVE CONTRACT THAT UTILIZES A NETWORK OF PROVIDERS offered by the corporation with [(i)] (A) a life-threatening condition or disease, or [(ii)] (B) a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center and the procedure by which such access may be obtained;

(16-a) where applicable, notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

(17) where applicable, a listing by specialty, which may be in a separate document that is updated annually, of the name, address, and telephone number of all participating providers, including facilities, and in addition, in the case of physicians, board certification[; and], LANGUAGES SPOKEN AND ANY AFFILIATIONS WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE CORPORATION'S WEBSITE AND THE CORPORATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE CORPORATION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(18) a description of the mechanisms by which subscribers may participate in the development of the policies of the corporation[.];

(19) THE METHOD BY WHICH A SUBSCRIBER MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES;

(20) WITH RESPECT TO OUT-OF-NETWORK COVERAGE:

(A) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE CORPORATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(B) A DESCRIPTION OF THE AMOUNT THAT THE CORPORATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(C) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(21) INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS A SUBSCRIBER OR PROSPECTIVE SUBSCRIBER TO ESTIMATE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE CORPORATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 9. Paragraphs 11 and 12 of subsection (b) of section 4324 of the insurance law, as added by chapter 705 of the laws of 1996, are amended and two new paragraphs 13 and 14 are added to read as follows:

(11) where applicable, provide the written application procedures and minimum qualification requirements for health care providers to be considered by the corporation for participation in the corporation's network for a managed care product; [and]

(12) disclose such other information as required by the superintendent, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(13) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; AND

(14) WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE APPROXIMATE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE. THE CORPORATION SHALL ALSO INFORM THE INSURED THROUGH SUCH DISCLOSURE THAT SUCH APPROXIMATION IS NOT BINDING ON THE CORPORATION AND THAT THE APPROXIMATE DOLLAR AMOUNT THAT THE CORPORATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE MAY CHANGE.

S 10. Section 4324 of the insurance law is amended by adding a new subsection (f) to read as follows:

(F) FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO THIS ARTICLE, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THIS CHAPTER, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 11. Section 4900 of the insurance law is amended by adding a new subsection (g-6-a) to read as follows:

(G-6-A) "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL UNDER A MANAGED CARE PRODUCT AS DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF AN OUT-OF-NETWORK REFERRAL DENIAL PROVIDED TO AN INSURED SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE INSURED MUST SUBMIT IN ORDER TO APPEAL THE OUT-OF-NETWORK REFERRAL DENIAL PURSUANT TO SUBSECTION (A-2) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. AN OUT-OF-NETWORK REFERRAL DENIAL UNDER THIS SUBSECTION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. AN OUT-OF-NETWORK REFERRAL DENIAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBSECTION (G-6) OF THIS SECTION.

S 12. Subsection (b) of section 4903 of the insurance law, as amended by chapter 514 of the laws of 2013, is amended to read as follows:

(b) A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's

health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. THE NOTIFICATION SHALL IDENTIFY: (1) WHETHER THE SERVICES ARE CONSIDERED IN-NETWORK OR OUT-OF-NETWORK; (2) WHETHER THE INSURED WILL BE HELD HARMLESS FOR THE SERVICES AND NOT BE RESPONSIBLE FOR ANY PAYMENT, OTHER THAN ANY APPLICABLE CO-PAYMENT, CO-INSURANCE OR DEDUCTIBLE; (3) AS APPLICABLE, THE DOLLAR AMOUNT THE HEALTH CARE PLAN WILL PAY IF THE SERVICE IS OUT-OF-NETWORK; AND (4) AS APPLICABLE, INFORMATION EXPLAINING HOW AN INSURED MAY DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH CARE PLAN WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 13. Section 4904 of the insurance law is amended by adding a new subsection (a-2) to read as follows:

(A-2) AN INSURED OR THE INSURED'S DESIGNEE MAY APPEAL AN OUT-OF-NETWORK REFERRAL DENIAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE INSURED'S ATTENDING PHYSICIAN, WHO MUST BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT, PROVIDED THAT: (1) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED FOR THE HEALTH SERVICE; AND (2) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 14. Subsection (b) of section 4910 of the insurance law is amended by adding a new paragraph 4 to read as follows:

(4)(A) THE INSURED HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(B) THE INSURED'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE INSURED FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 15. Paragraph 4 of subsection (b) of section 4914 of the insurance law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL DENIAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(I) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE INSURED, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE INSURED'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN INSURED, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(II) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE INSURED; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 16. The public health law is amended by adding a new section 23 to read as follows:

S 23. CLAIM FORMS. A NON-PARTICIPATING PHYSICIAN SHALL INCLUDE A CLAIM FORM FOR A THIRD-PARTY PAYOR WITH A PATIENT BILL FOR HEALTH CARE SERVICES, OTHER THAN A BILL FOR THE PATIENT'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE.

S 17. The public health law is amended by adding a new section 24 to read as follows:

S 24. DISCLOSURE. 1. A HEALTH CARE PROFESSIONAL, OR A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS, A DIAGNOSTIC AND TREATMENT CENTER OR A HEALTH CENTER DEFINED UNDER 42 U.S.C. S 254B ON BEHALF OF HEALTH CARE PROFESSIONALS RENDERING SERVICES AT THE GROUP PRACTICE, DIAGNOSTIC AND TREATMENT CENTER OR HEALTH CENTER, SHALL DISCLOSE TO PATIENTS OR PROSPECTIVE PATIENTS IN WRITING OR THROUGH AN INTERNET WEBSITE THE HEALTH CARE PLANS IN WHICH THE HEALTH CARE PROFESSIONAL, GROUP PRACTICE, DIAGNOSTIC AND TREATMENT CENTER OR HEALTH CENTER, IS A PARTICIPATING PROVIDER AND THE HOSPITALS WITH WHICH THE HEALTH CARE PROFESSIONAL IS AFFILIATED PRIOR TO THE PROVISION OF NON-EMERGENCY SERVICES AND VERBALLY AT THE TIME AN APPOINTMENT IS SCHEDULED.

2. IF A HEALTH CARE PROFESSIONAL, OR A GROUP PRACTICE OF HEALTH CARE PROFESSIONALS, A DIAGNOSTIC AND TREATMENT CENTER OR A HEALTH CENTER DEFINED UNDER 42 U.S.C. S 254B ON BEHALF OF HEALTH CARE PROFESSIONALS RENDERING SERVICES AT THE GROUP PRACTICE, DIAGNOSTIC AND TREATMENT CENTER OR HEALTH CENTER, DOES NOT PARTICIPATE IN THE NETWORK OF A PATIENT'S OR PROSPECTIVE PATIENT'S HEALTH CARE PLAN, THE HEALTH CARE PROFESSIONAL, GROUP PRACTICE, DIAGNOSTIC AND TREATMENT CENTER OR HEALTH CENTER, SHALL: (A) PRIOR TO THE PROVISION OF NON-EMERGENCY SERVICES, INFORM A PATIENT OR PROSPECTIVE PATIENT THAT THE AMOUNT OR ESTIMATED AMOUNT THE HEALTH CARE PROFESSIONAL WILL BILL THE PATIENT FOR HEALTH CARE SERVICES IS AVAILABLE UPON REQUEST; AND (B) UPON RECEIPT OF A REQUEST FROM A PATIENT OR PROSPECTIVE PATIENT, DISCLOSE TO THE PATIENT OR PROSPECTIVE PATIENT IN WRITING THE AMOUNT OR ESTIMATED AMOUNT OR, WITH RESPECT TO A HEALTH CENTER, A SCHEDULE OF FEES PROVIDED UNDER 42 U.S.C. S 254B(K)(3)(G)(I), THAT THE HEALTH CARE PROFESSIONAL, GROUP PRACTICE, DIAGNOSTIC AND TREATMENT CENTER OR HEALTH CENTER, WILL BILL THE PATIENT OR PROSPECTIVE PATIENT FOR HEALTH CARE SERVICES PROVIDED OR

ANTICIPATED TO BE PROVIDED TO THE PATIENT OR PROSPECTIVE PATIENT ABSENT UNFORESEEN MEDICAL CIRCUMSTANCES THAT MAY ARISE WHEN THE HEALTH CARE SERVICES ARE PROVIDED.

3. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL PROVIDE A PATIENT OR PROSPECTIVE PATIENT WITH THE NAME, PRACTICE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF ANY HEALTH CARE PROVIDER SCHEDULED TO PERFORM ANESTHESIOLOGY, LABORATORY, PATHOLOGY, RADIOLOGY OR ASSISTANT SURGEON SERVICES IN CONNECTION WITH CARE TO BE PROVIDED IN THE PHYSICIAN'S OFFICE FOR THE PATIENT OR COORDINATED OR REFERRED BY THE PHYSICIAN FOR THE PATIENT AT THE TIME OF REFERRAL TO OR COORDINATION OF SERVICES WITH SUCH PROVIDER.

4. A HEALTH CARE PROFESSIONAL WHO IS A PHYSICIAN SHALL, FOR A PATIENT'S SCHEDULED HOSPITAL ADMISSION OR SCHEDULED OUTPATIENT HOSPITAL SERVICES, PROVIDE A PATIENT AND THE HOSPITAL WITH THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY OTHER PHYSICIAN WHOSE SERVICES WILL BE ARRANGED BY THE PHYSICIAN AND ARE SCHEDULED AT THE TIME OF THE PRE-ADMISSION TESTING, REGISTRATION OR ADMISSION AT THE TIME NON-EMERGENCY SERVICES ARE SCHEDULED; AND INFORMATION AS TO HOW TO DETERMINE THE HEALTHCARE PLANS IN WHICH THE PHYSICIAN PARTICIPATES.

5. A HOSPITAL SHALL ESTABLISH, UPDATE AND MAKE PUBLIC THROUGH POSTING ON THE HOSPITAL'S WEBSITE, TO THE EXTENT REQUIRED BY FEDERAL GUIDELINES, A LIST OF THE HOSPITAL'S STANDARD CHARGES FOR ITEMS AND SERVICES PROVIDED BY THE HOSPITAL, INCLUDING FOR DIAGNOSIS-RELATED GROUPS ESTABLISHED UNDER SECTION 1886(D)(4) OF THE FEDERAL SOCIAL SECURITY ACT.

6. A HOSPITAL SHALL POST ON THE HOSPITAL'S WEBSITE: (A) THE HEALTH CARE PLANS IN WHICH THE HOSPITAL IS A PARTICIPATING PROVIDER; (B) A STATEMENT THAT (I) PHYSICIAN SERVICES PROVIDED IN THE HOSPITAL ARE NOT INCLUDED IN THE HOSPITAL'S CHARGES; (II) PHYSICIANS WHO PROVIDE SERVICES IN THE HOSPITAL MAY OR MAY NOT PARTICIPATE WITH THE SAME HEALTH CARE PLANS AS THE HOSPITAL, AND; (III) THE PROSPECTIVE PATIENT SHOULD CHECK WITH THE PHYSICIAN ARRANGING FOR THE HOSPITAL SERVICES TO DETERMINE THE HEALTH CARE PLANS IN WHICH THE PHYSICIAN PARTICIPATES; (C) AS APPLICABLE, THE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF THE PHYSICIAN GROUPS THAT THE HOSPITAL HAS CONTRACTED WITH TO PROVIDE SERVICES INCLUDING ANESTHESIOLOGY, PATHOLOGY OR RADIOLOGY, AND INSTRUCTIONS HOW TO CONTACT THESE GROUPS TO DETERMINE THE HEALTH CARE PLAN PARTICIPATION OF THE PHYSICIANS IN THESE GROUPS; AND (D) AS APPLICABLE, THE NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF PHYSICIANS EMPLOYED BY THE HOSPITAL AND WHOSE SERVICES MAY BE PROVIDED AT THE HOSPITAL, AND THE HEALTH CARE PLANS IN WHICH THEY PARTICIPATE.

7. IN REGISTRATION OR ADMISSION MATERIALS PROVIDED IN ADVANCE OF NON-EMERGENCY HOSPITAL SERVICES, A HOSPITAL SHALL: (A) ADVISE THE PATIENT OR PROSPECTIVE PATIENT TO CHECK WITH THE PHYSICIAN ARRANGING THE HOSPITAL SERVICES TO DETERMINE: (I) THE NAME, PRACTICE NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF ANY OTHER PHYSICIAN WHOSE SERVICES WILL BE ARRANGED BY THE PHYSICIAN; AND (II) WHETHER THE SERVICES OF PHYSICIANS WHO ARE EMPLOYED OR CONTRACTED BY THE HOSPITAL TO PROVIDE SERVICES INCLUDING ANESTHESIOLOGY, PATHOLOGY AND/OR RADIOLOGY ARE REASONABLY ANTICIPATED TO BE PROVIDED TO THE PATIENT; AND (B) PROVIDE PATIENTS OR PROSPECTIVE PATIENTS WITH INFORMATION AS TO HOW TO TIMELY DETERMINE THE HEALTH CARE PLANS PARTICIPATED IN BY PHYSICIANS WHO ARE REASONABLY ANTICIPATED TO PROVIDE SERVICES TO THE PATIENT AT THE HOSPITAL, AS DETERMINED BY THE PHYSICIAN ARRANGING THE PATIENT'S HOSPITAL SERVICES, AND WHO ARE EMPLOYEES OF THE HOSPITAL OR CONTRACTED BY THE HOSPITAL TO PROVIDE SERVICES INCLUDING ANESTHESIOLOGY, RADIOLOGY AND/OR PATHOLOGY.

8. FOR PURPOSES OF THIS SECTION:

(A) "HEALTH CARE PLAN" MEANS A HEALTH INSURER INCLUDING AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE SUBJECT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER; A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THE INSURANCE LAW OR A SELF-FUNDED EMPLOYEE WELFARE BENEFIT PLAN.

(B) "HEALTH CARE PROFESSIONAL" MEANS AN APPROPRIATELY LICENSED, REGISTERED OR CERTIFIED HEALTH CARE PROFESSIONAL PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

(C) "HOSPITAL" MEANS A GENERAL HOSPITAL AS DEFINED IN SUBDIVISION TEN OF SECTION TWO THOUSAND EIGHT HUNDRED ONE OF THIS CHAPTER.

S 18. Paragraphs (k), (p-1), (q) and (r) of subdivision 1 of section 4408 of the public health law, paragraphs (k), (q) and (r) as added by chapter 705 of the laws of 1996, and paragraph (p-1) as added by chapter 554 of the laws of 2002, are amended and three new paragraphs (s), (t) and (u) are added to read as follows:

(k) notice that an enrollee may obtain a referral to a health care provider outside of the health maintenance organization's network or panel when the health maintenance organization does not have a health care provider [with] WHO IS GEOGRAPHICALLY ACCESSIBLE TO THE ENROLLEE AND WHO HAS appropriate training and experience in the network or panel to meet the particular health care needs of the enrollee and the procedure by which the enrollee can obtain such referral;

(p-1) notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, INCLUDING ANNUAL EXAMINATIONS, CARE RESULTING FROM SUCH ANNUAL EXAMINATIONS, AND TREATMENT OF ACUTE GYNECOLOGIC CONDITIONS, from a qualified provider of such services of her choice from within the plan [for no fewer than two examinations annually for such services] or [to] FOR any care related to A pregnancy [and that additionally, the enrollee shall have direct access to primary and preventive obstetric and gynecologic services required as a result of such annual examinations or as a result of an acute gynecologic condition];

(q) notice of all appropriate mailing addresses and telephone numbers to be utilized by enrollees seeking information or authorization; [and]

(r) a listing by specialty, which may be in a separate document that is updated annually, of the name, address and telephone number of all participating providers, including facilities, and, in addition, in the case of physicians, board certification[.], LANGUAGES SPOKEN AND ANY AFFILIATIONS WITH PARTICIPATING HOSPITALS. THE LISTING SHALL ALSO BE POSTED ON THE HEALTH MAINTENANCE ORGANIZATION'S WEBSITE AND THE HEALTH MAINTENANCE ORGANIZATION SHALL UPDATE THE WEBSITE WITHIN FIFTEEN DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE HEALTH MAINTENANCE ORGANIZATION'S NETWORK OR A CHANGE IN A PHYSICIAN'S HOSPITAL AFFILIATION;

(S) WHERE APPLICABLE, A DESCRIPTION OF THE METHOD BY WHICH AN ENROLLEE MAY SUBMIT A CLAIM FOR HEALTH CARE SERVICES;

(T) WITH RESPECT TO OUT-OF-NETWORK COVERAGE:

(I) A CLEAR DESCRIPTION OF THE METHODOLOGY USED BY THE HEALTH MAINTENANCE ORGANIZATION TO DETERMINE REIMBURSEMENT FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(II) THE AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE UNDER THE METHODOLOGY FOR OUT-OF-NETWORK HEALTH CARE SERVICES SET

FORTH AS A PERCENTAGE OF THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES;

(III) EXAMPLES OF ANTICIPATED OUT-OF-POCKET COSTS FOR FREQUENTLY BILLED OUT-OF-NETWORK HEALTH CARE SERVICES; AND

(U) INFORMATION IN WRITING AND THROUGH AN INTERNET WEBSITE THAT REASONABLY PERMITS AN ENROLLEE OR PROSPECTIVE ENROLLEE TO ESTIMATE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH MAINTENANCE ORGANIZATION WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 19. Paragraphs (k) and (l) of subdivision 2 of section 4408 of the public health law, as added by chapter 705 of the laws of 1996, are amended and two new paragraphs (m) and (n) are added to read as follows:

(k) provide the written application procedures and minimum qualification requirements for health care providers to be considered by the health maintenance organization; [and]

(l) disclose other information as required by the commissioner, provided that such requirements are promulgated pursuant to the state administrative procedure act[.];

(M) DISCLOSE WHETHER A HEALTH CARE PROVIDER SCHEDULED TO PROVIDE A HEALTH CARE SERVICE IS AN IN-NETWORK PROVIDER; AND

(N) WITH RESPECT TO OUT-OF-NETWORK COVERAGE, DISCLOSE THE APPROXIMATE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE. THE HEALTH MAINTENANCE ORGANIZATION SHALL ALSO INFORM AN ENROLLEE THROUGH SUCH DISCLOSURE THAT SUCH APPROXIMATION IS NOT BINDING ON THE HEALTH MAINTENANCE ORGANIZATION AND THAT THE APPROXIMATE DOLLAR AMOUNT THAT THE HEALTH MAINTENANCE ORGANIZATION WILL PAY FOR A SPECIFIC OUT-OF-NETWORK HEALTH CARE SERVICE MAY CHANGE.

S 20. Section 4408 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. FOR PURPOSES OF THIS SECTION, "USUAL AND CUSTOMARY COST" SHALL MEAN THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT OF FINANCIAL SERVICES. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO THIS ARTICLE.

S 21. Section 4900 of the public health law is amended by adding a new subdivision 7-f-1 to read as follows:

7-F-1. "OUT-OF-NETWORK REFERRAL DENIAL" MEANS A DENIAL OF A REQUEST FOR AN AUTHORIZATION OR REFERRAL TO AN OUT-OF-NETWORK PROVIDER ON THE BASIS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE. THE NOTICE OF AN OUT-OF-NETWORK REFERRAL DENIAL PROVIDED TO AN ENROLLEE SHALL INCLUDE INFORMATION EXPLAINING WHAT INFORMATION THE ENROLLEE MUST SUBMIT IN ORDER TO APPEAL THE OUT-OF-NETWORK REFERRAL DENIAL PURSUANT TO SUBDIVISION ONE-B OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE. AN OUT-OF-NETWORK REFERRAL DENIAL UNDER THIS SUBDIVISION DOES NOT CONSTITUTE AN ADVERSE DETERMINATION AS DEFINED IN THIS ARTICLE. AN OUT-

OF-NETWORK REFERRAL DENIAL SHALL NOT BE CONSTRUED TO INCLUDE AN OUT-OF-NETWORK DENIAL AS DEFINED IN SUBDIVISION SEVEN-F OF THIS SECTION.

S 22. Subdivision 2 of section 4903 of the public health law, as amended by chapter 514 of the laws of 2013, is amended to read as follows:

2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information. To the extent practicable, such written notification to the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. THE NOTIFICATION SHALL IDENTIFY; (A) WHETHER THE SERVICES ARE CONSIDERED IN-NETWORK OR OUT-OF-NETWORK; (B) AND WHETHER THE ENROLLEE WILL BE HELD HARMLESS FOR THE SERVICES AND NOT BE RESPONSIBLE FOR ANY PAYMENT, OTHER THAN ANY APPLICABLE CO-PAYMENT OR CO-INSURANCE; (C) AS APPLICABLE, THE DOLLAR AMOUNT THE HEALTH CARE PLAN WILL PAY IF THE SERVICE IS OUT-OF-NETWORK; AND (D) AS APPLICABLE, INFORMATION EXPLAINING HOW AN ENROLLEE MAY DETERMINE THE ANTICIPATED OUT-OF-POCKET COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES IN A GEOGRAPHICAL AREA OR ZIP CODE BASED UPON THE DIFFERENCE BETWEEN WHAT THE HEALTH CARE PLAN WILL REIMBURSE FOR OUT-OF-NETWORK HEALTH CARE SERVICES AND THE USUAL AND CUSTOMARY COST FOR OUT-OF-NETWORK HEALTH CARE SERVICES.

S 23. Section 4904 of the public health law is amended by adding a new subdivision 1-b to read as follows:

1-B. AN ENROLLEE OR THE ENROLLEE'S DESIGNEE MAY APPEAL A DENIAL OF AN OUT-OF-NETWORK REFERRAL BY A HEALTH CARE PLAN BY SUBMITTING A WRITTEN STATEMENT FROM THE ENROLLEE'S ATTENDING PHYSICIAN, WHO MUST BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT, PROVIDED THAT: (A) THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE FOR THE HEALTH SERVICE; AND (B) RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF THE ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 24. Subdivision 2 of section 4910 of the public health law is amended by adding a new paragraph (d) to read as follows:

(D)(I) THE ENROLLEE HAS HAD AN OUT-OF-NETWORK REFERRAL DENIED ON THE GROUNDS THAT THE HEALTH CARE PLAN HAS A HEALTH CARE PROVIDER IN THE IN-NETWORK BENEFITS PORTION OF ITS NETWORK WITH APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

(II) THE ENROLLEE'S ATTENDING PHYSICIAN, WHO SHALL BE A LICENSED, BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIAN QUALIFIED TO PRACTICE IN THE SPECIALTY AREA OF PRACTICE APPROPRIATE TO TREAT THE ENROLLEE FOR THE HEALTH SERVICE SOUGHT, CERTIFIES THAT THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS RECOMMENDED BY THE HEALTH CARE PLAN DO NOT HAVE THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND RECOMMENDS AN OUT-OF-NETWORK PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, AND WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE.

S 25. Paragraph (d) of subdivision 2 of section 4914 of the public health law is amended by adding a new subparagraph (D) to read as follows:

(D) FOR EXTERNAL APPEALS REQUESTED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED TEN OF THIS TITLE RELATING TO AN OUT-OF-NETWORK REFERRAL DENIAL, THE EXTERNAL APPEAL AGENT SHALL REVIEW THE UTILIZATION REVIEW AGENT'S FINAL ADVERSE DETERMINATION AND, IN ACCORDANCE WITH THE PROVISIONS OF THIS TITLE, SHALL MAKE A DETERMINATION AS TO WHETHER THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH PLAN; PROVIDED THAT SUCH DETERMINATION SHALL:

(I) BE CONDUCTED ONLY BY ONE OR A GREATER ODD NUMBER OF CLINICAL PEER REVIEWERS;

(II) BE ACCOMPANIED BY A WRITTEN STATEMENT:

(1) THAT THE OUT-OF-NETWORK REFERRAL SHALL BE COVERED BY THE HEALTH CARE PLAN EITHER WHEN THE REVIEWER OR A MAJORITY OF THE PANEL OF REVIEWERS DETERMINES, UPON REVIEW OF THE TRAINING AND EXPERIENCE OF THE IN-NETWORK HEALTH CARE PROVIDER OR PROVIDERS PROPOSED BY THE PLAN, THE TRAINING AND EXPERIENCE OF THE REQUESTED OUT-OF-NETWORK PROVIDER, THE CLINICAL STANDARDS OF THE PLAN, THE INFORMATION PROVIDED CONCERNING THE ENROLLEE, THE ATTENDING PHYSICIAN'S RECOMMENDATION, THE ENROLLEE'S MEDICAL RECORD, AND ANY OTHER PERTINENT INFORMATION, THAT THE HEALTH PLAN DOES NOT HAVE A PROVIDER WITH THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE WHO IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND THAT THE OUT-OF-NETWORK PROVIDER HAS THE APPROPRIATE TRAINING AND EXPERIENCE TO MEET THE PARTICULAR HEALTH CARE NEEDS OF AN ENROLLEE, IS ABLE TO PROVIDE THE REQUESTED HEALTH SERVICE, AND IS LIKELY TO PRODUCE A MORE CLINICALLY BENEFICIAL OUTCOME; OR

(2) UPHOLDING THE HEALTH PLAN'S DENIAL OF COVERAGE;

(III) BE SUBJECT TO THE TERMS AND CONDITIONS GENERALLY APPLICABLE TO BENEFITS UNDER THE EVIDENCE OF COVERAGE UNDER THE HEALTH CARE PLAN;

(IV) BE BINDING ON THE PLAN AND THE ENROLLEE; AND

(V) BE ADMISSIBLE IN ANY COURT PROCEEDING.

S 26. The financial services law is amended by adding a new article 6 to read as follows:

ARTICLE 6

EMERGENCY MEDICAL SERVICES AND SURPRISE BILLS

SECTION 601. DISPUTE RESOLUTION PROCESS ESTABLISHED.
602. APPLICABILITY.
603. DEFINITIONS.
604. CRITERIA FOR DETERMINING A REASONABLE FEE.
605. DISPUTE RESOLUTION FOR EMERGENCY SERVICES.
606. HOLD HARMLESS AND ASSIGNMENT OF BENEFITS FOR SURPRISE BILLS FOR INSUREDS.
607. DISPUTE RESOLUTION FOR SURPRISE BILLS.
608. PAYMENT FOR INDEPENDENT DISPUTE RESOLUTION ENTITY.

S 601. DISPUTE RESOLUTION PROCESS ESTABLISHED. THE SUPERINTENDENT SHALL ESTABLISH A DISPUTE RESOLUTION PROCESS BY WHICH A DISPUTE FOR A BILL FOR EMERGENCY SERVICES OR A SURPRISE BILL MAY BE RESOLVED. THE SUPERINTENDENT SHALL HAVE THE POWER TO GRANT AND REVOKE CERTIFICATIONS OF INDEPENDENT DISPUTE RESOLUTION ENTITIES TO CONDUCT THE DISPUTE RESOLUTION PROCESS. THE SUPERINTENDENT SHALL PROMULGATE REGULATIONS ESTABLISHING STANDARDS FOR THE DISPUTE RESOLUTION PROCESS, INCLUDING A PROCESS FOR CERTIFYING AND SELECTING INDEPENDENT DISPUTE RESOLUTION ENTITIES. AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL USE LICENSED PHYSICIANS IN ACTIVE PRACTICE IN THE SAME OR SIMILAR SPECIALTY AS THE

PHYSICIAN PROVIDING THE SERVICE THAT IS SUBJECT TO THE DISPUTE RESOLUTION PROCESS OF THIS ARTICLE. TO THE EXTENT PRACTICABLE, THE PHYSICIAN SHALL BE LICENSED IN THIS STATE.

S 602. APPLICABILITY. (A) THIS ARTICLE SHALL NOT APPLY TO HEALTH CARE SERVICES, INCLUDING EMERGENCY SERVICES, WHERE PHYSICIAN FEES ARE SUBJECT TO SCHEDULES OR OTHER MONETARY LIMITATIONS UNDER ANY OTHER LAW, INCLUDING THE WORKERS' COMPENSATION LAW AND ARTICLE FIFTY-ONE OF THE INSURANCE LAW, AND SHALL NOT PREEMPT ANY SUCH LAW.

(B)(1) WITH REGARD TO EMERGENCY SERVICES BILLED UNDER AMERICAN MEDICAL ASSOCIATION CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES 99281 THROUGH 99285, 99288, 99291 THROUGH 99292, 99217 THROUGH 99220, 99224 THROUGH 99226, AND 99234 THROUGH 99236, THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE SHALL NOT APPLY WHEN:

(A) THE AMOUNT BILLED FOR ANY SUCH CPT CODE MEETS THE REQUIREMENTS SET FORTH IN PARAGRAPH THREE OF THIS SUBSECTION, AFTER ANY APPLICABLE CO-INSURANCE, CO-PAYMENT AND DEDUCTIBLE; AND

(B) THE AMOUNT BILLED FOR ANY SUCH CPT CODE DOES NOT EXCEED ONE HUNDRED TWENTY PERCENT OF THE USUAL AND CUSTOMARY COST FOR SUCH CPT CODE.

(2) THE HEALTH CARE PLAN SHALL ENSURE THAT AN INSURED SHALL NOT INCUR ANY GREATER OUT-OF-POCKET COSTS FOR EMERGENCY SERVICES BILLED UNDER A CPT CODE AS SET FORTH IN THIS SUBSECTION THAN THE INSURED WOULD HAVE INCURRED IF SUCH EMERGENCY SERVICES WERE PROVIDED BY A PARTICIPATING PHYSICIAN.

(3) BEGINNING JANUARY FIRST, TWO THOUSAND FIFTEEN AND EACH JANUARY FIRST THEREAFTER, THE SUPERINTENDENT SHALL PUBLISH ON A WEBSITE MAINTAINED BY THE DEPARTMENT OF FINANCIAL SERVICES, AND PROVIDE IN WRITING TO EACH HEALTH CARE PLAN, A DOLLAR AMOUNT FOR WHICH BILLS FOR THE PROCEDURE CODES IDENTIFIED IN THIS SUBSECTION SHALL BE EXEMPT FROM THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE. SUCH AMOUNT SHALL EQUAL THE AMOUNT FROM THE PRIOR YEAR, BEGINNING WITH SIX HUNDRED DOLLARS IN TWO THOUSAND FOURTEEN, ADJUSTED BY THE AVERAGE OF THE ANNUAL AVERAGE INFLATION RATES FOR THE MEDICAL CARE COMMODITIES AND MEDICAL CARE SERVICES COMPONENTS OF THE CONSUMER PRICE INDEX. IN NO EVENT SHALL AN AMOUNT EXCEEDING ONE THOUSAND TWO HUNDRED DOLLARS FOR A SPECIFIC CPT CODE BILLED BE EXEMPT FROM THE DISPUTE RESOLUTION PROCESS ESTABLISHED IN THIS ARTICLE.

S 603. DEFINITIONS. FOR THE PURPOSES OF THIS ARTICLE:

(A) "EMERGENCY CONDITION" MEANS A MEDICAL OR BEHAVIORAL CONDITION THAT MANIFESTS ITSELF BY ACUTE SYMPTOMS OF SUFFICIENT SEVERITY, INCLUDING SEVERE PAIN, SUCH THAT A PRUDENT LAYPERSON, POSSESSING AN AVERAGE KNOWLEDGE OF MEDICINE AND HEALTH, COULD REASONABLY EXPECT THE ABSENCE OF IMMEDIATE MEDICAL ATTENTION TO RESULT IN : (1) PLACING THE HEALTH OF THE PERSON AFFLICTED WITH SUCH CONDITION IN SERIOUS JEOPARDY, OR IN THE CASE OF A BEHAVIORAL CONDITION PLACING THE HEALTH OF SUCH PERSON OR OTHERS IN SERIOUS JEOPARDY; (2) SERIOUS IMPAIRMENT TO SUCH PERSON'S BODILY FUNCTIONS; (3) SERIOUS DYSFUNCTION OF ANY BODILY ORGAN OR PART OF SUCH PERSON; (4) SERIOUS DISFIGUREMENT OF SUCH PERSON; OR (5) A CONDITION DESCRIBED IN CLAUSE (I), (II) OR (III) OF SECTION 1867(E)(1)(A) OF THE SOCIAL SECURITY ACT 42 U.S.C. S 1395DD.

(B) "EMERGENCY SERVICES" MEANS, WITH RESPECT TO AN EMERGENCY CONDITION: (1) A MEDICAL SCREENING EXAMINATION AS REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, WHICH IS WITHIN THE CAPABILITY OF THE EMERGENCY DEPARTMENT OF A HOSPITAL, INCLUDING ANCILLARY SERVICES ROUTINELY AVAILABLE TO THE EMERGENCY DEPARTMENT TO EVALUATE SUCH EMERGENCY MEDICAL CONDITION; AND (2) WITHIN THE CAPABILITIES OF

THE STAFF AND FACILITIES AVAILABLE AT THE HOSPITAL, SUCH FURTHER MEDICAL EXAMINATION AND TREATMENT AS ARE REQUIRED UNDER SECTION 1867 OF THE SOCIAL SECURITY ACT, 42 U.S.C. S 1395DD, TO STABILIZE THE PATIENT.

(C) "HEALTH CARE PLAN" MEANS AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE PURSUANT TO ARTICLE THIRTY-TWO OF THE INSURANCE LAW; A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW; A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW; A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW; OR A STUDENT HEALTH PLAN ESTABLISHED OR MAINTAINED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THE INSURANCE LAW.

(D) "INSURED" MEANS A PATIENT COVERED UNDER A HEALTH CARE PLAN'S POLICY OR CONTRACT.

(E) "NON-PARTICIPATING" MEANS NOT HAVING A CONTRACT WITH A HEALTH CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO AN INSURED.

(F) "PARTICIPATING" MEANS HAVING A CONTRACT WITH A HEALTH CARE PLAN TO PROVIDE HEALTH CARE SERVICES TO AN INSURED.

(G) "PATIENT" MEANS A PERSON WHO RECEIVES HEALTH CARE SERVICES, INCLUDING EMERGENCY SERVICES, IN THIS STATE.

(H) "SURPRISE BILL" MEANS A BILL FOR HEALTH CARE SERVICES, OTHER THAN EMERGENCY SERVICES, RECEIVED BY:

(1) AN INSURED FOR SERVICES RENDERED BY A NON-PARTICIPATING PHYSICIAN AT A PARTICIPATING HOSPITAL OR AMBULATORY SURGICAL CENTER, WHERE A PARTICIPATING PHYSICIAN IS UNAVAILABLE OR A NON-PARTICIPATING PHYSICIAN RENDERS SERVICES WITHOUT THE INSURED'S KNOWLEDGE, OR UNFORESEEN MEDICAL SERVICES ARISE AT THE TIME THE HEALTH CARE SERVICES ARE RENDERED; PROVIDED, HOWEVER, THAT A SURPRISE BILL SHALL NOT MEAN A BILL RECEIVED FOR HEALTH CARE SERVICES WHEN A PARTICIPATING PHYSICIAN IS AVAILABLE AND THE INSURED HAS ELECTED TO OBTAIN SERVICES FROM A NON-PARTICIPATING PHYSICIAN;

(2) AN INSURED FOR SERVICES RENDERED BY A NON-PARTICIPATING PROVIDER, WHERE THE SERVICES WERE REFERRED BY A PARTICIPATING PHYSICIAN TO A NON-PARTICIPATING PROVIDER WITHOUT EXPLICIT WRITTEN CONSENT OF THE INSURED ACKNOWLEDGING THAT THE PARTICIPATING PHYSICIAN IS REFERRING THE INSURED TO A NON-PARTICIPATING PROVIDER AND THAT THE REFERRAL MAY RESULT IN COSTS NOT COVERED BY THE HEALTH CARE PLAN; OR

(3) A PATIENT WHO IS NOT AN INSURED FOR SERVICES RENDERED BY A PHYSICIAN AT A HOSPITAL OR AMBULATORY SURGICAL CENTER, WHERE THE PATIENT HAS NOT TIMELY RECEIVED ALL OF THE DISCLOSURES REQUIRED PURSUANT TO SECTION TWENTY-FOUR OF THE PUBLIC HEALTH LAW.

(I) "USUAL AND CUSTOMARY COST" MEANS THE EIGHTIETH PERCENTILE OF ALL CHARGES FOR THE PARTICULAR HEALTH CARE SERVICE PERFORMED BY A PROVIDER IN THE SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA AS REPORTED IN A BENCHMARKING DATABASE MAINTAINED BY A NONPROFIT ORGANIZATION SPECIFIED BY THE SUPERINTENDENT. THE NONPROFIT ORGANIZATION SHALL NOT BE AFFILIATED WITH AN INSURER, A CORPORATION SUBJECT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, A MUNICIPAL COOPERATIVE HEALTH BENEFIT PLAN CERTIFIED PURSUANT TO ARTICLE FORTY-SEVEN OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION CERTIFIED PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW.

S 604. CRITERIA FOR DETERMINING A REASONABLE FEE. IN DETERMINING THE APPROPRIATE AMOUNT TO PAY FOR A HEALTH CARE SERVICE, AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL CONSIDER ALL RELEVANT FACTORS, INCLUDING:

(A) WHETHER THERE IS A GROSS DISPARITY BETWEEN THE FEE CHARGED BY THE PHYSICIAN FOR SERVICES RENDERED AS COMPARED TO:

(1) FEES PAID TO THE INVOLVED PHYSICIAN FOR THE SAME SERVICES RENDERED BY THE PHYSICIAN TO OTHER PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN IS NOT PARTICIPATING, AND

(2) IN THE CASE OF A DISPUTE INVOLVING A HEALTH CARE PLAN, FEES PAID BY THE HEALTH CARE PLAN TO REIMBURSE SIMILARLY QUALIFIED PHYSICIANS FOR THE SAME SERVICES IN THE SAME REGION WHO ARE NOT PARTICIPATING WITH THE HEALTH CARE PLAN;

(B) THE LEVEL OF TRAINING, EDUCATION AND EXPERIENCE OF THE PHYSICIAN;

(C) THE PHYSICIAN'S USUAL CHARGE FOR COMPARABLE SERVICES WITH REGARD TO PATIENTS IN HEALTH CARE PLANS IN WHICH THE PHYSICIAN IS NOT PARTICIPATING;

(D) THE CIRCUMSTANCES AND COMPLEXITY OF THE PARTICULAR CASE, INCLUDING TIME AND PLACE OF THE SERVICE;

(E) INDIVIDUAL PATIENT CHARACTERISTICS; AND

(F) THE USUAL AND CUSTOMARY COST OF THE SERVICE.

S 605. DISPUTE RESOLUTION FOR EMERGENCY SERVICES. (A) EMERGENCY SERVICES FOR AN INSURED. (1) WHEN A HEALTH CARE PLAN RECEIVES A BILL FOR EMERGENCY SERVICES FROM A NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN SHALL PAY AN AMOUNT THAT IT DETERMINES IS REASONABLE FOR THE EMERGENCY SERVICES RENDERED BY THE NON-PARTICIPATING PHYSICIAN, IN ACCORDANCE WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW, EXCEPT FOR THE INSURED'S CO-PAYMENT, COINSURANCE OR DEDUCTIBLE, IF ANY, AND SHALL ENSURE THAT THE INSURED SHALL INCUR NO GREATER OUT-OF-POCKET COSTS FOR THE EMERGENCY SERVICES THAN THE INSURED WOULD HAVE INCURRED WITH A PARTICIPATING PHYSICIAN PURSUANT TO SUBSECTION (C) OF SECTION THREE THOUSAND TWO HUNDRED FORTY-ONE OF THE INSURANCE LAW.

(2) A NON-PARTICIPATING PHYSICIAN OR A HEALTH CARE PLAN MAY SUBMIT A DISPUTE REGARDING A FEE OR PAYMENT FOR EMERGENCY SERVICES FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(3) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL MAKE A DETERMINATION WITHIN THIRTY DAYS OF RECEIPT OF THE DISPUTE FOR REVIEW.

(4) IN DETERMINING A REASONABLE FEE FOR THE SERVICES RENDERED, AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL SELECT EITHER THE HEALTH CARE PLAN'S PAYMENT OR THE NON-PARTICIPATING PHYSICIAN'S FEE. THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE WHICH AMOUNT TO SELECT BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE. IF AN INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES, BASED ON THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE, THAT A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN IS REASONABLY LIKELY, OR THAT BOTH THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE REPRESENT UNREASONABLE EXTREMES, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY MAY DIRECT BOTH PARTIES TO ATTEMPT A GOOD FAITH NEGOTIATION FOR SETTLEMENT. THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN MAY BE GRANTED UP TO TEN BUSINESS DAYS FOR THIS NEGOTIATION, WHICH SHALL RUN CONCURRENTLY WITH THE THIRTY DAY PERIOD FOR DISPUTE RESOLUTION.

(B) EMERGENCY SERVICES FOR A PATIENT THAT IS NOT AN INSURED. (1) A PATIENT THAT IS NOT AN INSURED OR THE PATIENT'S PHYSICIAN MAY SUBMIT A DISPUTE REGARDING A FEE FOR EMERGENCY SERVICES FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY UPON APPROVAL OF THE SUPERINTENDENT.

(2) AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES BASED UPON THE SAME CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE.

(3) A PATIENT THAT IS NOT AN INSURED SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE IN ORDER TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(C) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE HEALTH CARE PLAN, PHYSICIAN AND PATIENT, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE HEALTH CARE PLAN, PHYSICIAN OR PATIENT, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE PHYSICIAN.

S 606. HOLD HARMLESS AND ASSIGNMENT OF BENEFITS FOR SURPRISE BILLS FOR INSUREDS. WHEN AN INSURED ASSIGNS BENEFITS FOR A SURPRISE BILL IN WRITING TO A NON-PARTICIPATING PHYSICIAN THAT KNOWS THE INSURED IS INSURED UNDER A HEALTH CARE PLAN, THE NON-PARTICIPATING PHYSICIAN SHALL NOT BILL THE INSURED EXCEPT FOR ANY APPLICABLE COPAYMENT, COINSURANCE OR DEDUCTIBLE THAT WOULD BE OWED IF THE INSURED UTILIZED A PARTICIPATING PHYSICIAN.

S 607. DISPUTE RESOLUTION FOR SURPRISE BILLS. (A) SURPRISE BILL RECEIVED BY AN INSURED WHO ASSIGNS BENEFITS. (1) IF AN INSURED ASSIGNS BENEFITS TO A NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN IN ACCORDANCE WITH PARAGRAPHS TWO AND THREE OF THIS SUBSECTION.

(2) THE NON-PARTICIPATING PHYSICIAN MAY BILL THE HEALTH CARE PLAN FOR THE HEALTH CARE SERVICES RENDERED, AND THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN THE BILLED AMOUNT OR ATTEMPT TO NEGOTIATE REIMBURSEMENT WITH THE NON-PARTICIPATING PHYSICIAN.

(3) IF THE HEALTH CARE PLAN'S ATTEMPTS TO NEGOTIATE REIMBURSEMENT FOR HEALTH CARE SERVICES PROVIDED BY A NON-PARTICIPATING PHYSICIAN DOES NOT RESULT IN A RESOLUTION OF THE PAYMENT DISPUTE BETWEEN THE NON-PARTICIPATING PHYSICIAN AND THE HEALTH CARE PLAN, THE HEALTH CARE PLAN SHALL PAY THE NON-PARTICIPATING PHYSICIAN AN AMOUNT THE HEALTH CARE PLAN DETERMINES IS REASONABLE FOR THE HEALTH CARE SERVICES RENDERED, EXCEPT FOR THE INSURED'S COPAYMENT, COINSURANCE OR DEDUCTIBLE, IN ACCORDANCE WITH SECTION THREE THOUSAND TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW.

(4) EITHER THE HEALTH CARE PLAN OR THE NON-PARTICIPATING PHYSICIAN MAY SUBMIT THE DISPUTE REGARDING THE SURPRISE BILL FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY, PROVIDED HOWEVER, THE HEALTH CARE PLAN MAY NOT SUBMIT THE DISPUTE UNLESS IT HAS COMPLIED WITH THE REQUIREMENTS OF PARAGRAPHS ONE, TWO AND THREE OF THIS SUBSECTION.

(5) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL MAKE A DETERMINATION WITHIN THIRTY DAYS OF RECEIPT OF THE DISPUTE FOR REVIEW.

(6) WHEN DETERMINING A REASONABLE FEE FOR THE SERVICES RENDERED, THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL SELECT EITHER THE HEALTH CARE PLAN'S PAYMENT OR THE NON-PARTICIPATING PHYSICIAN'S FEE. AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE WHICH AMOUNT TO SELECT BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE. IF AN INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES, BASED ON THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE, THAT A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN IS REASONABLY LIKELY, OR THAT BOTH THE HEALTH CARE PLAN'S PAYMENT AND THE NON-PARTICIPATING PHYSICIAN'S FEE REPRESENT UNREASONABLE EXTREMES, THEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY MAY DIRECT BOTH PARTIES TO ATTEMPT A GOOD FAITH NEGOTIATION FOR SETTLEMENT. THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN MAY BE GRANTED UP TO TEN BUSINESS DAYS FOR THIS NEGOTIATION, WHICH SHALL RUN CONCURRENTLY WITH THE THIRTY DAY PERIOD FOR DISPUTE RESOLUTION.

(B) SURPRISE BILL RECEIVED BY AN INSURED WHO DOES NOT ASSIGN BENEFITS OR BY A PATIENT WHO IS NOT AN INSURED. (1) AN INSURED WHO DOES NOT ASSIGN BENEFITS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION OR A PATIENT WHO IS NOT AN INSURED AND WHO RECEIVES A SURPRISE BILL MAY SUBMIT A DISPUTE REGARDING THE SURPRISE BILL FOR REVIEW TO AN INDEPENDENT DISPUTE RESOLUTION ENTITY.

(2) THE INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL DETERMINE A REASONABLE FEE FOR THE SERVICES RENDERED BASED UPON THE CONDITIONS AND FACTORS SET FORTH IN SECTION SIX HUNDRED FOUR OF THIS ARTICLE.

(3) A PATIENT OR INSURED WHO DOES NOT ASSIGN BENEFITS IN ACCORDANCE WITH SUBSECTION (A) OF THIS SECTION SHALL NOT BE REQUIRED TO PAY THE PHYSICIAN'S FEE TO BE ELIGIBLE TO SUBMIT THE DISPUTE FOR REVIEW TO THE INDEPENDENT DISPUTE ENTITY.

(C) THE DETERMINATION OF AN INDEPENDENT DISPUTE RESOLUTION ENTITY SHALL BE BINDING ON THE PATIENT, PHYSICIAN AND HEALTH CARE PLAN, AND SHALL BE ADMISSIBLE IN ANY COURT PROCEEDING BETWEEN THE PATIENT OR INSURED, PHYSICIAN OR HEALTH CARE PLAN, OR IN ANY ADMINISTRATIVE PROCEEDING BETWEEN THIS STATE AND THE PHYSICIAN.

S 608. PAYMENT FOR INDEPENDENT DISPUTE RESOLUTION ENTITY. (A) FOR DISPUTES INVOLVING AN INSURED, WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE HEALTH CARE PLAN'S PAYMENT IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE NON-PARTICIPATING PHYSICIAN. WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE NON-PARTICIPATING PHYSICIAN'S FEE IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE HEALTH CARE PLAN. WHEN A GOOD FAITH NEGOTIATION DIRECTED BY THE INDEPENDENT DISPUTE RESOLUTION ENTITY PURSUANT TO PARAGRAPH FOUR OF SUBSECTION (A) OF SECTION SIX HUNDRED FIVE OF THIS ARTICLE, OR PARAGRAPH SIX OF SUBSECTION (A) OF SECTION SIX HUNDRED SEVEN OF THIS ARTICLE RESULTS IN A SETTLEMENT BETWEEN THE HEALTH CARE PLAN AND NON-PARTICIPATING PHYSICIAN, THE HEALTH CARE PLAN AND THE NON-PARTICIPATING PHYSICIAN SHALL EVENLY DIVIDE AND SHARE THE PRORATED COST FOR DISPUTE RESOLUTION.

(B) FOR DISPUTES INVOLVING A PATIENT THAT IS NOT AN INSURED, WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE PHYSICIAN'S FEE IS REASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE PATIENT UNLESS PAYMENT FOR THE DISPUTE RESOLUTION PROCESS WOULD POSE A HARDSHIP TO THE PATIENT. THE SUPERINTENDENT SHALL PROMULGATE A REGULATION TO DETERMINE PAYMENT FOR THE DISPUTE RESOLUTION PROCESS IN CASES OF HARDSHIP. WHEN THE INDEPENDENT DISPUTE RESOLUTION ENTITY DETERMINES THE PHYSICIAN'S FEE IS UNREASONABLE, PAYMENT FOR THE DISPUTE RESOLUTION PROCESS SHALL BE THE RESPONSIBILITY OF THE PHYSICIAN.

S 27. Paragraphs 5 and 6 of subsection (a) of section 2601 of the insurance law, paragraph 5 as amended by chapter 547 of the laws of 1997 and paragraph 6 as amended by chapter 388 of the laws of 2008, are amended and a new paragraph 7 is added to read as follows:

(5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; [or]

(6) failing to promptly disclose coverage pursuant to subsection (d) or subparagraph (A) of paragraph two of subsection (f) of section three thousand four hundred twenty of this chapter[.]; OR

(7) SUBMITTING REASONABLY RENDERED CLAIMS TO THE INDEPENDENT DISPUTE RESOLUTION PROCESS ESTABLISHED UNDER ARTICLE SIX OF THE FINANCIAL SERVICES LAW.

S 28. 1. An out-of-network reimbursement rate workgroup shall be convened and shall consist of 9 members appointed by the governor. Two

members shall be appointed on the recommendation of the speaker of the assembly and two members shall be appointed on the recommendation of the temporary president of the senate and shall consist of two physicians, two representatives of health plans, and three consumers and shall be co-chaired by the superintendent of the department of financial services and the commissioner of the department of health. Such representatives of the workgroup must represent different regions of the state. The members shall receive no compensation for their services, but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

2. The workgroup shall review the current out-of-network reimbursement rates used by health insurers licensed under the insurance law and health maintenance organizations certified under the public health law and the rate methodology as required under the laws of 2014 and make recommendations regarding an alternative rate methodology taking into consideration the following factors:

a. current physician charges for out-of-network services;

b. trends in medical care and the actual costs of medical care;

c. regional differences regarding medical costs and trends;

d. the current methodologies and levels of reimbursement for out-of-network services currently paid by health plans, including insurers, HMOs, Medicare, and Medicaid;

e. the current in-network rates paid by health plans, including insurers, HMOs, Medicare and Medicaid for the same service and by the same provider;

f. the impact different rate methodologies would have on out-of-pocket costs for consumers who access out-of-network services;

g. the impact different rate methodologies would have on premium costs in different regions of the state;

h. reimbursement data from all health plans both public and private as well as charge data from medical professionals and hospitals available through the All Payer Database as developed and maintained by the department of health including data provided in the annual report published pursuant to section 2816 of the public health law; and

i. other issues deemed appropriate by either the superintendent of the department of financial services or the commissioner of the department of health.

3. The workgroup shall review out-of-network coverage in the individual and small group markets and make recommendations regarding the availability and adequacy of the coverage, taking into consideration the following factors:

a. the extent to which out-of-network coverage is available in each rating region in this state;

b. the extent to which a significant level of out-of-network benefits is available in every rating region in this state, including the prevalence of coverage based on the usual and customary cost as well as coverage based on other set reimbursement methodologies, such as Medicare; and

c. other issues deemed appropriate by either the superintendent of the department of financial services or the commissioner of the department of health.

4. The workgroup shall report its findings and make recommendations for legislation and regulations to the governor, the speaker of the assembly, the senate majority leader, the chairs of the insurance and health committees in both the assembly and the senate, and the super-

intendent of the department of financial services no later than January 1, 2016.

S 29. This act shall take effect one year after it shall have become a law, provided, however, that:

1. if the amendments by chapter 514 of the laws of 2013 made to subsection (b) of section 4903 of the insurance law and subdivision 2 of section 4903 of the public health law, as amended by sections twelve and twenty-two of this act, respectively, take effect after such date, then sections twelve and twenty-two of this act shall take effect on the same date as chapter 514 of the laws of 2013 takes effect;

2. for policies renewed on and after such date this act shall take effect on the renewal date;

3. sections twelve, sixteen, seventeen, twenty-two and twenty-six of this act shall apply to health care services provided on and after such date;

4. sections eleven, thirteen, fourteen, fifteen, twenty-one, twenty-three, twenty-four and twenty-five of this act shall apply to denials issued on and after such date; and

5. effective immediately, the superintendent of financial services may promulgate any regulations necessary for the implementation of the provisions of this act on its effective date, and may certify one or more independent dispute resolution entities.

PART I

Section 1. Subdivisions 3-b and 3-c of section 1 and section 4 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, as amended by section 1 of part N of chapter 56 of the laws of 2013, are amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [2014] 2016, the commissioners shall not include a COLA for the purpose of establishing rates of payments, contracts or any other form of reimbursement.

3-c. Notwithstanding any inconsistent provision of law, beginning April 1, [2014] 2016 and ending March 31, [2017] 2019, 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 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2006; provided section one of this act shall expire and be deemed repealed April 1, [2017] 2019; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

S 2. Section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, is amended by adding a new subdivision 3-d to read as follows:

3-D. (I) NOTWITHSTANDING THE PROVISIONS OF SUBDIVISION 3-B OF THIS SECTION, AS AMENDED BY SECTION ONE OF A CHAPTER OF THE LAWS OF 2014 WHICH ADDED THIS SUBDIVISION, OR ANY OTHER INCONSISTENT PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF THE APPROPRIATION THEREFOR, FOR THE PROGRAMS LISTED IN PARAGRAPHS (I), (II), (III), (IV), (V) AND (VI)

OF SUBDIVISION 4 OF THIS SECTION, THE COMMISSIONERS SHALL PROVIDE FUNDING TO SUPPORT (1) A TWO PERCENT (2%) INCREASE IN ANNUAL SALARY AND SALARY-RELATED FRINGE BENEFITS FOR DIRECT CARE STAFF AND DIRECT SUPPORT PROFESSIONALS, AND IN PAYMENT TO FOSTER PARENTS AND ADOPTIVE PARENTS, AS DEFINED BY THE COMMISSIONER OF THE APPLICABLE STATE AGENCY SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET BEGINNING JANUARY 1, 2015, AND (2) A TWO PERCENT (2%) INCREASE IN ANNUAL SALARY AND SALARY-RELATED FRINGE BENEFITS FOR DIRECT CARE STAFF, DIRECT SUPPORT PROFESSIONALS AND CLINICAL STAFF, AND IN PAYMENT TO FOSTER PARENTS AND ADOPTIVE PARENTS, AS DEFINED BY THE COMMISSIONER OF THE APPLICABLE STATE AGENCY SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET BEGINNING APRIL 1, 2015. SUCH COMMISSIONERS SHALL USE THE CONSOLIDATED FISCAL REPORTING MANUAL AS A REFERENCE, TO THE EXTENT THAT APPLICABLE JOB TITLES ARE LISTED THEREIN. WHERE APPLICABLE, THE FUNDING PROVIDED UNDER THIS SUBDIVISION SHALL BE APPLIED TO REIMBURSABLE COSTS OR CONTRACT AMOUNTS TO SUPPORT SALARY INCREASES AND SALARY-RELATED FRINGE BENEFITS OF ELIGIBLE PERSONS, THAT TOOK EFFECT ON OR AFTER JANUARY 1, 2014. THE COMMISSIONERS SHALL PROVIDE FUNDING FOR SUCH SALARY AND ASSOCIATED FRINGE BENEFIT INCREASES IN A MANNER WHICH WILL RESULT IN A CONSISTENT METHODOLOGY AMONG PROGRAMS AND PROVIDER TYPES.

(II) THE COMMISSIONERS SHALL DEVELOP STANDARDS, INCLUDING BUT NOT LIMITED TO, REQUIRING THAT A LOCAL GOVERNMENT UNIT OR PROVIDER AGENCY DEVELOP A PLAN OF IMPLEMENTATION TO ENSURE THAT SUCH FUNDING INCREASES SHALL BE DIRECTED TO DIRECT CARE STAFF, DIRECT SUPPORT PROFESSIONALS, CLINICAL STAFF, FOSTER PARENTS AND ADOPTIVE PARENTS, AS APPROPRIATE, PURSUANT TO PARAGRAPH (I) OF THIS SUBDIVISION. EACH LOCAL GOVERNMENT UNIT OR DIRECT CONTRACT PROVIDER RECEIVING SUCH FUNDING SHALL SUBMIT A WRITTEN CERTIFICATION, IN SUCH FORM AND AT SUCH TIME AS EACH COMMISSIONER SHALL PRESCRIBE, ATTESTING TO HOW SUCH FUNDING WILL BE OR WAS USED FOR PURPOSES ELIGIBLE UNDER THIS SECTION. FURTHER, PROVIDERS SHALL SUBMIT A RESOLUTION FROM THEIR GOVERNING BODY TO THE APPROPRIATE COMMISSIONER, ATTESTING THAT THE FUNDING RECEIVED WILL BE USED SOLELY TO SUPPORT SALARY AND SALARY-RELATED FRINGE BENEFIT INCREASES FOR DIRECT CARE STAFF, DIRECT SUPPORT PROFESSIONALS, CLINICAL STAFF, FOSTER PARENTS AND ADOPTIVE PARENTS, PURSUANT TO PARAGRAPH (I) OF THIS SUBDIVISION AND THE APPLICABLE STANDARDS ISSUED BY THE APPROPRIATE COMMISSIONER PURSUANT TO THIS PARAGRAPH. SUCH COMMISSIONERS SHALL BE AUTHORIZED TO RECOUP ANY FUNDS AS APPROPRIATED HEREIN DETERMINED TO HAVE BEEN USED IN A MANNER INCONSISTENT WITH SUCH STANDARDS OR INCONSISTENT WITH THE PROVISIONS OF THIS SUBDIVISION, AND SUCH COMMISSIONERS SHALL BE AUTHORIZED TO EMPLOY ANY LEGAL MECHANISM TO RECOUP SUCH FUNDS, INCLUDING AN OFFSET OF OTHER FUNDS THAT ARE OWED TO SUCH LOCAL GOVERNMENTAL UNIT OR PROVIDER.

(III) WHERE APPROPRIATE, TRANSFERS TO THE DEPARTMENT OF HEALTH SHALL BE MADE AS REIMBURSEMENT FOR THE STATE SHARE OF MEDICAL ASSISTANCE.

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, 2014; provided, however, that the amendments to subdivisions 3-b and 3-c of section 1 of part C of chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs made by section one of this act shall not affect the repeal of such subdivisions and shall be deemed repealed therewith.

S 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section

or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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