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

S. 2606--D A. 3006--D

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

January 22, 2013

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

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

AN ACT to amend chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, in relation to the cap on local Medicaid expenditures; in relation to the determination of rates of payments by certain state governmental agencies; to amend the social services law, in relation to the medical assistance information and payment system; to amend the social services law, in relation to managed care programs; to amend the public health law, in relation to managed long term care plans; to amend the public health law, in relation to participation in the state health insurance exchange; to amend the state finance law, in relation to liability for certain acts under the false claims act; to amend the state finance law, in relation to civil actions pursuant to the false claims act; to amend part C of chapter 58 of the laws of 2005, amending the public health law and other laws authorizing reimbursements for expenditures made by social services districts for medical assistance, in relation to delay of certain administrative costs; to amend the public health law, in relation to

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

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the preferred drug program; to amend the public health law, in relation to antipsychotic therapeutic drugs; to amend the social services law, in relation to reducing pharmacy reimbursement for name brand drugs; to amend the public health law, in relation to eliminating the summary posting requirement for the pharmacy and therapeutic committee; to amend the social services law, in relation to early refill of prescriptions; to amend the social services law, in relation to authorizing the commissioner of health to implement an incontinence supply utilization management program; to amend the social services law, in relation to the funding of health home infrastructure development; to amend the public health law, in relation to general hospital inpatient reimbursement; to amend the social services law, in relation to managed care programs; to amend 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, in relation to the effectiveness thereof; to amend the public health law, in relation to rates of payment for residential health care facilities and in relation to rates of reimbursement for inpatient detoxification and withdrawal services; to amend the public health law, in relation to hospital inpatient base years; to amend the public health law, in relation to the Medicaid managed care inpatient psychiatric care default rate; to amend the public health law, in relation to the Medicaid managed care default rate; to amend the public health law, in relation to moving rate setting for child health plus to the department of health; 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 repealing the twentieth day of the month enrollment cut-off for managed long term care enrollees; to amend the public health law, in relation to the nursing home financially disadvantaged program; to amend the public health law, in relation to eliminating the recruitment and retention attestation requirement for certain certified home health agencies; to amend the public health law, in relation to extending the office of the Medicaid inspector general's power to audit rebasing rates; to amend the public health law, in relation to rebasing transition payments; to amend the public health law, in relation to payment of claims; to amend the insurance law, in relation to health care providers; in relation to establishing the home and community-based care work group; in relation to critical access hospitals; to amend the public health law, in relation to eliminating the bed hold requirement; to amend the social services law, in relation to eligibility for Medicaid; to amend the social services law, in relation to treatment of income and resources of institutionalized persons; to amend the public health law, in relation to certain payments for certain home care agencies and services; to amend the social services law, in relation to Medicaid eligibility; to amend the mental hygiene law, in relation to people first waiver program; to amend 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, in relation to the effectiveness thereof; to amend 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 funds Medicaid expenditures, in relation to the effectiveness thereof; in relation to elimi-

nating the 2013-2014 trend factor and thereafter; to repeal certain provisions of the social services law and the public health law relating to managed care programs; and to repeal certain provisions of the public health law and the social services law relating to the pharmacy and therapeutics committee; providing for the repeal of certain provisions upon expiration thereof (Part A); to amend the public health law, in relation to payments to hospital assessments; to amend part C of chapter 58 of the laws of 2009 amending the public health law relating to payment by governmental agencies for general hospital inpatient services, in relation to the effectiveness of eligibility for medical assistance and the family health plus program; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to reimbursements; to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend the long term care integration and finance act of 1997, in relation to extending the expiration of operating demonstrations operating a managed long term care plan; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend the public health law, in relation to capital related inpatient expenses; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to rates of payment by state governmental agencies and the effectiveness of certain provisions of such chapter; to amend the social services law, in relation to reports on chronic illness demonstration projects and reports by the commissioner of health on health homes; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to extending the effectiveness of certain provisions thereof; to amend the public health law, in relation to rates of payment for long term home health care programs; to amend chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings and chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, in relation to the effectiveness of certain provisions thereof; to amend the public health law, in relation to extending a demonstration program for physicians suffering from alcoholism, drug abuse or mental illness; to amend part X2 of chapter 62 of the laws of 2003 amending the public health law relating to allowing the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to the effectiveness of certain provisions thereof; and to amend chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, in relation to the effectiveness thereof (Part B); to amend the public health law, in relation to indigent care (Part C); to amend the social services law, in relation to eligibility conditions; to amend the social services law, in relation to permitting online and telephone Medicaid applications; to amend the social services law, in relation to allowing

administrative renewals and self-attestation of residency; to amend the social services law, in relation to ending applications for family health plus; to amend the social services law, in relation to modified adjusted gross income and Medicaid eligibility groups; to amend the public health law, in relation to establishing methodology for modified adjusted gross income; to amend the public health law, in relation to centralizing child health plus eligibility determinations; to amend the public health law, in relation to requiring audit standards for eligibility; to amend the public health law, in relation to residency and income attestation and verification for child health plus; to amend the public health law, in relation to eliminating temporary enrollment in child health plus; to amend the public health law, in relation to expanding the child health plus social security number requirement to lawfully residing children; to amend the public health law, in relation to modified adjusted gross income under child health plus; to amend the public health law, in relation to personal interviews under child health plus; to amend the social services law, in relation to amendment of contracts awarded by the commissioner of health; to amend the public health law, in relation to requiring a status report on the health benefit exchange; to amend the insurance law, in relation to health benefit exchange navigators and in relation to clarifying the identity of persons to whom insurance licensing requirements apply; to amend the insurance law, in relation to coverage limitations requirements and student accident and health insurance; to amend the insurance law, in relation to standardization of individual enrollee direct payment contracts; to amend the public health law, in relation to HMOs; to amend the insurance law, in relation to ensuring that group and individual insurance policy provisions conform to applicable requirements of federal law and to make conforming changes; to repeal sections 369-ee and 369-ff of the social services law, relating to the family health plus program; to repeal certain other provisions of the social services law relating thereto; to repeal certain provisions of the insurance law relating thereto; providing for the repeal of certain provisions upon expiration thereof (Part D); to amend the public health law, in relation to the general public health work program; to amend chapter 577 of the laws of 2008 amending the public health law, relating to expedited partner therapy for persons infected with chlamydia trachomatis, in relation to the effectiveness of such chapter; to amend the public health law and the mental hygiene law, in relation to consolidating the excess medical malpractice liability coverage pool; to amend part C of chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, in relation to the use of Medicaid recovery savings; to repeal sections 602, 610 and 612 and subdivisions 5 and 7 of section 613 of the public health law relating to state aid; to repeal sections 2300, 2301, 2302, 2303, 2309 and 2310 of the public health law relating to the control of sexually transmitted diseases; and providing for the repeal of certain provisions upon expiration thereof (Part E); to amend the mental hygiene law, in relation to the addition to the methadone registry of dosage and such other information as is necessary to facilitate disaster management (Part F); to amend the mental hygiene law, in relation to state aid funding authorization of services funded by the office of alcoholism and substance abuse services; to repeal article 26 of such law relating thereto

(Part G); to amend the mental hygiene law and chapter 56 of the laws of 2012, amending the mental hygiene law relating to the closure and the reduction in size of certain facilities serving persons with mental illness, in relation to references to certain former children's psychiatric centers in the city of New York, and in relation to the expiration and repeal of certain provisions thereof; 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 H); to amend chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part I); to amend the mental hygiene law, in relation to vesting all authority to appoint and remove officers and employees of the office of mental health (Part J); intentionally omitted (Part K); to amend the mental hygiene law, in relation to creating mental health incident review panels (Part L); to amend the mental hygiene law, in relation to psychiatric emergency programs; and to repeal certain provisions of the mental hygiene law and certain provisions of chapter 723 of the laws of 1989, amending the mental hygiene law and other laws relating to the establishment of comprehensive psychiatric emergency programs, relating to eliminating the annual reports on the comprehensive psychiatric emergency program; family care; and the confinement, care and treatment of persons with developmental disabilities (Part M); to amend chapter 57 of the laws of 2006, relating to establishing a cost of living adjustment for designated human services programs, in relation to foregoing such adjustment during the 2013-2014 state fiscal year (Part N); to authorize the actions necessary to manage the loss of federal revenue and create the Mental Hygiene Stabilization Fund (Part O); to provide medical assistance to certain retirees of the New York city off-track betting corporation (Part P); and to amend the education law and the public health law, in relation to funding to SUNY Downstate Medical Center and directing the restructuring of hospital (Part Q)

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 2013-2014 state fiscal year. Each component is wholly contained within a Part identified as Parts A through Q. 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. 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, is amended to read as follows:

(a) Notwithstanding any other provision of law to the contrary, for the state fiscal years beginning April 1, 2011 and ending on March 31, [2013] 2015, 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 [year] YEARS 2012-13, 2013-14 AND 2014-15 except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, [2013] 2015. 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.

S 2. Subdivision 1 of section 91 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital reimbursement for annual rates, as amended by section 5 of part F of chapter 56 of the laws of 2012, is amended to read as follows:

1. Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds Medicaid spending shall not exceed the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years[.]; PROVIDED, HOWEVER, THAT FOR STATE FISCAL YEAR 2013-14 AND FOR EACH FISCAL YEAR THEREAFTER, THE MAXIMUM ALLOWABLE ANNUAL INCREASE IN THE AMOUNT OF DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING SHALL BE CALCULATED BY MULTIPLYING THE DEPARTMENT OF HEALTH STATE FUNDS MEDICAID SPENDING FOR THE PREVIOUS YEAR, MINUS THE AMOUNT OF ANY DEPARTMENT OF HEALTH STATE OPERATIONS SPENDING INCLUDED THEREIN, BY SUCH TEN YEAR ROLLING AVERAGE.

S 3. Subdivisions 1 and 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, subdivision 1 as amended by section 57 of part D of chapter 56 of the laws of 2012, are amended to read as follows:

1. For state fiscal years 2011-12 through [2013-14] 2014-15, 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.

5. The department of health 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.

S 4. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after April 1, 2013, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing inpatient services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2013 and 2014 calendar years in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2013 and 2014 calendar years shall also be applied to rates of payment for rate periods on and after April 1, 2013 for personal care services provided in those local social services

districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after April 1, 2013, such trend factors attributable to the 2013 and 2014 calendar years shall be established at no greater than zero percent.

S 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2015 through March 31, 2015, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2015 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2015 calendar year shall also be applied to rates of payment provided on and after January 1, 2015 through March 31, 2015 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2015 through March 31, 2015, such trend factors attributable to the 2015 calendar year shall be established at no greater than zero percent.

S 5. Paragraph (a) of subdivision 8 of section 367-b of the social services law, as amended by chapter 109 of the laws of 2007, is amended to read as follows:

(a) For the purpose of orderly and timely implementation of the medical assistance information and payment system, the department is hereby authorized to enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payments, subject to audits being conducted by the state in accordance with the terms of such agreements, for medical assistance claims under the system described by this section in any social services district. Such agreements shall specifically provide that the state shall have complete oversight responsibility for the fiscal intermediaries' or fiscal agents' performance and shall be solely responsible for establishing eligibility requirements for recipients, provider qualifications, rates of payment, investigation of suspected fraud and abuse, issuance of identification cards, establishing and maintaining recipient eligibility files, provider profiles, and conducting state audits of the fiscal intermediaries' or agents' at least once annually. The system described in this subdivision shall be

operated by [a] ONE OR MORE fiscal [intermediary] INTERMEDIARIES or fiscal [agent] AGENTS in accordance with this subdivision unless the department is otherwise authorized by a law enacted subsequent to the effective date of this subdivision to operate the system in another manner. In no event shall such intermediary or agent be a political subdivision of the state or any other governmental agency or entity. NOTWITHSTANDING THE FOREGOING, THE DEPARTMENT MAY MAKE PAYMENTS TO A PROVIDER UPON THE COMMISSIONER'S DETERMINATION THAT THE PROVIDER IS TEMPORARILY UNABLE TO COMPLY WITH BILLING REQUIREMENTS. The department shall consult with the office of Medicaid inspector general regarding any activities undertaken by the fiscal intermediaries or fiscal agents regarding investigation of suspected fraud and abuse.

S 6. Section 365-l of the social services law is amended by adding a new subdivision 9 to read as follows:

9. ANY 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, AND/OR ANY WORKGROUPS REQUIRED TO BE ESTABLISHED BY THE CHAPTER OF THE LAWS OF TWO THOUSAND THIRTEEN THAT ADDED THIS SUBDIVISION.

S 7. Section 364-j of the social services law is amended by adding a new subdivision 27 to read as follows:

27. THE COMMISSIONER OF THE DEPARTMENT OF HEALTH MAY MAKE ANY NECESSARY AMENDMENTS TO A CONTRACT PURSUANT TO THIS SECTION WITH A MANAGED CARE PROVIDER, AS DEFINED IN PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION, TO ALLOW SUCH MANAGED CARE PROVIDER TO PARTICIPATE AS A QUALIFIED HEALTH PLAN IN A STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152).

S 7-a. Section 4403-f of the public health law is amended by adding a new subdivision 12 to read as follows:

12. THE COMMISSIONER MAY MAKE ANY NECESSARY AMENDMENTS TO A CONTRACT PURSUANT TO THIS SECTION WITH A MANAGED LONG TERM CARE PLAN, AS DEFINED IN PARAGRAPH (A) OF SUBDIVISION ONE OF THIS SECTION, TO ALLOW SUCH MANAGED LONG TERM CARE PLAN TO PARTICIPATE AS A QUALIFIED HEALTH PLAN IN A STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152).

S 7-b. Section 2511 of the public health law is amended by adding a new subdivision 21 to read as follows:

21. THE COMMISSIONER MAY MAKE ANY NECESSARY AMENDMENTS TO A CONTRACT PURSUANT TO THIS SECTION WITH AN APPROVED ORGANIZATION, AS DEFINED IN SUBDIVISION TWO OF SECTION TWENTY-FIVE HUNDRED TEN OF THIS TITLE, TO ALLOW SUCH APPROVED ORGANIZATION TO PARTICIPATE AS A QUALIFIED HEALTH PLAN IN A STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE

FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152).

S 8. Subdivisions 1 and 4 of section 189 of the state finance law, as amended by chapter 379 of the laws of 2010, are amended to read as follows:

1. Subject to the provisions of subdivision two of this section, any person who:

(a) knowingly presents, or causes to be presented a false or fraudulent claim for payment or approval;

(b) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(c) conspires to commit a violation of paragraph (a), (b), (d), (e), (f) or (g) of this subdivision;

(d) has possession, custody, or control of property or money used, or to be used, by the state or a local government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(e) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the state or a local government and, intending to defraud the state or a local government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(f) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state or a local government knowing that the officer or employee violates a provision of law when selling or pledging such property; [or]

(g) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a local government; OR

(H) KNOWINGLY CONCEALS OR KNOWINGLY AND IMPROPERLY AVOIDS OR DECREASES AN OBLIGATION TO PAY OR TRANSMIT MONEY OR PROPERTY TO THE STATE OR A LOCAL GOVERNMENT, OR CONSPIRES TO DO THE SAME; shall be liable to the state or a local government, as applicable, for a civil penalty of not less than six thousand dollars and not more than twelve thousand dollars, plus three times the amount of all damages, including consequential damages, which the state or local government sustains because of the act of that person.

4. (a) This section shall apply to claims, records, or statements made under the tax law only if (i) the net income or sales of the person against whom the action is brought equals or exceeds one million dollars for any taxable year subject to any action brought pursuant to this article; [and] (ii) the damages pleaded in such action exceed three hundred and fifty thousand dollars; AND (III) THE PERSON IS ALLEGED TO HAVE VIOLATED PARAGRAPH (A), (B), (C), (D), (E), (F) OR (G) OF SUBDIVISION ONE OF THIS SECTION; PROVIDED, HOWEVER, THAT NOTHING IN THIS SUBPARAGRAPH SHALL BE DEEMED TO MODIFY OR RESTRICT THE APPLICATION OF SUCH PARAGRAPHS TO ANY ACT ALLEGED THAT RELATES TO A VIOLATION OF THE TAX LAW.

(b) The attorney general shall consult with the commissioner of the department of taxation and finance prior to filing or intervening in any action under this article that is based on the filing of false claims, records or statements made under the tax law. If the state declines to participate or to authorize participation by a local government in such an action pursuant to subdivision two of section one hundred ninety of this article, the qui tam plaintiff must obtain approval from the attor-

ney general before making any motion to compel the department of taxation and finance to disclose tax records.

S 9. Subparagraphs (d) and (e) of subdivision 2 of section 190 of the state finance law, paragraph (d) as amended by chapter 379 of the laws of 2010, paragraph (e) as amended by section 39 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

(d) If the state notifies the court that it intends to file a complaint against the defendant and thereby be substituted as the plaintiff in the action, or to permit a local government to do so, such complaint, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, must be filed within thirty days after the notification to the court. For statute of limitations purposes, any such complaint filed by the state or a local government shall relate back to the filing date of the complaint of the qui tam plaintiff, to the extent that the cause of action of the state or local government arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the [prior] complaint of the qui tam plaintiff.

(e) If the state notifies the court that it intends to intervene in the action, or to permit a local government to do so, then such motion [for intervention] TO INTERVENE, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, shall be filed within thirty days after the notification to the court. FOR STATUTE OF LIMITATIONS PURPOSES, ANY COMPLAINT FILED BY THE STATE OR A LOCAL GOVERNMENT, WHETHER FILED SEPARATELY OR AS AN AMENDMENT TO THE QUI TAM PLAINTIFF'S COMPLAINT, SHALL RELATE BACK TO THE FILING DATE OF THE COMPLAINT OF THE QUI TAM PLAINTIFF, TO THE EXTENT THAT THE CAUSE OF ACTION OF THE STATE OR LOCAL GOVERNMENT ARISES OUT OF THE CONDUCT, TRANSACTIONS, OR OCCURRENCES SET FORTH, OR ATTEMPTED TO BE SET FORTH, IN THE COMPLAINT OF THE QUI TAM PLAINTIFF.

S 9-a. Subdivision 4 of section 190 of the state finance law, as added by section 39 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

4. Related actions. When a person brings a qui tam action under this section, no person other than the attorney general, or a local government attorney acting pursuant to subdivision one of this section or paragraph (b) of subdivision two of this section, may intervene or bring a related civil action based upon the facts underlying the pending action[, unless such other person has first obtained the permission of the attorney general to intervene or to bring such related action]; provided, however, that nothing in this subdivision shall be deemed to deny persons the right, upon leave of court, to file briefs amicus curiae.

S 9-b. Subdivisions 6 and 7 of section 190 of the state finance law, as added by section 39 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

6. Awards to qui tam plaintiff. (a) If the attorney general elects to convert the qui tam civil action into an attorney general enforcement action, or to permit a local government to convert the action into a civil enforcement action by such local government, or if the attorney general or a local government elects to intervene in the qui tam civil action, then the person or persons who initiated the qui tam civil action collectively shall be entitled to receive between fifteen and twenty-five percent of the proceeds recovered in the action or in settlement of the action. The court shall determine the percentage of the proceeds to which a person commencing a qui tam civil action is entitled, by considering the extent to which the plaintiff substantially

contributed to the prosecution of the action. Where the court finds that the action was based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil or administrative hearing, in a legislative or administrative report, hearing, audit or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the person or persons bringing the action in advancing the case to litigation. ANY SUCH PERSON SHALL ALSO RECEIVE AN AMOUNT FOR REASONABLE EXPENSES THAT THE COURT FINDS TO HAVE BEEN NECESSARILY INCURRED, REASONABLE ATTORNEYS' FEES, AND COSTS PURSUANT TO ARTICLE EIGHTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. ALL SUCH EXPENSES, FEES, AND COSTS SHALL BE AWARDED AGAINST THE DEFENDANT.

(b) If the attorney general or a local government does not elect to intervene or convert the action, and the action is successful, then the person or persons who initiated the qui tam action which obtains proceeds shall be entitled to receive between twenty-five and thirty percent of the proceeds recovered in the action or settlement of the action. The court shall determine the percentage of the proceeds to which a person commencing a qui tam civil action is entitled, by considering the extent to which the plaintiff substantially contributed to the prosecution of the action. SUCH PERSON SHALL ALSO RECEIVE AN AMOUNT FOR REASONABLE EXPENSES THAT THE COURT FINDS TO HAVE BEEN NECESSARILY INCURRED, REASONABLE ATTORNEYS' FEES, AND COSTS PURSUANT TO ARTICLE EIGHTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. ALL SUCH EXPENSES, FEES, AND COSTS SHALL BE AWARDED AGAINST THE DEFENDANT.

(c) With the exception of a court award of costs, expenses or attorneys' fees, any payment to a person pursuant to this paragraph shall be made from the proceeds.

(D) IF THE ATTORNEY GENERAL OR A LOCAL GOVERNMENT DOES NOT PROCEED WITH THE ACTION AND THE PERSON BRINGING THE ACTION CONDUCTS THE ACTION, THE COURT MAY AWARD TO THE DEFENDANT ITS REASONABLE ATTORNEYS' FEES AND EXPENSES IF THE DEFENDANT PREVAILS IN THE ACTION AND THE COURT FINDS THAT THE CLAIM OF THE PERSON BRINGING THE ACTION WAS CLEARLY FRIVOLOUS, CLEARLY VEXATIOUS, OR BROUGHT PRIMARILY FOR PURPOSES OF HARASSMENT.

7. Costs, expenses, disbursements and attorneys' fees. In any action brought pursuant to this article, the court may award [the attorney general, on behalf of the people of the state of New York, and] any local government that participates as a party in the action[, and any person who is a qui tam plaintiff,] an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees, plus costs pursuant to article eighty-one of the civil practice law and rules. All such expenses, fees and costs shall be awarded directly against the defendant and shall not be charged from the proceeds, but shall only be awarded if [the state or] a local government [or the qui tam civil action plaintiff] prevails in the action.

S 10. Paragraph (a) of section 4-a of part C of chapter 58 of the laws of 2005, amending the public health law and other laws authorizing reimbursements for expenditures made by social services districts for medical assistance, as added by section 4 of part F of chapter 56 of the laws of 2012, is amended to read as follows:

(a) For state fiscal year 2012-13, and for each state fiscal year thereafter, a social services district will be reimbursed by the state for the full non-federal share of expenditures by the district for the administration of the medical assistance program, not to exceed the

administrative cap amount determined in accordance with subdivision (b) of this section. Any portion of the non-federal share of such expenditures in excess of the administrative cap amount shall be the responsibility of the social services district and shall be in addition to the medical assistance expenditure amount calculated in accordance with subdivisions (b), (c), (c-1), and (d) of section one of this act. Beginning in state fiscal year 2013-14, no reimbursement will be made for administrative expenditures in excess of such cap, WITH THE EXCEPTION OF ADMINISTRATIVE COSTS FROM A PRIOR FISCAL YEAR IF REIMBURSEMENT FOR SUCH EXPENDITURES WAS DELAYED DUE TO A DEFERRAL OF THE FEDERAL SHARE OF THE EXPENDITURES.

S 11. Part C of chapter 58 of the laws of 2005, amending the public health law and other laws relating to authorizing reimbursements for expenditures made by social services districts for medical assistance, is amended by adding a new section 7-a to read as follows:

S 7-A. (A) THE COMMISSIONER OF HEALTH, WITH THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF BUDGET, SHALL REDUCE THE WEEKLY AMOUNTS REQUIRED BY PARAGRAPH (F) OF SECTION ONE OF THIS ACT TO REFLECT INCREASED FEDERAL REIMBURSEMENT THAT IS EXPECTED TO BE RECEIVED IN THE FIRST CALENDAR QUARTER OF 2014 AS THE RESULT OF AN INCREASE IN THE STATE'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE FOR CARE, SERVICES, AND SUPPLIES PROVIDED TO CERTAIN RECIPIENTS PURSUANT TO 42 U.S.C. S 1396D(Z), AND THAT MUST BE SHARED WITH SOCIAL SERVICES DISTRICTS IN ACCORDANCE WITH THE PROVISIONS OF 42 U.S.C. S 1396(CC). THE WEEKLY REDUCTIONS DESCRIBED IN THIS PARAGRAPH WILL BEGIN APRIL 1, 2013 AND CONTINUE THROUGH MARCH 31, 2014.

(B) AMOUNTS ADVANCED TO SOCIAL SERVICES DISTRICTS THROUGH THE WEEKLY REDUCTIONS DESCRIBED IN PARAGRAPH (A) OF THIS SECTION SHALL BE RECONCILED AGAINST THE AMOUNT OF INCREASED FEDERAL ASSISTANCE ACTUALLY RECEIVED PURSUANT TO 42 U.S.C. S 1396D(Z) FOR THE FIRST CALENDAR QUARTER OF 2014, AND ANY EXCESS AMOUNTS ADVANCED TO DISTRICTS SHALL BE RECOVERED BY THE COMMISSIONER OF HEALTH THROUGH AN ADJUSTMENT TO THE WEEKLY AMOUNTS REQUIRED FROM SUCH DISTRICTS BY PARAGRAPH (F) OF SECTION ONE OF THIS ACT FOR THE PERIOD FROM APRIL 1, 2014 THROUGH MARCH 31, 2015.

S 12. Paragraph (u) of subdivision 4 of section 364-j of the social services law, as amended by section 40 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

(u) A managed care provider that provides coverage for prescription drugs shall permit each participant to fill any mail order covered prescription, at his or her option, at any mail order pharmacy or non-mail-order retail pharmacy in the managed care provider network. IF THE MANAGED CARE PROVIDER HAS DESIGNATED ONE OR MORE PHARMACIES FOR FILLING PRESCRIPTIONS FOR A PARTICULAR DRUG OR DRUGS, THEN SUCH PRESCRIPTIONS MAY BE FILLED, AT THE PARTICIPANT'S OPTION, AT ANY OTHER PHARMACY IN THE NETWORK, if the [non-mail-order retail pharmacy] NETWORK PHARMACY CHOSEN BY THE PARTICIPANT offers to accept a price that is comparable to that of the [mail order] pharmacy DESIGNATED BY THE MANAGED CARE PROVIDER. FOR THE PURPOSES OF THIS SECTION, "MAIL ORDER PHARMACY" MEANS A PHARMACY WHOSE PRIMARY BUSINESS IS TO RECEIVE PRESCRIPTIONS BY MAIL, TELEFAX OR THROUGH ELECTRONIC SUBMISSIONS, AND TO DISPENSE MEDICATION TO PATIENTS THROUGH THE USE OF THE UNITED STATES MAIL OR OTHER COMMON OR CONTRACT CARRIER SERVICES, AND PROVIDES ANY CONSULTATION WITH PATIENTS ELECTRONICALLY RATHER THAN FACE TO FACE. Every non-mail-order retail pharmacy in the managed care provider's network with respect to any prescription drug shall be deemed to be in the managed care provider's network for every covered prescription drug[; provided, however, that the managed care provider may limit its network of pharmacies for specified drugs,

approved by the commissioner, based on clinical, professional or cost criteria. Such limitation shall not be based solely on cost].

S 13. Section 364-j of the social services law is amended by adding a new subdivision 25-a to read as follows:

25-A. EFFECTIVE JULY FIRST, TWO THOUSAND THIRTEEN, NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, MANAGED CARE PROVIDERS SHALL COVER MEDICALLY NECESSARY PRESCRIPTION DRUGS IN THE ANTI-DEPRESSANT, ANTI-RETROVIRAL, ANTI-REJECTION, SEIZURE, EPILEPSY, ENDOCRINE, HEMATOLOGIC AND IMMUNOLOGIC THERAPEUTIC CLASSES, INCLUDING NON-FORMULARY DRUGS, UPON DEMONSTRATION BY THE PRESCRIBER, AFTER CONSULTING WITH THE MANAGED CARE PROVIDER, THAT SUCH DRUGS, IN THE PRESCRIBER'S REASONABLE PROFESSIONAL JUDGMENT, ARE MEDICALLY NECESSARY AND WARRANTED.

S 14. Section 271 of the public health law is REPEALED.

S 15. Subdivision 3 of section 270 of the public health law is REPEALED, subdivision 2 is renumbered subdivision 3 and a new subdivision 2 is added to read as follows:

2. "BOARD" SHALL MEAN THE DRUG UTILIZATION REVIEW BOARD.

S 15-a. Subdivision 12 of section 270 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

12. "Supplemental rebate" means a supplemental rebate under subdivision [ten] ELEVEN of section two hundred seventy-two of this article.

S 16. Section 272 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, subdivision 4 as amended by section 30 of part A of chapter 58 of the laws of 2008, subdivision 8 as amended by section 5 of part B of chapter 109 of the laws of 2010, paragraph (d) of subdivision 10 as added by section 17 of part H of chapter 59 of the laws of 2011, subdivision 11 as amended by section 36 of part C of chapter 58 of the laws of 2009, paragraph (b) of subdivision 11 as amended by section 9 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 272. Preferred drug program. 1. There is hereby established a preferred drug program to promote access to the most effective prescription drugs while reducing the cost of prescription drugs for persons in state public health plans.

2. When a prescriber prescribes a non-preferred drug, state public health plan reimbursement shall be denied unless prior authorization is obtained, unless no prior authorization is required under this article.

3. The commissioner shall establish performance standards for the program that, at a minimum, ensure that the preferred drug program and the clinical drug review program provide sufficient technical support and timely responses to consumers, prescribers and pharmacists.

4. Notwithstanding any other provision of law to the contrary, no preferred drug program or prior authorization requirement for prescription drugs, except as created by this article, paragraph (a-1) or (a-2) of subdivision four of section three hundred sixty-five-a of the social services law, paragraph (g) of subdivision two of section three hundred sixty-five-a of the social services law, subdivision one of section two hundred forty-one of the elder law and shall apply to the state public health plans.

5. The [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD shall consider and make recommendations to the commissioner for the adoption of a preferred drug program. (a) In developing the preferred drug program, the [committee] BOARD shall, without limitation: (i) identify therapeutic classes or drugs to be included in the preferred drug program; (ii) identify preferred drugs in each of the

chosen therapeutic classes; (iii) evaluate the clinical effectiveness and safety of drugs considering the latest peer-reviewed research and may consider studies submitted to the federal food and drug administration in connection with its drug approval system; (iv) consider the potential impact on patient care and the potential fiscal impact that may result from making such a therapeutic class subject to prior authorization; and (v) consider the potential impact of the preferred drug program on the health of special populations such as children, the elderly, the chronically ill, persons with HIV/AIDS and persons with mental health conditions.

(b) In developing the preferred drug program, the [committee] BOARD may consider preferred drug programs or evidence based research operated or conducted by or for other state governments, the federal government, or multi-state coalitions. Notwithstanding any inconsistent provision of section one hundred twelve or article eleven of the state finance law or section one hundred forty-two of the economic development law or any other law, the department may enter into contractual agreements with the Oregon Health and Science University Drug Effectiveness Review Project to provide technical and clinical support to the [committee] BOARD and the department in researching and recommending drugs to be placed on the preferred drug list.

(c) The [committee] BOARD shall from time to time review all therapeutic classes included in the preferred drug program, and may recommend that the commissioner add or delete drugs or classes of drugs to or from the preferred drug program, subject to this subdivision.

(d) The [committee] BOARD shall establish procedures to promptly review prescription drugs newly approved by the federal food and drug administration.

6. The [committee] BOARD shall recommend a procedure and criteria for the approval of non-preferred drugs as part of the prior authorization process. In developing these criteria, the [committee] BOARD shall include consideration of the following:

(a) the preferred drug has been tried by the patient and has failed to produce the desired health outcomes;

(b) the patient has tried the preferred drug and has experienced unacceptable side effects;

(c) the patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated; and

(d) other clinical indications for the use of the non-preferred drug, which shall include consideration of the medical needs of special populations, including children, the elderly, the chronically ill, persons with mental health conditions, and persons affected by HIV/AIDS.

7. The commissioner shall provide thirty days public notice on the department's website prior to any meeting of the [committee] BOARD to develop recommendations concerning the preferred drug program. Such notice regarding meetings of the [committee] BOARD shall include a description of the proposed therapeutic class to be reviewed, a listing of drug products in the therapeutic class, and the proposals to be considered by the [committee] BOARD. The [committee] BOARD shall allow interested parties a reasonable opportunity to make an oral presentation to the [committee] BOARD related to the prior authorization of the therapeutic class to be reviewed. The [committee] BOARD shall consider any information provided by any interested party, including, but not limited to, prescribers, dispensers, patients, consumers and manufacturers of the drug in developing their recommendations.

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

9. Within ten days of a final determination regarding the preferred drug program, the commissioner shall provide public notice on the department's website of such determinations, including: the nature of the determination; and analysis of the impact of the commissioner's determination on state public health plan populations and providers; and the projected fiscal impact to the state public health plan programs of the commissioner's determination.

10. The commissioner shall adopt a preferred drug program and amendments after considering the recommendations from the [committee] BOARD and any comments received from prescribers, dispensers, patients, consumers and manufacturers of the drug.

(a) The preferred drug list in any therapeutic class included in the preferred drug program shall be developed based initially on an evaluation of the clinical effectiveness, safety and patient outcomes, followed by consideration of the cost-effectiveness of the drugs.

(b) In each therapeutic class included in the preferred drug program, the [committee] BOARD shall determine whether there is one drug which is significantly more clinically effective and safe, and that drug shall be included on the preferred drug list without consideration of cost. If, among two or more drugs in a therapeutic class, the difference in clinical effectiveness and safety is not clinically significant, then cost effectiveness (including price and supplemental rebates) may also be considered in determining which drug or drugs shall be included on the preferred drug list.

(c) In addition to drugs selected under paragraph (b) of this subdivision, any prescription drug in the therapeutic class, whose cost to the state public health plans (including net price and supplemental rebates) is equal to or less than the cost of another drug in the therapeutic class that is on the preferred drug list under paragraph (b) of this subdivision, may be selected to be on the preferred drug list, based on clinical effectiveness, safety and cost-effectiveness.

(d) Notwithstanding any provision of this section to the contrary, the commissioner may designate therapeutic classes of drugs, including classes with only one drug, as all preferred prior to any review that may be conducted by the [committee] BOARD pursuant to this section.

11. (a) The commissioner shall provide an opportunity for pharmaceutical manufacturers to provide supplemental rebates to the state public health plans for drugs within a therapeutic class; such supplemental rebates shall be taken into consideration by the [committee] BOARD and the commissioner in determining the cost-effectiveness of drugs within a therapeutic class under the state public health plans.

(b) The commissioner may designate a pharmaceutical manufacturer as one with whom the commissioner is negotiating or has negotiated a manufacturer agreement, and all of the drugs it manufactures or markets shall be included in the preferred drug program. The commissioner may negotiate directly with a pharmaceutical manufacturer for rebates relating to any or all of the drugs it manufactures or markets. A manufactur-

er agreement shall designate any or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as being preferred or non preferred drugs. When a pharmaceutical manufacturer has been designated by the commissioner under this paragraph but the commissioner has not reached a manufacturer agreement with the pharmaceutical manufacturer, then the commissioner may designate some or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as non preferred drugs. However, notwithstanding this paragraph, any drug that is selected to be on the preferred drug list under paragraph (b) of subdivision ten of this section on grounds that it is significantly more clinically effective and safer than other drugs in its therapeutic class shall be a preferred drug.

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

13. The commissioner may implement all or a portion of the preferred drug program through contracts with administrators with expertise in management of pharmacy services, subject to applicable laws.

14. For a period of eighteen months, commencing with the date of enactment of this article, and without regard to the preferred drug program or the clinical drug review program requirements of this article, the commissioner is authorized to implement, or continue, a prior authorization requirement for a drug which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law, for which there is a non-prescription version within the same drug class, or for which there is a comparable non-prescription version of the same drug. Any such prior authorization requirement shall be implemented in a manner that is consistent with the process employed by the commissioner for such authorizations as of one day prior to the date of enactment of this article. At the conclusion of the eighteen month period, any such drug or drug class shall be subject to the preferred drug program requirements of this article; provided, however, that the commissioner is authorized to immediately subject any such drug to prior authorization without regard to the provisions of subdivisions five through eleven of this section.

S 17. Subdivisions 4, 5 and 6 of section 274 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended to read as follows:

4. The commissioner shall obtain an evaluation of the factors set forth in subdivision three of this section and a recommendation as to the establishment of a prior authorization requirement for a drug under the clinical drug review program from the [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD. For this purpose, the commissioner and the [committee] BOARD, as applicable, shall comply with the following meeting and notice processes established by this article:

(a) the open meetings law and freedom of information law provisions of subdivision six of section two hundred seventy-one of this article; and

(b) the public notice and interested party provisions of subdivisions seven, eight and nine of section two hundred seventy-two of this article.

5. The [committee] BOARD shall recommend a procedure and criteria for the approval of drugs subject to prior authorization under the clinical drug review program. Such criteria shall include the specific approved clinical indications for use of the drug.

6. The commissioner shall identify a drug for which prior authorization is required, as well as the procedures and criteria for approval of use of the drug, under the clinical drug review program after considering the recommendations from the [committee] BOARD and any comments received from prescribers, dispensers, consumers and manufacturers of the drug. In no event shall the prior authorization criteria for approval pursuant to this subdivision result in denial of the prior authorization request based on the relative cost of the drug subject to prior authorization.

S 18. Section 277 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

S 277. Review and reports. 1. The commissioner, in consultation with the [pharmacy and therapeutics committee] DRUG UTILIZATION REVIEW BOARD, shall undertake periodic reviews, at least annually, of the preferred drug program which shall include consideration of:

(a) the volume of prior authorizations being handled, including data on the number and characteristics of prior authorization requests for particular prescription drugs;

(b) the quality of the program's responsiveness, including the quality of the administrator's responsiveness;

(c) complaints received from patients and providers;

(d) the savings attributable to the state, and to each county and the city of New York, due to the provisions of this article;

(e) the aggregate amount of supplemental rebates received in the previous fiscal year and in the current fiscal year, to date; and such amounts are to be broken out by fiscal year and by month;

(f) the education and outreach program established by section two hundred seventy-six of this article.

2. The commissioner and the [panel] BOARD shall, beginning March thirty-first, two thousand six and annually thereafter, submit a report to the governor and the legislature concerning each of the items subject to periodic review under subdivision one of this section.

3. The commissioner and the [panel] BOARD shall, beginning with the commencement of the preferred drug program and monthly thereafter, submit a report to the governor and the legislature concerning the amount of supplemental rebates received.

S 19. Subdivision 5 of section 369-bb of the social services law is REPEALED and a new subdivision 5 is added to read as follows:

5. (A) THE FUNCTIONS, POWERS AND DUTIES OF THE FORMER PHARMACY AND THERAPEUTICS COMMITTEE AS ESTABLISHED IN ARTICLE TWO-A OF THE PUBLIC HEALTH LAW SHALL NOW BE CONSIDERED A FUNCTION OF THE DRUG UTILIZATION REVIEW BOARD, INCLUDING BUT NOT LIMITED TO:

(I) CONDUCTING AN EXECUTIVE SESSION FOR THE PURPOSE OF RECEIVING AND EVALUATING DRUG PRICING INFORMATION RELATED TO SUPPLEMENTAL REBATES, OR RECEIVING AND EVALUATING TRADE SECRETS, OR OTHER INFORMATION WHICH, IF DISCLOSED, WOULD CAUSE SUBSTANTIAL INJURY TO THE COMPETITIVE POSITION OF THE MANUFACTURER; AND

(II) EVALUATING AND PROVIDING RECOMMENDATIONS TO THE COMMISSIONER OF HEALTH ON OTHER ISSUES RELATING TO PHARMACY SERVICES UNDER MEDICAID OR EPIC, INCLUDING, BUT NOT LIMITED TO: THERAPEUTIC COMPARISONS; ENHANCED USE OF GENERIC DRUG PRODUCTS; ENHANCED TARGETING OF PHYSICIAN PRESCRIBING PATTERNS; AND

(III) COLLABORATING WITH MANAGED CARE ORGANIZATIONS TO ADDRESS DRUG UTILIZATION CONCERNS AND TO IMPLEMENT CONSISTENT MANAGEMENT STRATEGIES ACROSS THE FEE-FOR-SERVICE AND MANAGED CARE PHARMACY BENEFITS.

(B) ANY BUSINESS OR OTHER MATTER UNDERTAKEN OR COMMENCED BY THE PHARMACY AND THERAPEUTICS COMMITTEE PERTAINING TO OR CONNECTED WITH THE FUNCTIONS, POWERS, OBLIGATIONS AND DUTIES ARE HEREBY TRANSFERRED AND ASSIGNED TO THE DRUG UTILIZATION REVIEW BOARD AND PENDING ON THE EFFECTIVE DATE OF THIS SUBDIVISION, MAY BE CONDUCTED AND COMPLETED BY THE DRUG UTILIZATION REVIEW BOARD IN THE SAME MANNER AND UNDER THE SAME TERMS AND CONDITIONS AND WITH THE SAME EFFECT AS IF CONDUCTED AND COMPLETED BY THE PHARMACY AND THERAPEUTICS COMMITTEE. ALL BOOKS, PAPERS, AND PROPERTY OF THE PHARMACY AND THERAPEUTICS COMMITTEE SHALL CONTINUE TO BE MAINTAINED BY THE DRUG UTILIZATION REVIEW BOARD.

(C) ALL RULES, REGULATIONS, ACTS, ORDERS, DETERMINATIONS, AND DECISIONS OF THE PHARMACY AND THERAPEUTICS COMMITTEE PERTAINING TO THE FUNCTIONS AND POWERS HEREIN TRANSFERRED AND ASSIGNED, IN FORCE AT THE TIME OF SUCH TRANSFER AND ASSUMPTION, SHALL CONTINUE IN FULL FORCE AND EFFECT AS RULES, REGULATIONS, ACTS, ORDERS, DETERMINATIONS AND DECISIONS OF THE DRUG UTILIZATION REVIEW BOARD UNTIL DULY MODIFIED OR ABROGATED BY THE COMMISSIONER OF HEALTH.

S 20. Subdivisions 1 and 2 of section 369-bb of the social services law, as added by chapter 632 of the laws of 1992, paragraph (a) of subdivision 2 as amended by chapter 843 of the laws of 1992, are amended to read as follows:

1. A [thirteen-member] NINETEEN-MEMBER drug utilization review board is hereby created in the department. The board is responsible for the establishment and implementation of medical standards and criteria for the retrospective and prospective DUR program.

2. The members of the DUR board shall be appointed by the commissioner and shall serve a three-year term. Members may be reappointed upon the completion of other terms. The membership shall be comprised of the following:

(a) [Five] SIX persons licensed and actively engaged in the practice of medicine in the state, [at least one of whom shall have expertise in the area of mental health, who shall be selected from a list of nominees provided by the medical society of the state of New York and other medical associations] WITH EXPERTISE IN THE AREAS OF MENTAL HEALTH, HIV/AIDS, GERIATRICS, PEDIATRICS OR INTERNAL MEDICINE AND WHO MAY BE SELECTED BASED ON INPUT FROM PROFESSIONAL ASSOCIATIONS AND/OR ADVOCACY GROUPS IN NEW YORK STATE.

(b) [Five] SIX persons licensed and actively practicing in [community] pharmacy in the state who [shall] MAY be selected [from a list of nominees provided by pharmaceutical societies/associations of] BASED ON INPUT FROM PROFESSIONAL ASSOCIATIONS AND/OR ADVOCACY GROUPS IN New York state.

(c) Two persons with expertise in drug utilization review who are [either] health care professionals licensed under Title VIII of the education law [or who are pharmacologists] AT LEAST ONE OF WHOM IS A PHARMACOLOGIST.

(d) [One person from the department of social services (commissioner or designee).] THREE PERSONS THAT ARE CONSUMERS OR CONSUMER REPRESENTATIVES OF ORGANIZATIONS WITH A REGIONAL OR STATEWIDE CONSTITUENCY AND WHO HAVE BEEN INVOLVED IN ACTIVITIES RELATED TO HEALTH CARE CONSUMER ADVOCACY, INCLUDING ISSUES AFFECTING MEDICAID OR EPIC RECIPIENTS.

(E) ONE PERSON LICENSED AND ACTIVELY PRACTICING AS A NURSE PRACTITIONER OR MIDWIFE.

(F) THE COMMISSIONER SHALL DESIGNATE A PERSON FROM THE DEPARTMENT TO SERVE AS CHAIRPERSON OF THE BOARD.

S 21. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 7 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department; provided further that: (i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy and nutritional supplements are limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding, for treatment of an inborn metabolic disorder, or to address growth and development problems in children, or, subject to standards established by the commissioner, for persons with a diagnosis of HIV infection, AIDS or HIV-related illness or other diseases and conditions; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; [and] (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers; AND (V) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO IMPLEMENT AN INCONTINENCE SUPPLY UTILIZATION MANAGEMENT PROGRAM TO REDUCE COSTS WITHOUT LIMITING ACCESS THROUGH THE EXISTING PROVIDER NETWORK, INCLUDING BUT NOT LIMITED TO SINGLE OR MULTIPLE SOURCE CONTRACTS OR, A PREFERRED INCONTINENCE SUPPLY PROGRAM WHEREIN THE DEPARTMENT OF HEALTH WILL RECEIVE ENHANCED REBATES FROM PREFERRED MANUFACTURERS OF INCONTINENCE SUPPLIES, AND MAY SUBJECT NON-PREFERRED MANUFACTURERS' INCONTINENCE SUPPLIES TO PRIOR APPROVAL PURSUANT TO REGULATIONS OF THE DEPARTMENT, PROVIDED ANY NECESSARY APPROVALS UNDER FEDERAL LAW HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF INCONTINENCE SUPPLIES PROVIDED PURSUANT TO THIS SUBPARAGRAPH;

S 22. Intentionally omitted.

S 23. Section 365-l of the social services law is amended by adding a new subdivision 2-a to read as follows:

2-A. UP TO FIFTEEN MILLION DOLLARS IN STATE FUNDING MAY BE USED TO FUND HEALTH HOME INFRASTRUCTURE DEVELOPMENT. SUCH FUNDS SHALL BE USED TO DEVELOP ENHANCED SYSTEMS TO SUPPORT HEALTH HOME OPERATIONS INCLUDING ASSIGNMENTS, WORKFLOW, AND TRANSMISSION OF DATA. FUNDING WILL ALSO BE DISBURSED PURSUANT TO A FORMULA ESTABLISHED BY THE COMMISSIONER TO BE DESIGNATED HEALTH HOMES. SUCH FORMULA MAY CONSIDER PRIOR ACCESS TO SIMILAR FUNDING OPPORTUNITIES, GEOGRAPHIC AND DEMOGRAPHIC FACTORS, INCLUDING THE POPULATION SERVED, AND PREVALENCE OF QUALIFYING CONDITIONS, CONNECTIVITY TO PROVIDERS, AND OTHER CRITERIA AS ESTABLISHED BY THE COMMISSIONER.

S 24. Paragraph (c) of subdivision 2 of section 365-a of the social services law, as amended by chapter 778 of the laws of 1977, 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 INTE-

GRATED 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 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 [the mentally retarded] PERSONS WITH DEVELOPMENTAL DISABILITIES;

S 25. The opening paragraph of paragraph 1 of subdivision 4 of section 2807-c of the public health law, as amended by section 11 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

Notwithstanding any inconsistent provision of this section and subject to the availability of federal financial participation, rates of payment by governmental agencies for general hospitals which are certified by the office of alcoholism and substance abuse services to provide inpatient detoxification and withdrawal services and, with regard to inpatient services provided to patients discharged on and after December first, two thousand eight and who are determined to be in diagnosis-related groups [numbered seven hundred forty-three, seven hundred forty-four, seven hundred forty-five, seven hundred forty-six, seven hundred forty-seven, seven hundred forty-eight, seven hundred forty-nine, seven hundred fifty, or seven hundred fifty-one] AS DEFINED BY THE COMMISSIONER AND PUBLISHED ON THE NEW YORK STATE DEPARTMENT OF HEALTH WEBSITE, shall be made on a per diem basis in accordance with the following:

S 26. Paragraph (c) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(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 FIRST, TWO THOUSAND FOURTEEN.

S 27. Intentionally omitted.

S 28. Intentionally omitted.

S 29. Intentionally omitted.

S 30. 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 (D) to read as follows:

(D) NOTWITHSTANDING ANY OTHER PROVISIONS OF LAW TO THE CONTRARY AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR ALL RATE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE OPERATING COMPONENT OF OUTPATIENT SPECIALTY RATES OF HOSPITALS SUBJECT TO THIS SUBPARAGRAPH SHALL BE DETERMINED BY THE COMMISSIONER PURSUANT TO REGULATIONS, INCLUDING EMERGENCY REGULATIONS, AND IN CONSULTATION WITH SUCH SPECIALTY OUTPATIENT FACILITIES, PROVIDED HOWEVER, THAT FOR THE PERIOD BEGINNING OCTOBER FIRST, TWO THOUSAND THIRTEEN THROUGH SEPTEMBER THIRTIETH, TWO THOUSAND FOURTEEN, SERVICES PROVIDED TO PATIENTS ENROLLED IN MEDICAID MANAGED CARE SHALL BE PAID BY THE MEDICAID MANAGED CARE PLANS AT NO LESS THAN THE OTHERWISE APPLICABLE MEDICAID FEE-FOR-SERVICE RATES, AS COMPUTED IN ACCORDANCE WITH CLAUSE (B) OF THIS SUBPARAGRAPH FOR THE PERIOD BEGINNING OCTOBER FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN AND AS COMPUTED IN ACCORDANCE

WITH THIS CLAUSE FOR THE PERIOD BEGINNING APRIL FIRST, TWO THOUSAND FOURTEEN THROUGH SEPTEMBER THIRTIETH, TWO THOUSAND FOURTEEN.

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 33. Intentionally omitted.

S 33-a. Subparagraphs (ii) and (x) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(ii) Only those two thousand five base year costs which relate to the cost of services provided to Medicaid inpatients, as determined by the applicable ratio of costs to charges methodology, shall be utilized for rate-setting purposes, PROVIDED, HOWEVER, THAT THE COMMISSIONER MAY UTILIZE UPDATED MEDICAID INPATIENT RELATED BASE YEAR COSTS AND STATISTICS AS NECESSARY TO ADJUST INPATIENT RATES IN ACCORDANCE WITH CLAUSE (C) OF SUBPARAGRAPH (X) OF THIS PARAGRAPH;

(x) Such regulations shall provide for administrative rate appeals, but only with regard to: (A) the correction of computational errors or omissions of data, including with regard to the hospital specific computations pertaining to graduate medical education, wage equalization factor adjustments, [and] (B) capital cost reimbursement, AND, (C) CHANGES TO THE BASE YEAR STATISTICS AND COSTS USED TO DETERMINE THE DIRECT AND INDIRECT GRADUATE MEDICAL EDUCATION COMPONENTS OF THE RATES AS A RESULT OF NEW TEACHING PROGRAMS AT NEW TEACHING HOSPITALS AND/OR AS A RESULT OF RESIDENTS DISPLACED AND TRANSFERRED AS A RESULT OF TEACHING HOSPITAL CLOSURES;

S 34. Section 364-i of the social services law is amended by adding a new subdivision 7 to read as follows:

7. NOTWITHSTANDING SECTION ONE HUNDRED THIRTY-THREE OF THIS CHAPTER, WHERE CARE OR SERVICES ARE RECEIVED PRIOR TO THE DATE THE INDIVIDUAL IS DETERMINED ELIGIBLE FOR ASSISTANCE UNDER THIS TITLE, MEDICAL ASSISTANCE REIMBURSEMENT SHALL BE AVAILABLE FOR SUCH CARE OR SERVICES ONLY (A) IF THE CARE OR SERVICES ARE RECEIVED DURING THE THREE MONTH PERIOD PRECEDING THE MONTH OF APPLICATION FOR MEDICAL ASSISTANCE AND THE RECIPIENT IS DETERMINED TO HAVE BEEN ELIGIBLE IN THE MONTH IN WHICH THE CARE OR SERVICE WAS RECEIVED, OR (B) AS PROVIDED FOR IN THIS SECTION OR REGULATIONS OF THE DEPARTMENT.

S 35. Intentionally omitted.

S 35-a. Subparagraph (i) of paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 433 of the laws of 1997, is amended to read as follows:

(i) is authorized to operate under article forty-four of the public health law or article forty-three of the insurance law and provides or arranges, directly or indirectly (including by referral) for covered comprehensive health services on a full capitation basis, INCLUDING A SPECIAL NEEDS MANAGED CARE PLAN OR COMPREHENSIVE HIV SPECIAL NEEDS PLAN; or

S 36. Paragraphs (c), (m) and (p) of subdivision 1 of section 364-j of the social services law, paragraph (c) as amended by section 12 of part C of chapter 58 of the laws of 2004, paragraph (m) as amended by section 42-b of part H of chapter 59 of the laws of 2011, and paragraph (p) as amended by chapter 649 of the laws of 1996, are amended and a new paragraph (z) is added to read as follows:

(c) "Managed care program". A statewide program in which medical assistance recipients enroll on a voluntary or mandatory basis to receive medical assistance services, including case management, directly

and indirectly (including by referral) from a managed care provider, [and] INCLUDING as applicable, a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN or a comprehensive HIV special needs plan, under this section.

(m) "Special needs managed care plan" [and "specialized managed care plan"] shall have the same meaning as in section forty-four hundred one of the public health law.

(p) "Grievance". Any complaint presented by a participant or a participant's representative for resolution through the grievance process of a managed care provider[, comprehensive HIV special needs plan or a mental health special needs plan].

(Z) "CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELOR (CASAC)". AN INDIVIDUAL CREDENTIALED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN ACCORDANCE WITH APPLICABLE REGULATIONS OF THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

S 37. Paragraph (c) of subdivision 2 of section 364-j of the social services law, as added by section 42-c of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(c) The commissioner of health, jointly with the commissioner of mental health and the commissioner of alcoholism and substance abuse services shall be authorized to establish special needs managed care [and specialized managed care] plans, under the medical assistance program, in accordance with applicable federal law and regulations. The commissioner of health, in cooperation with such commissioners, is authorized, subject to the approval of the director of the division of the budget, to apply for federal waivers when such action would be necessary to assist in promoting the objectives of this section. WITH REGARD TO SUCH SPECIAL NEEDS MANAGED CARE PLANS, IN ADDITION TO THE APPLICABLE REQUIREMENTS ESTABLISHED IN THIS SECTION, SUCH COMMISSIONERS SHALL JOINTLY ESTABLISH STANDARDS AND REQUIREMENTS TO:

(I) ENSURE THAT ANY SPECIAL NEEDS MANAGED CARE PLAN SHALL HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SPECIAL NEEDS MANAGED CARE PLAN, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE;

(II) ENSURE THAT ANY SPECIAL NEEDS MANAGED CARE PLAN SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES;

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF SPECIAL NEEDS MANAGED CARE PLANS; AND

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

S 37-a. Paragraphs (b) and (c) of subdivision 3 of section 364-j of the social services law are REPEALED.

S 38. Paragraphs (a), (d) and (e) of subdivision 3 of section 364-j of the social services law, paragraph (a) as amended by section 13 of part C of chapter 58 of the laws of 2004, paragraph (d) as relettered by section 77 and paragraph (e) as amended by section 77-a of part H of chapter 59 of the laws of 2011, and paragraph (d) as amended by chapter

648 of the laws of 1999, are amended and a new paragraph (d-1) is added to read as follows:

(a) Every person eligible for or receiving medical assistance under this article, who resides in a social services district providing medical assistance, which has implemented the state's managed care program shall participate in the program authorized by this section. Provided, however, that participation in a comprehensive HIV special needs plan also shall be in accordance with article forty-four of the public health law and participation in a [mental health special needs] SPECIAL NEEDS MANAGED CARE plan shall also be in accordance with article forty-four of the public health law and article thirty-one of the mental hygiene law.

(d) [The] UNTIL SUCH TIME AS PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH, THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, THE OFFICE OF CHILDREN AND FAMILY SERVICES, AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AS APPROPRIATE, THE following services shall not be provided to medical assistance recipients through managed care programs established pursuant to this section, and shall continue to be provided outside of managed care programs and in accordance with applicable reimbursement methodologies; PROVIDED, HOWEVER, THAT NO MEDICAL ASSISTANCE RECIPIENT SHALL BE REQUIRED TO OBTAIN SERVICES THAT ARE CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES THROUGH A MANAGED CARE PROGRAM UNTIL THE PROGRAM FEATURES APPROVED BY THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, INCLUDE FEATURES FOR HABILITATION SERVICES AS DEFINED IN PARAGRAPH C OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW:

(i) day treatment services provided to individuals with developmental disabilities;

(ii) comprehensive medicaid case management services provided to individuals with developmental disabilities;

(iii) [services provided pursuant to title two-A of article twenty-five of the public health law;

(iv)] services provided pursuant to article eighty-nine of the education law;

[(v)] (IV) mental health services provided by a certified voluntary free-standing day treatment program where such services are provided in conjunction with educational services authorized in an individualized education program in accordance with regulations promulgated pursuant to article eighty-nine of the education law;

[(vi)] (V) long term services as determined by the commissioner of [mental retardation and] THE OFFICE FOR PEOPLE WITH developmental disabilities, provided to individuals with developmental disabilities at facilities licensed pursuant to article sixteen of the mental hygiene law or clinics serving individuals with developmental disabilities at facilities licensed pursuant to article twenty-eight of the public health law;

[(vii)] (VI) TB directly observed therapy;

[(viii)] (VII) AIDS adult day health care;

[(ix)] (VIII) HIV COBRA case management; and

[(x)] (IX) other services as determined by the commissioner of health.

(D-1) SERVICES PROVIDED PURSUANT TO TITLE TWO-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW SHALL NOT BE PROVIDED TO MEDICAL ASSISTANCE RECIPIENTS THROUGH MANAGED CARE PROGRAMS ESTABLISHED PURSUANT TO THIS

SECTION, AND SHALL CONTINUE TO BE PROVIDED OUTSIDE OF MANAGED CARE PROGRAMS AND IN ACCORDANCE WITH APPLICABLE REIMBURSEMENT METHODOLOGIES.

(e) The following categories of individuals may be required to enroll with a managed care program when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioners of the [department] OFFICE of mental health, the office for [persons] PEOPLE with developmental disabilities, the office of children and family services, and the office of [alcohol] ALCOHOLISM and substance abuse services:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program [and enrolled in a Medicare managed care plan offered by an entity that is also a managed care provider; provided that (notwithstanding paragraph (g) of subdivision four of this section):

(a) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and enrolls in another Medicare managed care plan that is also a managed care provider, the individual shall be (if required by the commissioner under this paragraph) enrolled in that managed care provider;

(b) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, but enrolls in another Medicare managed care plan that is not also a managed care provider, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(c) if the individual disenrolls from his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and does not enroll in another Medicare managed care plan, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(d) nothing herein shall require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program.]; PROVIDED, HOWEVER, NOTHING HEREIN SHALL: (A) REQUIRE AN INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN, PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW, TO DISENROLL FROM SUCH PROGRAM; OR (B) MAKE ENROLLMENT IN A MEDICARE MANAGED CARE PLAN A CONDITION OF THE INDIVIDUAL'S PARTICIPATION IN THE MANAGED CARE PROGRAM PURSUANT TO THIS SECTION, OR AFFECT THE INDIVIDUAL'S ENTITLEMENT TO PAYMENT OF APPLICABLE MEDICARE MANAGED CARE OR FEE FOR SERVICE COINSURANCE AND DEDUCTIBLES BY THE INDIVIDUAL'S MANAGED CARE PROVIDER.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals;

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law;

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for the [mentally retarded] DEVELOPMENTALLY DISABLED;

(vi) a person receiving services provided by an intermediate care facility for the [mentally retarded] DEVELOPMENTALLY DISABLED or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of

the federal social security act or who has characteristics and needs similar to such persons;

(viii) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

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

(x) certified blind or disabled children living or expected to be living separate and apart from the parent for thirty days or more;

(xi) residents of nursing facilities;

(xii) a foster child in the placement of a voluntary agency or in the direct care of the local social services district;

(xiii) a person or family that is homeless; [and]

(xiv) individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services to the person. A managed care provider is not geographically accessible if the person cannot access the provider's services in a timely fashion due to distance or travel time[.];

(XV) A PERSON ELIGIBLE FOR MEDICARE PARTICIPATING IN A CAPITATED DEMONSTRATION PROGRAM FOR LONG TERM CARE;

(XVI) AN INFANT LIVING WITH AN INCARCERATED MOTHER IN A STATE OR LOCAL CORRECTIONAL FACILITY AS DEFINED IN SECTION TWO OF THE CORRECTION LAW;

(XVII) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR LESS THAN SIX MONTHS;

(XVIII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(XIX) INDIVIDUALS RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT; PROVIDED, HOWEVER, THAT THIS CLAUSE SHALL NOT BE CONSTRUED TO REQUIRE AN INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN OR ANOTHER CARE COORDINATION MODEL, WHO SUBSEQUENTLY ELECTS HOSPICE, TO DISENROLL FROM SUCH PROGRAM;

(XX) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAILABLE FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY PAYMENT, OR PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN PAYMENT OF SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE, AS DETERMINED BY THE LOCAL SOCIAL SERVICES DISTRICT;

(XXI) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARAGRAPH SIX OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(XXII) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO PARAGRAPH (D) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE;

(XXIII) INDIVIDUALS WITH A CHRONIC MEDICAL CONDITION WHO ARE BEING TREATED BY A SPECIALIST PHYSICIAN THAT IS NOT ASSOCIATED WITH A MANAGED CARE PROVIDER IN THE INDIVIDUAL'S SOCIAL SERVICES DISTRICT; AND

(XXIV) NATIVE AMERICANS.

S 39. Subparagraphs (ii), (iv) and (vii) of paragraph (e), subparagraphs (i) and (v) of paragraph (f) and paragraphs (g), (h), (i), (o), (p), (q) and (r) of subdivision 4 of section 364-j of the social services law, subparagraphs (ii), (iv) and (vii) of paragraph (e), subparagraph (v) of paragraph (f) and paragraph (g) as amended by section 14 of part C of chapter 58 of the laws of 2004, subparagraph (i) of paragraph (f) as amended by section 79 of part H of chapter 59 of the laws of 2011, paragraph (h) as amended by chapter 433 of the laws of

1997, and paragraphs (i), (o), (p), (q) and (r) as amended by chapter 649 of the laws of 1996, are amended and a new paragraph (v) is added to read as follows:

(ii) In any social services district which has implemented a mandatory managed care program pursuant to this section, the requirements of this subparagraph shall apply to the extent consistent with federal law and regulations. The department of health, may contract with one or more independent organizations to provide enrollment counseling and enrollment services, for participants required to enroll in managed care programs, for each social services district requesting the services of an enrollment broker. To select such organizations, the department of health shall issue a request for proposals (RFP), shall evaluate proposals submitted in response to such RFP and, pursuant to such RFP, shall award a contract to one or more qualified and responsive organizations. Such organizations shall not be owned, operated, or controlled by any governmental agency, managed care provider, [comprehensive HIV special needs plan, mental health special needs plan,] or medical services provider.

(iv) Local social services districts or enrollment organizations through their enrollment counselors shall provide participants with the opportunity for face to face counseling including individual counseling upon request of the participant. Local social services districts or enrollment organizations through their enrollment counselors shall also provide participants with information in a culturally and linguistically appropriate and understandable manner, in light of the participant's needs, circumstances and language proficiency, sufficient to enable the participant to make an informed selection of a managed care provider. Such information shall include, but shall not be limited to: how to access care within the program; a description of the medical assistance services that can be obtained other than through a managed care provider[, mental health special needs plan or comprehensive HIV special needs plan]; the available managed care providers[, mental health special needs plans and comprehensive HIV special needs plans] and the scope of services covered by each; a listing of the medical services providers associated with each managed care provider; the participants' rights within the managed care program; and how to exercise such rights. Enrollment counselors shall inquire into each participant's existing relationships with medical services providers and explain whether and how such relationships may be maintained within the managed care program. For enrollments made during face to face counseling, if the participant has a preference for particular medical services providers, enrollment counselors shall verify with the medical services providers that such medical services providers whom the participant prefers participate in the managed care provider's network and are available to serve the participant.

(vii) Any marketing materials developed by a managed care provider[, comprehensive HIV special needs plan or mental health special needs plan] shall be approved by the department of health or the local social services district, and the commissioner of mental health AND THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, where appropriate, within sixty days prior to distribution to recipients of medical assistance. All marketing materials shall be reviewed within sixty days of submission.

(i) Participants shall choose a managed care provider at the time of application for medical assistance; if the participant does not choose such a provider the commissioner shall assign such participant to a

managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of this paragraph. Participants already in receipt of medical assistance shall have no less than thirty days from the date selected by the district to enroll in the managed care program to select a managed care provider[, and as appropriate, a mental health special needs plan,] and shall be provided with information to make an informed choice. Where a participant has not selected such a provider [or mental health special needs plan,] the commissioner of health shall assign such participant to a managed care provider[, and as] WHICH, IF appropriate, [to] MAY BE a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN, taking into account capacity and geographic accessibility. The commissioner may after the period of time established in subparagraph (ii) of this paragraph assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants.

(v) The commissioner shall assign all participants not otherwise assigned to a managed care plan pursuant to subparagraphs (ii), (iii) and (iv) of this paragraph equally among each of the managed care providers that meet the criteria established in subparagraph (i) of this paragraph; PROVIDED, HOWEVER, THAT THE COMMISSIONER SHALL ASSIGN INDIVIDUALS MEETING THE CRITERIA FOR ENROLLMENT IN A SPECIAL NEEDS MANAGED CARE PLAN TO SUCH PLAN OR PLANS WHERE AVAILABLE.

(g) If another managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] is available, participants may change such provider or plan without cause within thirty days of notification of enrollment or the effective date of enrollment, whichever is later with a managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] by making a request of the local social services district except that such period shall be forty-five days for participants who have been assigned to a provider by the commissioner of health. However, after such thirty or forty-five day period, whichever is applicable, a participant may be prohibited from changing managed care providers more frequently than once every twelve months, as permitted by federal law except for good cause as determined by the commissioner of health through regulations.

(h) If another medical services provider is available, a participant may change his or her provider of medical services (including primary care practitioners) without cause within thirty days of the participant's first appointment with a medical services provider by making a request of the managed care provider[, mental health special needs plan or comprehensive HIV special needs plan]. However, after that thirty day period, no participant shall be permitted to change his or her provider of medical services other than once every six months except for good cause as determined by the commissioner through regulations.

(i) A managed care provider[, mental health special needs plan, and comprehensive HIV special needs plan] requesting a disenrollment shall not disenroll a participant without the prior approval of the local social services district in which the participant resides, provided that disenrollment from a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN must comply with the standards of the commissioner of health, THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, and the commissioner of mental health. A managed care provider[, mental health special needs plan or comprehensive HIV special needs plan] shall not request disenrollment of a participant based on any diagnosis, condition, or perceived diagnosis or condition, or a participant's

efforts to exercise his or her rights under a grievance process, provided however, that a managed care provider may, where medically appropriate, request permission to refer participants to a [mental health special needs plan] MANAGED CARE PROVIDER THAT IS A SPECIAL NEEDS MANAGED CARE PLAN or a comprehensive HIV special needs plan after consulting with such participant and upon obtaining his/her consent to such referral, and[,] provided further that a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN may, where clinically appropriate, disenroll individuals who no longer require the level of services provided by a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN.

(o) A managed care provider shall provide or arrange, directly or indirectly, (including by referral) for the full range of covered services to all participants, notwithstanding that such participants may be eligible to be enrolled in a comprehensive HIV special needs plan or [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN.

(p) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall implement procedures to communicate appropriately with participants who have difficulty communicating in English and to communicate appropriately with visually-impaired and hearing-impaired participants.

(q) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall comply with applicable state and federal law provisions prohibiting discrimination on the basis of disability.

(r) A managed care provider[, comprehensive HIV special needs plan and mental health special needs plan] shall provide services to participants pursuant to an order of a court of competent jurisdiction, provided however, that such services shall be within such provider's or plan's benefit package and are reimbursable under title xix of the federal social security act.

(V) A MANAGED CARE PROVIDER MUST ALLOW ENROLLEES TO ACCESS CHEMICAL DEPENDENCE TREATMENT SERVICES FROM FACILITIES CERTIFIED BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, EVEN IF SUCH SERVICES ARE RENDERED BY A PRACTITIONER WHO WOULD NOT OTHERWISE BE SEPARATELY REIMBURSED, INCLUDING BUT NOT LIMITED TO A CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELOR (CASAC).

S 40. Paragraph (a) of subdivision 5 of section 364-j of the social services law, as amended by section 15 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(a) The managed care program shall provide for the selection of qualified managed care providers by the commissioner of health [and, as appropriate, mental health special needs plans and comprehensive HIV special needs plans] to participate in the program, INCLUDING COMPREHENSIVE HIV SPECIAL NEEDS PLANS AND SPECIAL NEEDS MANAGED CARE PLANS IN ACCORDANCE WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FIVE-M OF THIS TITLE; provided, however, that the commissioner of health may contract directly with comprehensive HIV special needs plans consistent with standards set forth in this section, and assure that such providers are accessible taking into account the needs of persons with disabilities and the differences between rural, suburban, and urban settings, and in sufficient numbers to meet the health care needs of participants, and shall consider the extent to which major public hospitals are included within such providers' networks.

S 41. The opening paragraph of subdivision 6 of section 364-j of the social services law, as added by chapter 649 of the laws of 1996, is amended to read as follows:

A managed care provider[, mental health special needs plan or comprehensive HIV special needs plan provider] shall not engage in the following practices:

S 42. Subdivision 17 of section 364-j of the social services law, as amended by section 94 of part B of chapter 436 of the laws of 1997, is amended to read as follows:

17. (A) The provisions of this section regarding participation of persons receiving family assistance and supplemental security income in managed care programs shall be effective if, and as long as, federal financial participation is available for expenditures for services provided pursuant to this section.

(B) THE PROVISIONS OF THIS SECTION REGARDING THE FURNISHING OF HEALTH AND BEHAVIORAL HEALTH SERVICES THROUGH A SPECIAL NEEDS MANAGED CARE PLAN SHALL BE EFFECTIVE IF, AND AS LONG AS, FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR EXPENDITURES FOR SERVICES PROVIDED BY SUCH PLANS PURSUANT TO THIS SECTION.

S 43. Subdivision 20 of section 364-j of the social services law, as added by chapter 649 of the laws of 1996, is amended to read as follows:

20. Upon a determination that a participant appears to be suitable for admission to a comprehensive HIV special needs plan or a [mental health special needs plan] SPECIAL NEEDS MANAGED CARE PLAN, a managed care provider shall inform the participant of the availability of such plans, where available and appropriate.

S 44. Paragraph (a) of subdivision 23 of section 364-j of the social services law, as added by section 65 of part A of chapter 57 of the laws of 2006, is amended to read as follows:

(a) As a means of protecting the health, safety and welfare of recipients, in addition to any other sanctions that may be imposed, the commissioner, IN CONSULTATION WITH THE COMMISSIONERS OF THE OFFICE OF MENTAL HEALTH AND THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, WHERE APPROPRIATE, shall appoint temporary management of a managed care provider upon determining that the managed care provider has repeatedly failed to meet the substantive requirements of sections 1903(m) and 1932 of the federal Social Security Act and regulations. A hearing shall not be required prior to the appointment of temporary management.

S 45. The opening paragraph of subdivision 4 of section 365-m of the social services law, as added by section 42-d of part H of chapter 59 of the laws of 2011, is amended to read as follows:

The commissioners of the office of mental health, the office of alcoholism and substance abuse services and the department of health, shall have the responsibility for jointly designating on a regional basis, after consultation with the local social services district and local governmental unit, as such term is defined in the mental hygiene law, of a city with a population of over one million persons, and after consultation of other affected counties, a limited number of [specialized managed care plans under section three hundred sixty-four-j of this title,] special [need] NEEDS managed care plans under section three hundred sixty-four-j of this title[, and/or integrated physical and behavioral health provider systems certified under article twenty-nine-E of the public health law] capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs. Initial designations of such plans [or provider systems] should be made no later than April first, two thousand [thir-

teen] FOURTEEN, provided, however, such designations shall be contingent upon a determination by such state commissioners that the entities to be designated have the capacity and financial ability to provide services in such plans [or provider systems], and that the region has a sufficient population and service base to support such plans [and systems]. Once designated, the commissioner of health shall make arrangements to enroll such enrollees in such plans [or integrated provider systems] and to pay such plans [or provider systems] on a capitated or other basis to manage, coordinate, and pay for behavioral and physical health medical assistance services for such enrollees. Notwithstanding any inconsistent provision of section one hundred twelve and one hundred sixty-three of the state finance law, and section one hundred forty-two of the economic development law, or any other law to the contrary, the designations of such plans [and provider systems], and any resulting contracts with such plans[,] OR providers [or provider systems] are authorized to be entered into by such state commissioners without a competitive bid or request for proposal process, provided however that:

S 45-a. Paragraph (c) of subdivision 3 of section 365-m of the social services law, as added by section 42-d of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(c) the commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the commissioner of health and the impacted local governmental units, shall select such contractor or contractors that, in their discretion, have demonstrated the ability to effectively, efficiently, and economically integrate behavioral health and health services; have the requisite expertise and financial resources; have demonstrated that their directors, sponsors, members, managers, partners or operators have the requisite character, competence and standing in the community, and are best suited to serve the purposes of this section. IN SELECTING SUCH CONTRACTOR OR CONTRACTORS, THE COMMISSIONERS SHALL:

(I) ENSURE THAT ANY SUCH CONTRACTOR OR CONTRACTORS HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SUCH CONTRACT OR CONTRACTS, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE.

(II) ENSURE THAT SUCH CONTRACTOR OR CONTRACTORS SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNATED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES.

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF ANY SUCH CONTRACTOR OR CONTRACTORS.

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

S 45-b. Paragraph (c) of subdivision 4 of section 365-m of the social services law, as added by section 42-d of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(c) the commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the

commissioner of health, shall select such plans or systems that, in their discretion, have demonstrated the ability to effectively, efficiently, and economically manage the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs; have the requisite expertise and financial resources; have demonstrated that their directors, sponsors, members, managers, partners or operators have the requisite character, competence and standing in the community, and are best suited to serve the purposes of this section. Oversight of such contracts with such plans, providers or provider systems shall be the joint responsibility of such state commissioners, and for contracts affecting a city with a population of over one million persons, also with the city's local social services district and local governmental unit, as such term is defined in the mental hygiene law.

IN SELECTING SUCH PLANS OR SYSTEMS, THE COMMISSIONERS SHALL:

(I) ENSURE THAT ANY SUCH PLANS OR SYSTEMS HAVE AN ADEQUATE NETWORK OF PROVIDERS TO MEET THE BEHAVIORAL HEALTH AND HEALTH NEEDS OF ENROLLEES, AND SHALL REVIEW THE ADEQUACY PRIOR TO APPROVAL OF ANY SUCH PLANS OR SYSTEMS, AND UPON CONTRACT RENEWAL OR EXPANSION. TO THE EXTENT THAT THE NETWORK HAS BEEN DETERMINED TO MEET STANDARDS SET FORTH IN SUBDIVISION FIVE OF SECTION FOUR THOUSAND FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, SUCH NETWORK SHALL BE DEEMED ADEQUATE.

(II) ENSURE THAT SUCH PLANS OR SYSTEMS SHALL MAKE LEVEL OF CARE AND COVERAGE DETERMINATIONS UTILIZING EVIDENCE-BASED TOOLS OR GUIDELINES DESIGNED TO ADDRESS THE BEHAVIORAL HEALTH NEEDS OF ENROLLEES.

(III) ENSURE SUFFICIENT ACCESS TO BEHAVIORAL HEALTH AND HEALTH SERVICES FOR ELIGIBLE ENROLLEES BY ESTABLISHING AND MONITORING PENETRATION RATES OF ANY SUCH PLANS OR SYSTEMS.

(IV) ESTABLISH STANDARDS TO ENCOURAGE THE USE OF SERVICES, PRODUCTS AND CARE RECOMMENDED, ORDERED OR PRESCRIBED BY A PROVIDER TO SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES; AND MONITOR THE APPLICATION OF SUCH STANDARDS TO ENSURE THAT THEY SUFFICIENTLY ADDRESS THE BEHAVIORAL HEALTH AND HEALTH SERVICES NEEDS OF ENROLLEES.

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 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. 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.

S 46. Subdivision 8 of section 4401 of the public health law, as added by section 42 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

8. "Special needs managed care plan" [or "specialized managed care plan"] shall mean a combination of persons natural or corporate, or any groups of such persons, or a county or counties, who enter into an arrangement, agreement or plan, or combination of arrangements, agreements or plans, to provide health and behavioral health services to enrollees with significant behavioral health needs.

S 47. Section 4403-d of the public health law, as added by section 42-a of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 4403-d. Special needs managed care plans [and specialized managed care plans]. No person, group of persons, county or counties may operate a special needs managed care plan [or specialized managed care plan] without first obtaining a certificate of authority from the commissioner, issued jointly with the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services.

S 47-a. Subparagraphs (iii) and (iv) of paragraph (b) of subdivision 7 of section 4403-f of the public health law are REPEALED.

S 48. Subparagraph (v) of paragraph (b) 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:

(v) The following medical assistance recipients shall not be eligible to participate in a managed long term care program or other care coordination model established pursuant to this paragraph until program features and reimbursement rates are approved by the commissioner and, as applicable, the commissioner of developmental disabilities:

(1) a person enrolled in a managed care plan pursuant to section three hundred sixty-four-j of the social services law;

(2) a participant in the traumatic brain injury waiver program;

(3) a participant in the nursing home transition and diversion waiver program;

(4) a person enrolled in the assisted living program;

(5) a person enrolled in home and community based waiver programs administered by the office for people with developmental disabilities[.];

(6) A PERSON WHO IS EXPECTED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE FOR LESS THAN SIX MONTHS, FOR A REASON OTHER THAN THAT THE PERSON IS ELIGIBLE FOR MEDICAL ASSISTANCE ONLY THROUGH THE APPLICATION OF EXCESS INCOME TOWARD THE COST OF MEDICAL CARE AND SERVICES;

(7) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE BENEFITS ONLY WITH RESPECT TO TUBERCULOSIS-RELATED SERVICES;

(8) A PERSON RECEIVING HOSPICE SERVICES AT TIME OF ENROLLMENT; PROVIDED, HOWEVER, THAT THIS CLAUSE SHALL NOT BE CONSTRUED TO REQUIRE AN INDIVIDUAL ENROLLED IN A MANAGED LONG TERM CARE PLAN OR ANOTHER CARE COORDINATION MODEL, WHO SUBSEQUENTLY ELECTS HOSPICE, TO DISENROLL FROM SUCH PROGRAM;

(9) A PERSON WHO HAS PRIMARY MEDICAL OR HEALTH CARE COVERAGE AVAILABLE FROM OR UNDER A THIRD-PARTY PAYOR WHICH MAY BE MAINTAINED BY PAYMENT, OR PART PAYMENT, OF THE PREMIUM OR COST SHARING AMOUNTS, WHEN PAYMENT OF SUCH PREMIUM OR COST SHARING AMOUNTS WOULD BE COST-EFFECTIVE, AS DETERMINED BY THE SOCIAL SERVICES DISTRICT;

(10) A PERSON RECEIVING FAMILY PLANNING SERVICES PURSUANT TO SUBPARAGRAPH SIX OF PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW;

(11) A PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO PARAGRAPH (B) OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW; AND

(12) NATIVE AMERICANS.

S 48-a. Notwithstanding any contrary provision of law, the commissioner of alcoholism and substance abuse services is authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing hospital-based and free-standing chemical dependence outpatient and opioid treatment clinics licensed pursuant to article 28 of the public health law or article 32 of the mental hygiene law for chemical dependency services, as determined by the commissioner of health, in consultation with the 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 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 of alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services, promulgate regulations, including emergency regulations, as are necessary to implement the provisions of this section.

S 49. 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, 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.

S 50. Intentionally omitted.

S 51. Intentionally omitted.

S 52. Intentionally omitted.

S 53. Intentionally omitted.

S 54. Subparagraph (iii) of paragraph (g) 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:

(iii) The enrollment application shall be submitted by the managed long term care plan or demonstration to the entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. [For purposes of reimbursement of the managed long term care plan or demonstration, if the enrollment application is submitted on or before the twentieth day of the month, the enrollment shall commence on the first day of the month following the completion and submission and if the enrollment application is submitted

after the twentieth day of the month, the enrollment shall commence on the first day of the second month following submission.] Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department or a contractor selected pursuant to paragraph (d) of this subdivision.

S 55. Paragraph (a) of subdivision 8 of section 3614 of the public health law, as added by section 54 of part J of chapter 82 of the laws of 2002, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law, rule or regulation and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall adjust medical assistance rates of payment for services provided by certified home health agencies FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term home health care programs and AIDS home care programs in accordance with this paragraph and paragraph (b) of this subdivision for purposes of improving recruitment and retention of non-supervisory home care services workers or any worker with direct patient care responsibility in the following amounts for services provided on and after December first, two thousand two.

(i) rates of payment by governmental agencies for certified home health agency services FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT (including services provided through contracts with licensed home care services agencies) shall be increased by three percent;

(ii) rates of payment by governmental agencies for long term home health care program services (including services provided through contracts with licensed home care services agencies) shall be increased by three percent; and

(iii) rates of payment by governmental agencies for AIDS home care programs (including services provided through contracts with licensed home care services agencies) shall be increased by three percent.

S 56. The opening paragraph of subdivision 9 of section 3614 of the public health law, as amended by section 5 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment for certified home health agencies FOR SUCH SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT, long term home health care programs, AIDS home care programs established pursuant to this article, hospice programs established under article forty of this chapter and for 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. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

S 57. Paragraph (a) of subdivision 10 of section 3614 of the public health law, as amended by section 24 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

(a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health [agency's] AGENCY, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; PROVIDED THAT SUCH ADJUSTMENTS TO RATES OF PAYMENTS TO CERTIFIED HOME HEALTH AGENCIES SHALL ONLY BE FOR THAT PORTION OF SERVICES PROVIDED TO CHILDREN UNDER EIGHTEEN YEARS OF AGE AND FOR SERVICES PROVIDED TO A SPECIAL NEEDS POPULATION OF MEDICALLY COMPLEX AND FRAGILE CHILDREN, ADOLESCENTS AND YOUNG DISABLED ADULTS BY A CHHA OPERATING UNDER A PILOT PROGRAM APPROVED BY THE DEPARTMENT.

S 57-a. The public health law is amended by adding a new section 3621 to read as follows:

S 3621. PAYMENT OF CLAIMS. NOTWITHSTANDING ANY LAW TO THE CONTRARY, THE PROVISIONS OF SECTION THIRTY-TWO HUNDRED TWENTY-FOUR-A OF THE INSURANCE LAW, AND REGULATIONS THEREUNDER, SHALL APPLY TO CLAIMS FOR PAYMENT SUBMITTED BY A LICENSED HOME CARE SERVICES AGENCY, CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, OR FISCAL INTERMEDIARY OPERATING UNDER SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, PURSUANT TO A CONTRACT WITH A PAYOR UNDER SECTION FORTY-FOUR HUNDRED THREE-F OF THIS CHAPTER OR SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, AND SUCH CLAIMS SHALL BE SUBJECT TO AND SETTLED IN COMPLIANCE WITH THE STANDARDS SET FORTH IN SUCH SECTION.

S 57-b. Paragraph 2 of subsection (d) of section 3224-a of the insurance law, as amended by chapter 666 of the laws of 1997, is amended to read as follows:

(2) "health care provider" shall mean an entity licensed or certified pursuant to article twenty-eight, thirty-six or forty of the public health law, a facility licensed pursuant to article nineteen[, twenty-three] or thirty-one of the mental hygiene law, A FISCAL INTERMEDIARY OPERATING UNDER SECTION THREE HUNDRED SIXTY FIVE-F OF THE SOCIAL SERVICES LAW, a health care professional licensed, registered or certified pursuant to title eight of the education law, a dispenser or provider of pharmaceutical products, services or durable medical equipment, or a representative designated by such entity or person.

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.

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 and the group shall issue a report with recommendations by March 1, 2014.

S 58. Paragraph (h) of subdivision 21 of section 2808 of the public health law, as amended by section 8 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(h) The total amount of funds to be allocated and distributed as medical assistance for financially disadvantaged residential health care facility rate adjustments to eligible facilities for a rate period in accordance with this subdivision shall be thirty million dollars for the period October first, two thousand four through December thirty-first, two thousand four and thirty million dollars on an annualized basis for rate periods on and after January first, two thousand five through December thirty-first, two thousand eight and thirty million dollars on an annualized basis on and after January first, two thousand nine, PROVIDED THAT, SUBJECT TO ALL NECESSARY FEDERAL APPROVALS, ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN FUNDS ALLOCATED UNDER THIS PARAGRAPH SHALL BE DISTRIBUTED PURSUANT TO 10 NYCRR 86-2.39. The nonfederal share of such rate adjustments shall be paid by the state, with no local share, from allocations made pursuant to paragraph (hh) of subdivision one of section twenty-eight hundred seven-v of this article. In the event the statewide total of the annual rate adjustments determined pursuant to paragraph (g) of this subdivision varies from the amounts set forth in this paragraph, each qualifying facility's rate adjustment shall be proportionately increased or decreased such that the total of the annual rate adjustments made pursuant to this subdivision is equal to the amounts set forth in this paragraph on a statewide basis.

S 58-a. Notwithstanding any law to the contrary, and subject to the availability of federal financial participation, 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 in accordance with the provisions of 10 NYCRR 86-1.31. In addition, the department of health shall analyze the adequacy of rates for critical access hospitals and develop recommendations for consideration in preparing the 2014-15 Executive Budget.

S 59. Paragraph (d) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(d) Cost reports submitted by residential health care facilities for the two thousand two calendar year or any part thereof shall, notwithstanding any contrary provision of law, be subject to audit through December thirty-first, two thousand [fourteen] EIGHTEEN and facilities shall retain for the purpose of such audits all fiscal and statistical records relevant to such cost reports, provided, however, that any such audit commenced on or before December thirty-first, two thousand [fourteen] EIGHTEEN, may be completed and used for the purpose of adjusting any Medicaid rates which utilize such costs.

S 60. Subparagraph (ii) of paragraph (a) of subdivision 2-b of section 2808 of the public health law, as added by section 47 of part C of chapter 109 of the laws of 2006, is amended to read as follows:

(ii) Rates for the periods two thousand seven and two thousand eight shall be further adjusted by a per diem add-on amount, as determined by

the commissioner, reflecting the proportional amount of each facility's projected Medicaid benefit to the total projected Medicaid benefit for all facilities of the imputed use of the rate-setting methodology set forth in paragraph (b) of this subdivision, provided, however, that for those facilities that do not receive a per diem add-on adjustment pursuant to this subparagraph, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, provided, further, however, that the aggregate total of the rate adjustments made pursuant to this subparagraph shall not exceed one hundred thirty-seven million five hundred thousand dollars for the two thousand seven rate period and one hundred sixty-seven million five hundred thousand dollars for the two thousand eight rate period AND PROVIDED FURTHER, HOWEVER, THAT SUCH RATE ADJUSTMENTS AS MADE PURSUANT TO THIS SUBPARAGRAPH PRIOR TO TWO THOUSAND TWELVE SHALL NOT BE SUBJECT TO SUBSEQUENT ADJUSTMENT OR RECONCILIATION.

S 61. Subparagraph (i) of paragraph (b) of subdivision 2-b of section 2808 of the public health law, as amended by section 94 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(i) (A) Subject to the provisions of subparagraphs (ii) through (xiv) of this paragraph, for periods on and after April first, two thousand nine the operating cost component of rates of payment shall reflect allowable operating costs as reported in each facility's cost report for the two thousand two calendar year, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article, provided, however, that for those facilities which [do not receive a per diem add-on adjustment pursuant to subparagraph (ii) of paragraph (a) of this subdivision] ARE DETERMINED BY THE COMMISSIONER TO BE QUALIFYING FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B) OF THIS SUBPARAGRAPH, rates shall be further adjusted to include the proportionate benefit, as determined by the commissioner, of the expiration of the opening paragraph and paragraph (a) of subdivision sixteen of this section and of paragraph (a) of subdivision fourteen of this section, and provided further that the operating cost component of rates of payment for those facilities which [did not receive a per diem adjustment in accordance with subparagraph (ii) of paragraph (a) of this subdivision] ARE DETERMINED BY THE COMMISSIONER TO BE QUALIFYING FACILITIES IN ACCORDANCE WITH THE PROVISIONS OF CLAUSE (B) OF THIS SUBPARAGRAPH shall not be less than the operating component such facilities received in the two thousand eight rate period, as adjusted for inflation on an annual basis in accordance with the methodology set forth in paragraph (c) of subdivision ten of section twenty-eight hundred seven-c of this article and further provided, however, that rates for facilities whose operating cost component reflects base year costs subsequent to January first, two thousand two shall have rates computed in accordance with this paragraph, utilizing allowable operating costs as reported in such subsequent base year period, and trended forward to the rate year in accordance with applicable inflation factors.

(B) FOR THE PURPOSES OF THIS SUBPARAGRAPH QUALIFYING FACILITIES ARE THOSE FACILITIES FOR WHICH THE COMMISSIONER DETERMINES THAT THEIR REPORTED TWO THOUSAND TWO BASE YEAR OPERATING COST COMPONENT, AS DEFINED IN ACCORDANCE WITH THE REGULATIONS OF THE DEPARTMENT AS SET FORTH IN 10 NYCRR 86-2.10(A)(7); IS LESS THAN THE OPERATING COMPONENT SUCH FACILI-

TIES RECEIVED IN THE TWO THOUSAND EIGHT RATE PERIOD, AS ADJUSTED BY APPLICABLE TREND FACTORS.

S 62. Intentionally omitted.

S 63. Paragraph (e-1) of subdivision 12 of section 2808 of the public health law, as amended by section 1 of part D of chapter 59 of the laws of 2011, 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. 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 64. Subdivision 12 of section 2808 of the public health law is amended by adding a new paragraph (f-1) to read as follows:

(F-1) FUNDS ALLOCATED BY THE PROVISIONS OF PARAGRAPH (E-1) OF THIS SUBDIVISION FOR DISTRIBUTION PURSUANT TO THIS PARAGRAPH, SHALL BE ALLOCATED PROPORTIONALLY TO THOSE PUBLIC RESIDENTIAL HEALTH CARE FACILITIES WHICH WERE SUBJECT TO RETROACTIVE REDUCTIONS IN PAYMENTS MADE PURSUANT TO THIS SUBDIVISION FOR STATE FISCAL YEAR PERIODS BEGINNING APRIL FIRST, TWO THOUSAND SIX.

S 65. Intentionally omitted.

S 66. Intentionally omitted.

S 67. Intentionally omitted.

S 68. Paragraph (a) of subdivision 2 of section 366-c of the social services law, as added by chapter 558 of the laws of 1989, is amended to read as follows:

(a) For purposes of this section an "institutionalized spouse" is a person (I) WHO IS in a medical institution or nursing facility [(i) who is] AND expected to remain in such facility or institution for at least thirty consecutive days[,]; or (II) WHO is receiving care, services and supplies pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act OR IS RECEIVING CARE, SERVICES AND SUPPLIES IN A MANAGED LONG-TERM CARE PLAN

PURSUANT TO SECTION ELEVEN HUNDRED FIFTEEN OF THE SOCIAL SECURITY ACT; and [(ii)] (III) who is married to a person who is not in a medical institution or nursing facility or is not receiving WAIVER services [pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act] DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH; 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 69. Paragraph (b) of subdivision 6 of section 3614 of the public health law, as added by chapter 645 of the laws of 2003, is amended to read as follows:

(b) For purposes of this subdivision, real property capital construction costs shall only be included in rates of payment for assisted living programs if: THE FACILITY HOUSES EXCLUSIVELY ASSISTED LIVING PROGRAM BEDS AUTHORIZED PURSUANT TO PARAGRAPH (J) OF SUBDIVISION THREE OF SECTION FOUR HUNDRED SIXTY-ONE-L OF THE SOCIAL SERVICES LAW OR (i) the facility is operated by a not-for-profit corporation; (ii) the facility commenced operation after nineteen hundred ninety-eight and at least ninety-five percent of the certified approved beds are provided to residents who are subject to the assisted living program; and (iii) the assisted living program is in a county with a population of no less than two hundred eighty thousand persons. The methodology used to calculate the rate for such capital construction costs shall be the same methodology used to calculate the capital construction costs at residential health care facilities for such costs, PROVIDED THAT THE COMMISSIONER MAY ADOPT RULES AND REGULATIONS WHICH ESTABLISH A CAP ON REAL PROPERTY CAPITAL CONSTRUCTION COSTS FOR THOSE FACILITIES THAT HOUSE EXCLUSIVELY ASSISTED LIVING PROGRAM BEDS AUTHORIZED PURSUANT TO PARAGRAPH (J) OF SUBDIVISION THREE OF SECTION FOUR HUNDRED SIXTY-ONE-L OF THE SOCIAL SERVICES LAW.

S 70. Subdivision 3 of section 461-l of the social services law is amended by adding a new paragraph (j) to read as follows:

(J) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ADD UP TO FOUR THOUSAND FIVE HUNDRED 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 TWELVE. APPLICANTS ELIGIBLE TO SUBMIT AN APPLICATION UNDER THIS PARAGRAPH SHALL BE LIMITED TO ADULT HOMES ESTABLISHED PURSUANT TO SECTION FOUR HUNDRED SIXTY-ONE-B OF THIS ARTICLE WITH, AS OF SEPTEMBER FIRST, TWO THOUSAND TWELVE, A CERTIFIED CAPACITY OF EIGHTY BEDS OR MORE IN WHICH TWENTY-FIVE PERCENT OR MORE OF THE RESIDENT POPULATION ARE PERSONS WITH SERIOUS MENTAL ILLNESS AS DEFINED IN REGULATIONS PROMULGATED BY THE COMMISSIONER OF HEALTH. 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.

S 71. Subdivision 14 of section 366 of the social services law, as added by section 74 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval

under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services under this title, OTHER THAN SHORT-TERM REHABILITATION SERVICES, AND FOR INDIVIDUALS IN RECEIPT OF MEDICAL ASSISTANCE WHILE IN AN ADULT HOME, AS DEFINED IN SUBDIVISION TWENTY-FIVE OF SECTION TWO OF THIS CHAPTER, who [are]: ARE (i) discharged [from the nursing facility] to the community; AND (ii) IF ELIGIBLE, enrolled in a plan certified pursuant to section forty-four hundred three-f of the public health law; and (iii) [while so enrolled, not] DO NOT MEET THE CRITERIA TO BE considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

S 72. Section 364-j of the social services law is amended by adding a new subdivision 27 to read as follows:

27. (A) THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HAS ESTABLISHED AN INITIATIVE TO ALIGN INCENTIVES BETWEEN MEDICARE AND MEDICAID. THE GOAL OF THE INITIATIVE IS TO INCREASE ACCESS TO SEAMLESS, QUALITY PROGRAMS THAT INTEGRATE SERVICES FOR THE DUALLY ELIGIBLE BENEFICIARY AS WELL AS TO ACHIEVE BOTH STATE AND FEDERAL HEALTH CARE SAVINGS BY IMPROVING HEALTH CARE DELIVERY AND ENCOURAGING HIGH-QUALITY EFFICIENT CARE. IN FURTHERANCE OF THIS GOAL, THE LEGISLATURE AUTHORIZES THE COMMISSIONER OF HEALTH TO ESTABLISH A FULLY INTEGRATED DUAL ADVANTAGE (FIDA) PROGRAM.

(B) THE FIDA PROGRAM SHALL PROVIDE TARGETED POPULATIONS OF MEDICARE/MEDICAID DUALLY ELIGIBLE PERSONS WITH COMPREHENSIVE HEALTH SERVICES THAT INCLUDE THE FULL RANGE OF MEDICARE AND MEDICAID COVERED SERVICES, INCLUDING BUT NOT LIMITED TO PRIMARY AND ACUTE CARE, PRESCRIPTION DRUGS, BEHAVIORAL HEALTH SERVICES, CARE COORDINATION SERVICES, AND LONG-TERM SUPPORTS AND SERVICES, AS WELL AS OTHER SERVICES, THROUGH MANAGED CARE PROVIDERS, AS DEFINED IN SUBDIVISION ONE OF THIS SECTION, INCLUDING MANAGED LONG TERM CARE PLANS, CERTIFIED PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW.

(C) UNDER THE FIDA PROGRAM ESTABLISHED PURSUANT TO THIS SUBDIVISION, UP TO THREE MANAGED LONG TERM CARE PLANS MAY BE AUTHORIZED TO EXCLUSIVELY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW. THE COMMISSIONER OF HEALTH MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS SUCH COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICE FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY WAIVE ANY OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES' REGULATIONS AS SUCH COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.

(D) THE PROVISIONS OF THIS SUBDIVISION SHALL NOT APPLY UNLESS ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION HAVE BEEN OBTAINED TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF HEALTH CARE SERVICES PROVIDED PURSUANT TO THIS SUBDIVISION.

(E) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO SUBMIT AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT AS MAY BE NECESSARY TO OBTAIN THE FEDERAL APPROVALS NECESSARY TO IMPLEMENT THIS SUBDIVISION.

(F) NOTWITHSTANDING ANY INCONSISTENT PROVISIONS OF THIS SECTION AND SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE COMMISSIONER OF HEALTH AND, IN THE CASE OF FIDAS AUTHORIZED EXCLUSIVELY TO ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, MAY CONTRACT WITH FIDAS APPROVED UNDER THIS SECTION WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, ARE AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER THIS SECTION, PROVIDED, HOWEVER, THAT:

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

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

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

(C) 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

(D) 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 A TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONER OF HEALTH OR COMMISSIONERS, AS APPLICABLE; AND

(III) THE COMMISSIONER OR, IN THE CASE OF FIDAS AUTHORIZED EXCLUSIVELY TO ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, MAY SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY AND ECONOMICALLY INTEGRATE HEALTH AND LONG TERM CARE SERVICES, AND MEET THE STANDARDS FOR A CERTIFICATE OF AUTHORITY UNDER THE PUBLIC HEALTH LAW FOR THE PROVISION OF SERVICES APPLICABLE TO THE TYPE OF MANAGED LONG TERM CARE PLAN THAT SUCH CONTRACTOR PROPOSES TO OPERATE.

(G) NOTHING IN THIS SECTION SHALL BE CONSTRUED AS REQUIRING AN INDIVIDUAL WITH A DEVELOPMENTAL DISABILITY TO ENROLL IN A FIDA THAT IS AUTHORIZED TO EXCLUSIVELY ENROLL INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

(H) NOTHING IN THIS SECTION SHALL MAKE ENROLLMENT IN A MEDICARE MANAGED CARE PLAN A CONDITION OF AN INDIVIDUAL'S PARTICIPATION IN THE FIDA PROGRAM, OR AFFECT THE INDIVIDUAL'S ENTITLEMENT TO PAYMENT OF APPLICABLE MEDICARE MANAGED CARE OR FEE-FOR-SERVICE COINSURANCE DEDUCTIBLES BY THE INDIVIDUAL'S FIDA PLAN.

S 72-a. Legislative intent of the people first waiver act. The legislature finds that persons receiving services operated, certified, funded, authorized or approved by the office for people with developmental disabilities can benefit from care coordination and integrated care that incorporates both long-term habilitation supports and health care. The legislature also finds that services provided to individuals with developmental disabilities should be designed to achieve person-centered outcomes and to enable the person to live in the most-integrated setting appropriate to that person's needs, and to enable that person to interact with nondisabled persons to the fullest extent possible in social, workplace and other community settings, consistent with the person's needs and wishes, to the extent such wishes are known. As such, the legislature hereby enacts sections 72-b, 73, 74, 75, 76, 77, 78, 79, 80 and 80-a of this act, herein referred to as the people first waiver act. This program shall include the use of developmental disability individ-

ual support and care coordination organizations pursuant to section 4403-g of the public health law, health maintenance organizations as provided for in subdivision 8 of section 4403 of the public health law, and managed long term care plans providing services under subdivisions 12, 13 and 14 of section 4403-f of the public health law. It is the intent of the legislature that, to the greatest extent possible and consistent with a person's needs and known wishes, all services provided should be in the most-integrated setting appropriate for such individual persons receiving services through this act, and that such individuals should be able to make informed choices, either individually or through an authorized decision maker, regarding the development of a person-centered plan of care.

S 72-b. The mental hygiene law is amended by adding a new section 13.40 to read as follows:

S 13.40 PEOPLE FIRST WAIVER PROGRAM.

(A) THE COMMISSIONER AND THE COMMISSIONER OF HEALTH SHALL JOINTLY ESTABLISH A PEOPLE FIRST WAIVER PROGRAM FOR PURPOSES OF DEVELOPING A CARE COORDINATION MODEL THAT INTEGRATES VARIOUS LONG-TERM HABILITATION SUPPORTS AND/OR HEALTH CARE. THE PEOPLE FIRST WAIVER PROGRAM SHALL INCLUDE THE USE OF DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATIONS, HEREIN REFERRED TO AS DISCOS, PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, HEALTH MAINTENANCE ORGANIZATIONS, HEREIN REFERRED TO AS HMOS, PROVIDING SERVICES UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND MANAGED LONG TERM CARE PLANS, HEREIN REFERRED TO AS MLTCS, PROVIDING SERVICES UNDER SUBDIVISIONS TWELVE, THIRTEEN AND FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW. SERVICES SHALL BE PROVIDED AS DESCRIBED IN SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND SUBDIVISIONS TWELVE, THIRTEEN AND FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW.

(B) ENTITIES PROVIDING SERVICES PURSUANT TO THIS SECTION SHALL PROVIDE HEALTH AND LONG TERM CARE SERVICES AS THE TERM IS DEFINED IN SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

(C) NO PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS RECEIVING OR APPLYING FOR MEDICAL ASSISTANCE AND WHO IS RECEIVING, OR ELIGIBLE TO RECEIVE, SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE, SHALL BE REQUIRED TO ENROLL IN A DISCO, HMO OR MLTC IN ORDER TO RECEIVE SUCH SERVICES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF HEALTH, AND UNTIL SUCH COMMISSIONERS DETERMINE THAT A SUFFICIENT NUMBER OF PLANS THAT ARE AUTHORIZED TO COORDINATE CARE FOR INDIVIDUALS PURSUANT TO THIS SECTION OR THAT ARE AUTHORIZED TO OPERATE AND TO EXCLUSIVELY ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO SUBDIVISION TWENTY-SEVEN OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW ARE OPERATING IN SUCH PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH ENTITIES MEET THE STANDARDS OF THIS SECTION. NO PERSON SHALL BE REQUIRED TO ENROLL IN A DISCO, HMO OR MLTC IN ORDER TO RECEIVE SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE UNTIL THERE ARE AT LEAST TWO ENTITIES OPERATING UNDER THIS SECTION IN SUCH PERSON'S COUNTY OF RESIDENCE, UNLESS FEDERAL APPROVAL IS SECURED TO REQUIRE ENROLLMENT WHEN THERE ARE LESS THAN TWO SUCH ENTITIES OPERATING IN SUCH COUNTY.

(D) DISCOS, HMOS AND MLTCS OPERATING UNDER THIS SECTION SHALL ENSURE, TO THE GREATEST EXTENT PRACTICABLE, THAT THEIR ASSESSMENT, SERVICES, AND

THE GRIEVANCE AND APPEALS PROCESSES ARE CULTURALLY AND LINGUISTICALLY COMPETENT.

(E) 1. THE COMMISSIONER AND THE COMMISSIONER OF HEALTH SHALL IDENTIFY ONE OR MORE VALID AND RELIABLE QUALITY ASSURANCE INSTRUMENTS THAT INCLUDE ASSESSMENTS OF INDIVIDUAL AND FAMILY SATISFACTION, PROVISION OF SERVICES, AND PERSONAL OUTCOMES. THE INSTRUMENTS SHALL:

(1) PROVIDE NATIONALLY VALIDATED, BENCHMARKED, CONSISTENT, RELIABLE AND MEASURABLE DATA FOR A COMPREHENSIVE QUALITY IMPROVEMENT AND REVIEW PROCESS, AND

(2) INCLUDE OUTCOME-BASED MEASURES SUCH AS HEALTH, SAFETY, WELL-BEING, RELATIONSHIPS, INTERACTIONS WITH PEOPLE WHO DO NOT HAVE A DISABILITY, EMPLOYMENT, QUALITY OF LIFE, INTEGRATION, CHOICE, SERVICE AND CONSUMER SATISFACTION.

2. WITHIN AVAILABLE APPROPRIATIONS, THE INSTRUMENTS IDENTIFIED IN THIS SUBDIVISION MAY BE EXPANDED TO COLLECT ADDITIONAL DATA REQUESTED BY OTHER OFFICES, DEPARTMENTS OR AGENCIES OF THE STATE, LOCAL OR FEDERAL GOVERNMENT.

3. THE COMMISSIONER MAY CONTRACT WITH AN INDEPENDENT AGENCY OR ORGANIZATION FOR THE DEVELOPMENT OF THE QUALITY ASSURANCE INSTRUMENTS DESCRIBED IN THIS SUBDIVISION.

4. THE COMMISSIONER SHALL ESTABLISH THE METHODOLOGY BY WHICH THE QUALITY ASSURANCE INSTRUMENTS SHALL BE ADMINISTERED.

5. THE COMMISSIONER, IN CONSULTATION WITH STAKEHOLDERS, SHALL ANNUALLY REVIEW THE DATA COLLECTED FROM THE QUALITY ASSURANCE INSTRUMENTS DESCRIBED IN THIS SUBDIVISION AND SHALL REVIEW RECOMMENDATIONS REGARDING ADDITIONAL OR DIFFERENT CRITERIA FOR THE QUALITY ASSURANCE INSTRUMENTS IN ORDER TO ASSESS THE PERFORMANCE OF THE STATE'S DEVELOPMENTAL DISABILITIES SERVICES SYSTEM AND IMPROVE SERVICES FOR CONSUMERS.

(F) THERE SHALL BE A JOINT ADVISORY COUNCIL CHAIRED BY THE COMMISSIONER AND THE COMMISSIONER OF HEALTH THAT SHALL BE CHARGED WITH ADVISING BOTH COMMISSIONERS IN REGARD TO THE OVERSIGHT OF DISCOS, HMOS PROVIDING SERVICES UNDER SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND MLTCS PROVIDING SERVICES UNDER SUBDIVISIONS TWELVE, THIRTEEN AND FOURTEEN OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW. THE JOINT ADVISORY COUNCIL MAY BE COMPRISED OF THE MEMBERS OF EXISTING ADVISORY COUNCILS OR SIMILAR ENTITIES SERVING THE OFFICE, PROVIDED THAT IT SHALL BE COMPRISED OF TWELVE MEMBERS, INCLUDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, FAMILY MEMBERS OF, ADVOCATES FOR, AND PROVIDERS OF SERVICES TO PEOPLE WITH DEVELOPMENTAL DISABILITIES. THREE MEMBERS OF THE JOINT ADVISORY COUNCIL SHALL ALSO BE MEMBERS OF THE SPECIAL ADVISORY REVIEW PANEL ON MEDICAID MANAGED CARE ESTABLISHED UNDER SECTION THREE HUNDRED SIXTY-FOUR-JJ OF THE SOCIAL SERVICES LAW. THE JOINT ADVISORY COUNCIL SHALL REVIEW ALL MANAGED CARE OPTIONS PROVIDED TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, INCLUDING: THE ADEQUACY OF HABILITATION SERVICES; THE RECORD OF COMPLIANCE WITH PERSON-CENTERED PLANNING, PERSON-CENTERED SERVICES AND COMMUNITY INTEGRATION; THE ADEQUACY OF RATES PAID TO PROVIDERS IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH ONE OF SUBDIVISION FOUR OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, PARAGRAPH A-TWO OF SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW OR PARAGRAPH A-TWO OF SUBDIVISION TWELVE OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW; AND QUALITY OF LIFE, HEALTH, SAFETY AND COMMUNITY INTEGRATION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES ENROLLED IN MANAGED CARE. THE COMMISSIONER AND COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR THEIR DESIGNEES SHALL ATTEND ALL MEETINGS OF THE JOINT ADVISORY

COUNCIL. THE JOINT ADVISORY COUNCIL SHALL REPORT ITS FINDINGS, RECOMMENDATIONS, AND ANY PROPOSED AMENDMENTS TO PERTINENT SECTIONS OF THE LAW TO THE COMMISSIONER AND THE COMMISSIONER OF HEALTH, THE SENATE MAJORITY LEADER AND SPEAKER OF THE ASSEMBLY. THE JOINT ADVISORY COUNCIL SHALL HAVE ACCESS TO ANY AND ALL INFORMATION THAT MAY BE LAWFULLY DISCLOSED TO IT AND THAT IS NECESSARY TO PERFORM ITS FUNCTIONS UNDER THIS SECTION.

(G) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, OR SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR ANY OTHER LAW TO THE CONTRARY, THE COMMISSIONER AND THE COMMISSIONER OF HEALTH ARE AUTHORIZED TO ENTER INTO A CONTRACT OR CONTRACTS UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, SUBDIVISION EIGHT OF SECTION FORTY-FOUR HUNDRED THREE OF THE PUBLIC HEALTH LAW, AND SUBDIVISION TWELVE OF SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW, PROVIDED, HOWEVER, THAT:

1. THE OFFICE 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;

2. ALL REASONABLE AND RESPONSIVE SUBMISSIONS THAT ARE RECEIVED FROM PROSPECTIVE CONTRACTORS IN A TIMELY FASHION SHALL BE REVIEWED BY THE COMMISSIONERS; AND

3. THE COMMISSIONER AND THE COMMISSIONER OF HEALTH MAY JOINTLY SELECT SUCH CONTRACTOR OR CONTRACTORS THAT, IN THEIR DISCRETION, HAVE DEMONSTRATED THE ABILITY TO EFFECTIVELY, EFFICIENTLY AND ECONOMICALLY INTEGRATE HEALTH AND LONG TERM CARE SERVICES AS DEFINED IN SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, AND MEET THE STANDARDS FOR A CERTIFICATE OF AUTHORITY IN THE PUBLIC HEALTH LAW FOR THE PROVISION OF SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND APPLICABLE TO THE TYPE OF MANAGED CARE PLAN THAT SUCH CONTRACTOR PROPOSES TO OPERATE.

S 73. The public health law is amended by adding a new section 4403-g to read as follows:

S 4403-G. DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATIONS. 1. DEFINITIONS. AS USED IN THIS SECTION:

(A) "DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION" OR "DISCO" MEANS AN ENTITY THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY PURSUANT TO THIS SECTION TO PROVIDE, OR ARRANGE FOR, HEALTH AND LONG TERM CARE SERVICES, AS DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, ON A CAPITATED BASIS IN ACCORDANCE WITH THIS SECTION, FOR A POPULATION OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW, WHICH THE ORGANIZATION IS AUTHORIZED TO ENROLL.

(B) "ELIGIBLE APPLICANT" MEANS AN ENTITY CONTROLLED BY ONE OR MORE NON-PROFIT ORGANIZATIONS WHICH HAVE A HISTORY OF PROVIDING OR COORDINATING HEALTH AND LONG TERM CARE SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES.

(C) "HABILITATION SERVICES" MEANS SERVICES AVAILABLE THROUGH THE STATE'S HOME AND COMMUNITY BASED SERVICES WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, STATE PLAN FOR MEDICAL ASSISTANCE, AND ANY OTHER AUTHORIZED FEDERAL FUNDING FOR SUCH SERVICES DESIGNED TO ASSIST PERSONS IN ACQUIRING, RETAINING, AND IMPROVING THE SELF-HELP, SOCIALIZATION, AND ADAPTIVE SKILLS NECESSARY TO RESIDE SUCCESSFULLY IN HOME AND COMMUNITY BASED SETTINGS.

(D) "HEALTH AND LONG TERM CARE SERVICES" MEANS SERVICES, WHETHER PROVIDED BY STATE-OPERATED PROGRAMS OR NOT-FOR-PROFIT ENTITIES, INCLUDING, BUT NOT LIMITED TO, HABILITATION SERVICES, HOME AND COMMUNITY-BASED AND INSTITUTION-BASED LONG TERM CARE SERVICES, AND ANCILLARY SERVICES, THAT SHALL INCLUDE MEDICAL SUPPLIES AND NUTRITIONAL SUPPLEMENTS, THAT ARE NECESSARY TO MEET THE NEEDS OF PERSONS WHOM THE PLAN IS AUTHORIZED TO ENROLL, AND MAY INCLUDE PRIMARY CARE AND ACUTE CARE IF THE DISCO IS AUTHORIZED TO PROVIDE OR ARRANGE FOR SUCH SERVICES. EACH PERSON ENROLLED IN A DISCO SHALL RECEIVE HEALTH AND LONG TERM CARE SERVICES DESIGNED TO ACHIEVE PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON TO LIVE IN THE MOST INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT POSSIBLE IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE EXTENT THAT SUCH WISHES ARE KNOWN AND IN ACCORDANCE WITH SUCH PERSON'S NEEDS.

2. APPROVAL AUTHORITY. AN APPLICANT SHALL BE ISSUED A CERTIFICATE OF AUTHORITY AS A DISCO FOR PURPOSES OF PARTICIPATING IN THE PEOPLE FIRST WAIVER PROGRAM PURSUANT TO SECTION 13.40 OF THE MENTAL HYGIENE LAW UPON A DETERMINATION BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES THAT THE APPLICANT COMPLIES WITH THE OPERATING REQUIREMENTS FOR A DISCO UNDER THIS SECTION.

3. APPLICATION FOR CERTIFICATE OF AUTHORITY; FORM. THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL JOINTLY DEVELOP APPLICATION FORMS FOR A CERTIFICATE OF AUTHORITY TO OPERATE A DISCO. AN ELIGIBLE APPLICANT SHALL SUBMIT AN APPLICATION FOR A CERTIFICATE OF AUTHORITY TO OPERATE A DISCO UPON FORMS PRESCRIBED BY SUCH COMMISSIONERS. SUCH ELIGIBLE APPLICANT SHALL SUBMIT INFORMATION AND DOCUMENTATION TO THE COMMISSIONER WHICH SHALL INCLUDE, BUT NOT BE LIMITED TO:

(A) A DESCRIPTION OF THE SERVICE AREA PROPOSED TO BE SERVED BY THE DISCO WITH PROJECTIONS OF ENROLLMENT THAT WILL RESULT IN A FISCALLY SOUND PLAN;

(B) A DESCRIPTION OF THE SERVICES TO BE COVERED BY SUCH DISCO;

(C) A DESCRIPTION OF THE PROPOSED MARKETING PLAN AND HOW MARKETING MATERIALS WILL BE PRESENTED TO PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION MAKERS FOR THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE;

(D) THE NAMES OF THE PROVIDERS PROPOSED TO BE IN THE DISCO'S NETWORK;

(E) EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE APPLICANT'S PROPOSED OPERATORS, AND OF THE INCORPORATORS, DIRECTORS, STOCKHOLDERS OR MEMBERS OF THE APPLICANT;

(F) ADEQUATE DOCUMENTATION OF THE APPROPRIATE LICENSES, CERTIFICATIONS OR APPROVALS TO PROVIDE CARE AS PLANNED, INCLUDING AFFILIATE AGREEMENTS OR PROPOSED CONTRACTS WITH SUCH PROVIDERS AS MAY BE NECESSARY TO PROVIDE THE FULL COMPLEMENT OF SERVICES REQUIRED TO BE PROVIDED UNDER THIS SECTION;

(G) A DESCRIPTION OF THE PROPOSED QUALITY-ASSURANCE MECHANISMS, GRIEVANCE PROCEDURES, MECHANISMS TO PROTECT THE RIGHTS OF ENROLLEES AND CARE

COORDINATION SERVICES TO ENSURE CONTINUITY, QUALITY, APPROPRIATENESS AND COORDINATION OF CARE;

(H) A DESCRIPTION OF THE PROPOSED QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT INCLUDES PERFORMANCE AND OUTCOME BASED QUALITY STANDARDS FOR ENROLLEE HEALTH STATUS AND SATISFACTION, AND DATA COLLECTION AND REPORTING FOR STANDARD PERFORMANCE MEASURES;

(I) A DESCRIPTION OF THE MANAGEMENT SYSTEMS AND SYSTEMS TO PROCESS PAYMENT FOR COVERED SERVICES;

(J) A DESCRIPTION OF HOW ACHIEVEMENT OF PERSON-CENTERED OUTCOMES, AS DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE ASSESSED, AS WELL AS A DESCRIPTION OF HOW HEALTH AND LONG TERM CARE SERVICES SHALL BE USED TO MEET SUCH OUTCOMES;

(K) A DESCRIPTION OF THE MECHANISM TO MAXIMIZE REIMBURSEMENT OF AND COORDINATE SERVICES REIMBURSED PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER APPLICABLE BENEFITS, WITH SUCH BENEFIT COORDINATION INCLUDING, BUT NOT LIMITED TO, MEASURES TO SUPPORT SOUND CLINICAL DECISIONS, REDUCE ADMINISTRATIVE COMPLEXITY, COORDINATE ACCESS TO SERVICES, MAXIMIZE BENEFITS AVAILABLE PURSUANT TO SUCH TITLE AND ENSURE THAT NECESSARY CARE IS PROVIDED;

(L) A DESCRIPTION OF THE SYSTEMS FOR SECURING AND INTEGRATING ANY POTENTIAL SOURCES OF FUNDING FOR SERVICES PROVIDED BY OR THROUGH THE ORGANIZATION, INCLUDING, BUT NOT LIMITED TO, FUNDING AVAILABLE UNDER TITLES XVI, XVIII, XIX AND XX OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER AVAILABLE SOURCES OF FUNDING;

(M) A DESCRIPTION OF THE PROPOSED CONTRACTUAL ARRANGEMENTS FOR PROVIDERS OF HEALTH AND LONG TERM CARE SERVICES IN THE BENEFIT PACKAGE; AND

(N) INFORMATION RELATED TO THE FINANCIAL CONDITION OF THE APPLICANT.

4. CERTIFICATE OF AUTHORITY APPROVAL. THE COMMISSIONER SHALL NOT APPROVE AN APPLICATION FOR A CERTIFICATE OF AUTHORITY UNLESS THE APPLICANT DEMONSTRATES TO THE SATISFACTION OF THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES:

(A) THAT IT WILL HAVE IN PLACE ACCEPTABLE QUALITY ASSURANCE MECHANISMS, GRIEVANCE PROCEDURES AND MECHANISMS TO PROTECT THE RIGHTS OF ENROLLEES AND CARE COORDINATION SERVICES TO ENSURE CONTINUITY, QUALITY, APPROPRIATENESS AND COORDINATION OF CARE;

(B) THAT IT WILL HAVE IN PLACE A MECHANISM OR MEANS TO ASSURE THAT PERSONS WITH DEVELOPMENTAL DISABILITIES CAN MAKE INFORMED CHOICES EITHER INDIVIDUALLY OR THROUGH AN AUTHORIZED DECISION MAKER REGARDING THE DEVELOPMENT OF A PERSON-CENTERED PLAN, AS DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(C) THAT IT HAS DEVELOPED A QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM THAT INCLUDES PERFORMANCE AND OUTCOME BASED QUALITY STANDARDS FOR ENROLLEE HEALTH STATUS AND SATISFACTION, WHICH SHALL BE REVIEWED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE PROGRAM SHALL INCLUDE DATA COLLECTION AND REPORTING FOR STANDARD PERFORMANCE MEASURES AS REQUIRED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(D) THAT AN OTHERWISE ELIGIBLE ENROLLEE SHALL NOT BE INVOLUNTARILY DISENROLLED WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(E) THAT THE APPLICANT SHALL NOT USE DECEPTIVE OR COERCIVE MARKETING METHODS TO ENCOURAGE PARTICIPANTS TO ENROLL AND THAT THE APPLICANT SHALL NOT DISTRIBUTE MARKETING MATERIALS TO POTENTIAL ENROLLEES BEFORE SUCH MATERIALS HAVE BEEN APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(F) SATISFACTORY EVIDENCE OF THE CHARACTER AND COMPETENCE OF THE APPLICANT'S PROPOSED OPERATORS, INCORPORATORS, DIRECTORS, STOCKHOLDERS AND MEMBERS;

(G) REASONABLE ASSURANCE THAT THE APPLICANT WILL PROVIDE HIGH QUALITY SERVICES TO AN ENROLLED POPULATION, THAT THE APPLICANT'S NETWORK OF PROVIDERS IS ADEQUATE AND THAT SUCH PROVIDERS HAVE DEMONSTRATED SUFFICIENT COMPETENCY TO DELIVER HIGH QUALITY SERVICES TO THE ENROLLED POPULATION AND THAT POLICIES AND PROCEDURES WILL BE IN PLACE TO ADDRESS THE CULTURAL AND LINGUISTIC NEEDS OF THE ENROLLED POPULATION;

(H) SUFFICIENT MANAGEMENT SYSTEMS CAPACITY TO MEET THE REQUIREMENTS OF THIS SECTION AND THE ABILITY TO EFFICIENTLY PROCESS PAYMENT FOR COVERED SERVICES;

(I) READINESS AND CAPABILITY TO MAXIMIZE REIMBURSEMENT OF AND COORDINATE SERVICES REIMBURSED PURSUANT TO TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER APPLICABLE BENEFITS, WITH SUCH BENEFIT COORDINATION INCLUDING, BUT NOT LIMITED TO, MEASURES TO SUPPORT SOUND CLINICAL DECISIONS, REDUCE ADMINISTRATIVE COMPLEXITY, COORDINATE ACCESS TO SERVICES, MAXIMIZE BENEFITS AVAILABLE PURSUANT TO SUCH TITLE AND ENSURE THAT NECESSARY CARE IS PROVIDED;

(J) READINESS AND CAPABILITY TO ARRANGE AND MANAGE COVERED SERVICES;

(K) WILLINGNESS AND CAPABILITY OF TAKING, OR COOPERATING IN, ALL STEPS NECESSARY TO SECURE AND INTEGRATE ANY POTENTIAL SOURCES OF FUNDING FOR SERVICES PROVIDED BY OR THROUGH THE DISCO, INCLUDING, BUT NOT LIMITED TO, FUNDING AVAILABLE UNDER TITLES XVI, XVIII, XIX AND XX OF THE FEDERAL SOCIAL SECURITY ACT AND ALL OTHER AVAILABLE SOURCES OF FUNDING;

(L) THAT THE CONTRACTUAL ARRANGEMENTS FOR PROVIDERS OF HEALTH AND LONG TERM CARE SERVICES IN THE BENEFIT PACKAGE ARE SUFFICIENT TO ENSURE THE AVAILABILITY AND ACCESSIBILITY OF SUCH SERVICES TO THE PROPOSED ENROLLED POPULATION CONSISTENT WITH GUIDELINES ESTABLISHED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. WITH RESPECT TO A PERSON RECEIVING NON-RESIDENTIAL SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE DISCO, SUCH GUIDELINES SHALL REQUIRE THE DISCO TO CONTRACT WITH THE CURRENT PROVIDER OF NON-RESIDENTIAL SERVICES AT THE RATES ESTABLISHED BY THE OFFICE FOR NINETY DAYS, IN ORDER TO ENSURE CONTINUITY OF CARE. WITH RESPECT TO A PERSON LIVING IN A RESIDENTIAL FACILITY OPERATED OR CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE DISCO, SUCH GUIDELINES SHALL REQUIRE THE DISCO TO CONTRACT WITH THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT THE RATES ESTABLISHED BY THE OFFICE FOR SO LONG AS SUCH INDIVIDUAL LIVES IN THAT RESIDENCE PURSUANT TO AN APPROVED PLAN OF CARE;

(M) THAT THE APPLICANT IS FINANCIALLY RESPONSIBLE AND SHALL BE EXPECTED TO MEET ITS OBLIGATIONS TO ITS ENROLLED MEMBERS; AND

(N) THAT THE APPLICANT SHALL ASSESS PERSON-CENTERED OUTCOMES AS DEFINED BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND HAS SATISFACTORY MECHANISMS BY WHICH IT WILL ASSESS HOW HEALTH AND LONG TERM CARE SERVICES WILL BE USED TO MEET SUCH OUTCOMES.

5. ENROLLMENT. (A) ONLY PERSONS WITH DEVELOPMENTAL DISABILITIES, AS DETERMINED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE ELIGIBLE TO ENROLL IN DISCOS.

(B) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL ENROLL AN ELIGIBLE PERSON IN THE DISCO CHOSEN BY HIM OR HER, HIS OR HER GUARDIAN OR OTHER LEGAL REPRESENTATIVE, PROVIDED THAT SUCH DISCO IS AUTHORIZED TO ENROLL SUCH PERSON.

(C) NO PERSON WITH A DEVELOPMENTAL DISABILITY WHO IS RECEIVING OR APPLYING FOR MEDICAL ASSISTANCE AND WHO IS RECEIVING, OR ELIGIBLE TO RECEIVE, SERVICES FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE SUCH SERVICES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN SUCH PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH DISCOS MEET THE STANDARDS OF THIS SECTION. NO PERSON SHALL BE REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE SERVICES OPERATED, FUNDED, CERTIFIED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THERE ARE AT LEAST TWO PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE IN SUCH PERSON'S COUNTY OF RESIDENCE, UNLESS FEDERAL APPROVAL IS SECURED TO REQUIRE ENROLLMENT WHEN THERE ARE LESS THAN TWO SUCH ENTITIES OPERATING IN SUCH COUNTY.

(D) PERSONS REQUIRED TO ENROLL IN A DISCO SHALL HAVE NO LESS THAN SIXTY DAYS TO SELECT A DISCO, AND SUCH PERSONS AND THEIR GUARDIANS OR OTHER LEGAL REPRESENTATIVES SHALL BE PROVIDED WITH INFORMATION TO MAKE AN INFORMED CHOICE. WHERE A PERSON, GUARDIAN OR OTHER LEGAL REPRESENTATIVE HAS NOT SELECTED A DISCO, THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL ENROLL SUCH PERSON IN A DISCO CHOSEN BY SUCH COMMISSIONER, TAKING INTO ACCOUNT QUALITY, CAPACITY AND GEOGRAPHIC ACCESSIBILITY. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR ITS DESIGNEE SHALL AUTOMATICALLY RE-ENROLL A PERSON WITH THE SAME DISCO IF THERE IS A LOSS OF MEDICAID ELIGIBILITY OF TWO MONTHS OR LESS.

(E) ENROLLED PERSONS MAY CHANGE THEIR ENROLLMENT AT ANY TIME WITHOUT CAUSE, PROVIDED, HOWEVER, THAT A PERSON REQUIRED TO ENROLL IN A DISCO IN ORDER TO RECEIVE SERVICES FUNDED, LICENSED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY ONLY DISENROLL FROM A DISCO IF HE OR SHE ENROLLS IN ANOTHER DISCO AUTHORIZED TO ENROLL HIM OR HER. SUCH DISENROLLMENT SHALL BE EFFECTIVE NO LATER THAN THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE REQUEST.

(F) A DISCO MAY REQUEST THE INVOLUNTARY DISENROLLMENT OF AN ENROLLED PERSON IN WRITING TO THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH DISENROLLMENT SHALL NOT BE EFFECTIVE UNTIL THE REQUEST IS REVIEWED AND APPROVED BY SUCH OFFICE. NOTICE SHALL BE PROVIDED TO THE ENROLLEE AND THE ENROLLEE MAY REQUEST A FAIR HEARING REGARDING SUCH DISENROLLMENT. THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL ADOPT RULES AND REGULATIONS GOVERNING THIS PROCESS.

6. ASSESSMENTS. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT THAT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROLLEE IN A DISCO AS SUCH NEEDS RELATE TO EACH INDIVIDUAL'S HEALTH, SAFETY, LIVING ENVIRONMENT AND WISHES, TO THE EXTENT THAT SUCH WISHES ARE KNOWN. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED OUTCOMES AND SHALL BE CONSISTENT WITH AND HELP INFORM ANY OTHER PERSON-CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE

WITH DEVELOPMENTAL DISABILITIES. THE ASSESSMENT SHALL BE COMPLETED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR IN CONSULTATION WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY DESIGNATE THE DISCO TO PERFORM REASSESSMENTS, BUT SHALL NOT DESIGNATE THE DISCO TO PERFORM THE INITIAL ASSESSMENT OF A PROSPECTIVE ENROLLEE.

7. PROGRAM OVERSIGHT AND ADMINISTRATION. (A) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL JOINTLY PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION, TO PROVIDE FOR OVERSIGHT OF DISCOS, INCLUDING ON SITE REVIEWS, AND TO ENSURE THE QUALITY, APPROPRIATENESS AND COST-EFFECTIVENESS OF THE SERVICES PROVIDED BY DISCOS.

(B) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES MAY WAIVE RULES AND REGULATIONS OF THEIR RESPECTIVE DEPARTMENT OR OFFICE, INCLUDING BUT NOT LIMITED TO, THOSE PERTAINING TO DUPLICATIVE REQUIREMENTS CONCERNING RECORD KEEPING, BOARDS OF DIRECTORS, STAFFING AND REPORTING, WHEN SUCH WAIVER SHALL PROMOTE THE EFFICIENT DELIVERY OF APPROPRIATE, QUALITY, COST-EFFECTIVE SERVICES AND WHEN THE HEALTH, SAFETY AND GENERAL WELFARE OF DISCO ENROLLEES SHALL NOT BE IMPAIRED AS A RESULT OF SUCH WAIVER. THE COMMISSIONERS SHALL REPORT ANNUALLY TO THE LEGISLATURE AND TO THE JOINT ADVISORY COUNCIL ESTABLISHED PURSUANT TO SECTION 13.40 OF THE MENTAL HYGIENE LAW ON ALL RULES AND REGULATIONS WAIVED PURSUANT TO THIS PARAGRAPH. IN ORDER TO ACHIEVE DISCO SYSTEM EFFICIENCIES AND COORDINATION AND TO PROMOTE THE OBJECTIVES OF HIGH QUALITY, INTEGRATED AND COST EFFECTIVE CARE, THE COMMISSIONERS SHALL ESTABLISH A SINGLE COORDINATED SURVEILLANCE PROCESS, ALLOW FOR A COMPREHENSIVE QUALITY IMPROVEMENT AND REVIEW PROCESS TO MEET COMPONENT QUALITY REQUIREMENTS, AND REQUIRE A UNIFORM COST REPORT. THE COMMISSIONERS SHALL REQUIRE DISCOS TO UTILIZE QUALITY IMPROVEMENT MEASURES, BASED ON THE ACHIEVEMENT OF PERSONAL OUTCOMES AND QUALITY OF LIFE, HEALTH OUTCOMES DATA, AND ASSESSMENTS OF INDIVIDUAL AND FAMILY SATISFACTION, FOR INTERNAL QUALITY ASSESSMENT PROCESSES AND MAY UTILIZE SUCH MEASURES AS PART OF THE SINGLE COORDINATED SURVEILLANCE PROCESS.

(C) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THE SOCIAL SERVICES LAW TO THE CONTRARY, THE COMMISSIONER IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES 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 ARE INCONSISTENT WITH THE FLEXIBILITY NECESSARY FOR THE EFFICIENT ADMINISTRATION OF DISCOS, AND SUCH REGULATIONS SHALL PROVIDE THAT SUCH PROVISIONS SHALL NOT BE APPLICABLE TO ENROLLEES OF DISCOS, PROVIDED THAT SUCH DETERMINATIONS ARE CONSISTENT WITH APPLICABLE FEDERAL LAW AND REGULATION.

(D) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL ENSURE, THROUGH PERIODIC REVIEWS OF DISCOS, THAT ORGANIZATION SERVICES ARE PROMPTLY AVAILABLE TO ENROLLEES WHEN APPROPRIATE. SUCH PERIODIC REVIEWS SHALL BE MADE ACCORDING TO STANDARDS AS DETERMINED BY THE COMMISSIONERS IN REGULATIONS.

(E) THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL HAVE THE AUTHORITY TO CONDUCT BOTH ON SITE AND OFF SITE REVIEWS OF DISCOS. SUCH REVIEWS MAY INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING COMPONENTS: GOVERNANCE; FISCAL AND

FINANCIAL REPORTING; RECORDKEEPING; INTERNAL CONTROLS; MARKETING; NETWORK CONTRACTING AND ADEQUACY; PROGRAM INTEGRITY ASSURANCES; UTILIZATION CONTROL AND REVIEW SYSTEMS; GRIEVANCE AND APPEALS SYSTEMS; QUALITY ASSESSMENT AND ASSURANCE SYSTEMS; CARE MANAGEMENT; ENROLLMENT AND DISENROLLMENT; MANAGEMENT INFORMATION SYSTEMS, AND OTHER OPERATIONAL AND MANAGEMENT COMPONENTS.

8. SOLVENCY. (A) THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, SHALL BE RESPONSIBLE FOR EVALUATING, APPROVING AND REGULATING ALL MATTERS RELATING TO FISCAL SOLVENCY, INCLUDING RESERVES, SURPLUS AND PROVIDER CONTRACTS. THE COMMISSIONER SHALL PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION. THE COMMISSIONER, IN THE ADMINISTRATION OF THIS SUBDIVISION:

(I) SHALL BE GUIDED BY THE STANDARDS THAT GOVERN THE FISCAL SOLVENCY OF A HEALTH MAINTENANCE ORGANIZATION, PROVIDED, HOWEVER, THAT THE COMMISSIONER SHALL RECOGNIZE THE SPECIFIC DELIVERY COMPONENTS, OPERATIONAL CAPACITY AND FINANCIAL CAPABILITY OF THE ELIGIBLE APPLICANT FOR A CERTIFICATE OF AUTHORITY;

(II) SHALL NOT APPLY FINANCIAL SOLVENCY STANDARDS THAT EXCEED THOSE REQUIRED FOR A HEALTH MAINTENANCE ORGANIZATION; AND

(III) SHALL ESTABLISH REASONABLE CAPITALIZATION AND CONTINGENT RESERVE REQUIREMENTS.

(B) STANDARDS ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE ADEQUATE TO PROTECT THE INTERESTS OF ENROLLEES IN THE DISCO. THE COMMISSIONER SHALL BE SATISFIED THAT THE ELIGIBLE APPLICANT IS FINANCIALLY SOUND, AND HAS MADE ADEQUATE PROVISIONS TO PAY FOR QUALITY SERVICES THAT ARE COST EFFECTIVE AND APPROPRIATE TO NEEDS AND THE PROTECTION OF HEALTH, SAFETY, WELFARE AND SATISFACTION OF THOSE SERVED.

9. ROLE OF THE SUPERINTENDENT OF FINANCIAL SERVICES. (A) THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL DETERMINE AND APPROVE PREMIUMS IN ACCORDANCE WITH THE INSURANCE LAW WHENEVER ANY POPULATION OF ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT IS TO BE COVERED. THE DETERMINATION AND APPROVAL OF THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL RELATE TO PREMIUMS CHARGED TO SUCH ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

(B) THE SUPERINTENDENT OF FINANCIAL SERVICES SHALL EVALUATE AND APPROVE ANY ENROLLEE CONTRACTS WHENEVER SUCH ENROLLEE CONTRACTS ARE TO COVER ANY POPULATION OF ENROLLEES NOT ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

10. PAYMENT RATES FOR DISCO ENROLLEES ELIGIBLE FOR MEDICAL ASSISTANCE. THE COMMISSIONER SHALL ESTABLISH PAYMENT RATES FOR SERVICES PROVIDED TO ENROLLEES ELIGIBLE UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT. SUCH PAYMENT RATES SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF THE DIVISION OF THE BUDGET. PAYMENT RATES SHALL BE ACTUARIALLY SOUND FOR COVERED SERVICES, INCLUDING BUT NOT LIMITED TO HABILITATION SERVICES, AND, WHEN THERE IS SUFFICIENT RELIABLE DATA TO PERMIT, SHALL BE RISK-ADJUSTED TO TAKE INTO ACCOUNT THE CHARACTERISTICS OF ENROLLEES, OR PROPOSED ENROLLEES, WHICH MAY INCLUDE: FRAILTY, DISABILITY LEVEL, HEALTH AND FUNCTIONAL STATUS, AGE, GENDER, THE NATURE OF SERVICES PROVIDED TO SUCH ENROLLEES, AND OTHER FACTORS AS DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE RISK ADJUSTED PREMIUMS MAY ALSO BE COMBINED WITH DISINCENTIVES OR REQUIREMENTS DESIGNED TO MITIGATE ANY INCENTIVES TO OBTAIN HIGHER PAYMENT CATEGORIES.

11. CONTINUATION OF CERTIFICATE OF AUTHORITY. CONTINUATION OF A CERTIFICATE OF AUTHORITY ISSUED UNDER THIS SECTION SHALL BE CONTINGENT

UPON COMPLIANCE BY THE DISCO WITH APPLICABLE PROVISIONS OF THIS SECTION AND RULES AND REGULATIONS PROMULGATED THEREUNDER; THE CONTINUING FISCAL SOLVENCY OF THE DISCO; AND FEDERAL FINANCIAL PARTICIPATION IN PAYMENTS ON BEHALF OF ENROLLEES WHO ARE ELIGIBLE TO RECEIVE SERVICES UNDER TITLE XIX OF THE FEDERAL SOCIAL SECURITY ACT.

12. PROTECTION OF ENROLLEES. THE COMMISSIONER MAY, IN HIS OR HER DISCRETION AND WITH THE CONCURRENCE OF THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, FOR THE PURPOSE OF THE PROTECTION OF ENROLLEES, IMPOSE MEASURES INCLUDING, BUT NOT LIMITED TO BANS ON FURTHER ENROLLMENTS UNTIL ANY IDENTIFIED PROBLEMS ARE RESOLVED TO THE SATISFACTION OF THE COMMISSIONER, OR FINES UPON A FINDING THAT THE DISCO HAS FAILED TO COMPLY WITH THE PROVISIONS OF ANY APPLICABLE STATUTE, RULE OR REGULATION.

13. INFORMATION SHARING. THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL, AS NECESSARY AND CONSISTENT WITH FEDERAL REGULATIONS PROMULGATED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, SHARE WITH SUCH DISCO THE FOLLOWING DATA IF IT IS AVAILABLE:

(A) INFORMATION CONCERNING UTILIZATION OF SERVICES AND PROVIDERS BY EACH OF ITS ENROLLEES PRIOR TO AND DURING ENROLLMENT.

(B) AGGREGATE DATA CONCERNING UTILIZATION AND COSTS FOR ENROLLEES AND FOR COMPARABLE COHORTS SERVED THROUGH THE MEDICAID FEE-FOR-SERVICE PROGRAM.

14. APPLICABILITY OF OTHER LAWS. DISCOS SHALL BE SUBJECT TO THE PROVISIONS OF THE INSURANCE LAW AND REGULATIONS APPLICABLE TO HEALTH MAINTENANCE ORGANIZATIONS, THIS ARTICLE AND REGULATIONS PROMULGATED THEREUNDER. TO THE EXTENT THAT THE PROVISIONS OF THIS SECTION ARE INCONSISTENT WITH THE PROVISIONS OF THIS CHAPTER OR THE PROVISIONS OF THE INSURANCE LAW, THE PROVISIONS OF THIS SECTION SHALL PREVAIL.

15. EFFECTIVENESS. THE PROVISIONS OF THIS SECTION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED BY THE DISCOS TO ENROLLEES WHO ARE RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, IN ORDER TO ENSURE SUCH FEDERAL FINANCIAL PARTICIPATION.

S 74. Section 4403 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, A HEALTH MAINTENANCE ORGANIZATION MAY EXPAND ITS COMPREHENSIVE HEALTH SERVICES PLAN TO INCLUDE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, INCLUDING HABILITATION SERVICES AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE, AND MAY OFFER SUCH EXPANDED PLAN TO A POPULATION OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW, SUBJECT TO THE FOLLOWING:

(A) SUCH ORGANIZATION MUST HAVE THE ABILITY TO PROVIDE OR COORDINATE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AS DEMONSTRATED BY CRITERIA TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH CRITERIA SHALL INCLUDE, BUT NOT BE LIMITED TO, ADEQUATE EXPERIENCE PROVIDING OR COORDINATING SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

(A-1) IF THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES DETERMINE THAT SUCH ORGANIZATION LACKS THE EXPERIENCE REQUIRED IN PARAGRAPH (A) OF THIS SUBDIVISION, THE ORGANIZATION SHALL HAVE AN AFFILIATION ARRANGEMENT WITH AN ENTITY OR ENTITIES WITH EXPERIENCE SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES SUCH THAT THE AFFILIATED ENTITY WILL COORDINATE AND PLAN SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR WILL OVERSEE AND APPROVE SUCH COORDINATION AND PLANNING;

(A-2) EACH ENROLLEE SHALL RECEIVE SERVICES DESIGNED TO ACHIEVE PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON TO LIVE IN THE MOST INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT POSSIBLE IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE EXTENT THAT SUCH WISHES ARE KNOWN AND THE INDIVIDUAL'S NEEDS. WITH RESPECT TO AN INDIVIDUAL RECEIVING NON-RESIDENTIAL SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE ORGANIZATION, SUCH GUIDELINES SHALL REQUIRE THE ORGANIZATION TO CONTRACT WITH THE CURRENT PROVIDER OF SUCH NON-RESIDENTIAL SERVICES AT THE RATES ESTABLISHED BY THE OFFICE FOR NINETY DAYS, IN ORDER TO ENSURE CONTINUITY OF CARE. WITH RESPECT TO AN INDIVIDUAL LIVING IN A RESIDENTIAL FACILITY OPERATED OR CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE ORGANIZATION, THE ORGANIZATION SHALL CONTRACT WITH THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT THE RATES ESTABLISHED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR SO LONG AS SUCH PERSON LIVES IN THAT RESIDENCE PURSUANT TO AN APPROVED PLAN OF CARE;

(B) THE PROVISION BY SUCH ORGANIZATION OF SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO THE JOINT OVERSIGHT AND REVIEW OF BOTH THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE DEPARTMENT AND SUCH OFFICE SHALL REQUIRE SUCH ORGANIZATION TO PROVIDE COMPREHENSIVE CARE PLANNING, ASSESS QUALITY, MEET QUALITY ASSURANCE REQUIREMENTS AND ENSURE THE ENROLLEE IS INVOLVED IN CARE PLANNING.

(C) SUCH ORGANIZATION SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES APPROVE PROGRAM FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE THAT SUCH ORGANIZATION MEETS THE REQUIREMENTS OF THIS PARAGRAPH AND ANY OTHER REQUIREMENTS SET FORTH BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE ORGANIZATION THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL NOT BE INVOLUNTARILY DISENROLLED FROM SUCH ORGANIZATION WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. NOTICE SHALL BE PROVIDED TO THE ENROLLEE AND THE ENROLLEE MAY REQUEST A FAIR HEARING REGARDING SUCH DISENROLLMENT;

(E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETERMINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH A

PLAN AND SHALL ENROLL INDIVIDUALS IT DETERMINES ELIGIBLE IN AN ORGANIZATION CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

(F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES THAT RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROLLEE AS SUCH NEEDS RELATE TO SUCH ENROLLEE'S HEALTH, SAFETY, LIVING ENVIRONMENT AND WISHES, TO THE EXTENT SUCH WISHES ARE KNOWN. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED OUTCOMES AND SHALL BE CONSISTENT WITH AND HELP INFORM ANY OTHER PERSON-CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE INITIAL ASSESSMENT SHALL BE COMPLETED BY SUCH OFFICE OR ITS DESIGNEE OTHER THAN THE ORGANIZATION AND SHALL BE COMPLETED, IN CONSULTATION WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. REASSESSMENTS SHALL BE COMPLETED BY THE OFFICE OR ITS DESIGNEE, WHICH MAY BE THE ORGANIZATION. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE.

(F-1) SUCH ORGANIZATION SHALL PROVIDE THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES WITH A DESCRIPTION OF THE PROPOSED MARKETING PLAN AND HOW MARKETING MATERIALS WILL BE PRESENTED TO PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION MAKERS FOR THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE.

(G) NO PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE REQUIRED TO ENROLL IN A COMPREHENSIVE HEALTH SERVICES PLAN AS A CONDITION OF RECEIVING MEDICAL ASSISTANCE AND SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH PLANS MEET THE STANDARDS OF THIS SECTION.

(H) ORGANIZATIONS PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO ALL REQUIREMENTS APPLICABLE TO DISCOS OPERATING UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE WITH RESPECT TO QUALITY ASSURANCE, GRIEVANCES AND APPEALS, INFORMED CHOICE, PARTICIPATING IN DEVELOPMENT OF PLANS OF CARE AND REQUIREMENTS WITH RESPECT TO MARKETING, TO THE EXTENT THAT SUCH REQUIREMENTS ARE NOT INCONSISTENT WITH THIS SECTION.

(I) THE PROVISIONS OF THIS SUBDIVISION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED HEREUNDER TO RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, AS MAY BE NECESSARY TO ENSURE SUCH FEDERAL FINANCIAL PARTIC-

IPATION. TO THE EXTENT THAT THE PROVISIONS OF THIS SUBDIVISION ARE INCONSISTENT WITH OTHER PROVISIONS OF THIS ARTICLE OR WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, THE PROVISIONS OF THIS SUBDIVISION SHALL PREVAIL.

S 75. The opening paragraph of paragraph (h) 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:

The commissioner AND, IN THE CASE OF A PLAN ARRANGING FOR OR PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, shall, upon request by a managed long term care plan or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

S 76. Section 4403-f of the public health law is amended by adding three new subdivisions 12, 13 and 14 to read as follows:

12. NOTWITHSTANDING ANY PROVISION TO THE CONTRARY, A MANAGED LONG TERM CARE PLAN MAY EXPAND THE SERVICES IT PROVIDES OR ARRANGES FOR TO INCLUDE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR A POPULATION OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN THE MENTAL HYGIENE LAW, INCLUDING HABILTIATION SERVICES AS DEFINED IN PARAGRAPH (C) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE, SUBJECT TO THE FOLLOWING:

(A) SUCH PLAN MUST HAVE THE ABILITY TO PROVIDE OR COORDINATE SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AS DEMONSTRATED BY CRITERIA TO BE DETERMINED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. SUCH CRITERIA SHALL INCLUDE, BUT NOT BE LIMITED TO, ADEQUATE EXPERIENCE PROVIDING OR COORDINATING SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES;

(A-1) IF THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES DETERMINE THAT SUCH PLAN LACKS THE EXPERIENCE REQUIRED IN PARAGRAPH (A) OF THIS SUBDIVISION, THE PLAN SHALL HAVE AN AFFILIATION ARRANGEMENT WITH AN ENTITY OR ENTITIES WITH EXPERIENCE SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES SUCH THAT THE AFFILIATED ENTITY WILL COORDINATE AND PLAN SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR WILL OVERSEE AND APPROVE SUCH COORDINATION AND PLANNING;

(A-2) EACH ENROLLEE SHALL RECEIVE SERVICES DESIGNED TO ACHIEVE PERSON-CENTERED OUTCOMES, TO ENABLE THAT PERSON TO LIVE IN THE MOST INTEGRATED SETTING APPROPRIATE TO THAT PERSON'S NEEDS, AND TO ENABLE THAT PERSON TO INTERACT WITH NONDISABLED PERSONS TO THE FULLEST EXTENT POSSIBLE IN SOCIAL, WORKPLACE AND OTHER COMMUNITY SETTINGS, PROVIDED THAT ALL SUCH SERVICES ARE CONSISTENT WITH SUCH PERSON'S WISHES TO THE EXTENT THAT SUCH WISHES ARE KNOWN. WITH RESPECT TO AN INDIVIDUAL RECEIVING NON-RESIDENTIAL SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE PLAN, SUCH GUIDELINES SHALL REQUIRE THE PLAN TO CONTRACT WITH THE CURRENT PROVIDER OF SUCH NON-RESIDENTIAL SERVICES AT THE RATES ESTABLISHED BY THE OFFICE FOR NINETY DAYS IN ORDER TO ENSURE CONTINUITY OF CARE. WITH RESPECT TO AN INDIVIDUAL LIVING IN A RESIDENTIAL FACILITY OPERATED OR CERTIFIED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES PRIOR TO ENROLLMENT IN THE PLAN, THE PLAN SHALL CONTRACT WITH THE PROVIDER OF RESIDENTIAL SERVICES FOR THAT RESIDENCE AT

THE RATES ESTABLISHED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES FOR SO LONG AS SUCH INDIVIDUAL LIVES IN THAT RESIDENCE PURSUANT TO AN APPROVED PLAN OF CARE;

(B) THE PROVISION BY SUCH PLAN OF SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT THE JOINT OVERSIGHT AND REVIEW OF BOTH THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE DEPARTMENT AND SUCH OFFICE SHALL REQUIRE SUCH ORGANIZATION TO PROVIDE COMPREHENSIVE CARE PLANNING, ASSESS QUALITY, MEET QUALITY ASSURANCE REQUIREMENTS AND ENSURE THE ENROLLEE IS INVOLVED IN CARE PLANNING;

(C) SUCH PLAN SHALL NOT PROVIDE OR ARRANGE FOR SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES APPROVE PROGRAM FEATURES AND RATES THAT INCLUDE SUCH SERVICES, AND DETERMINE THAT SUCH ORGANIZATION MEETS THE REQUIREMENTS OF THIS SUBDIVISION AND ANY OTHER REQUIREMENTS SET FORTH BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES;

(D) AN OTHERWISE ELIGIBLE ENROLLEE RECEIVING SERVICES THROUGH THE PLAN THAT ARE OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL NOT BE INVOLUNTARILY DISENROLLED FROM SUCH PLAN WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. NOTICE SHALL BE PROVIDED TO THE ENROLLEE AND THE ENROLLEE MAY REQUEST A FAIR HEARING REGARDING SUCH DISENROLLMENT;

(E) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL DETERMINE THE ELIGIBILITY OF INDIVIDUALS RECEIVING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE TO ENROLL IN SUCH PLAN AND SHALL ENROLL INDIVIDUALS IT DETERMINES ELIGIBLE IN A PLAN CHOSEN BY SUCH INDIVIDUAL, GUARDIAN OR OTHER LEGAL REPRESENTATIVE;

(F) THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, OR ITS DESIGNEE, SHALL COMPLETE A COMPREHENSIVE ASSESSMENT FOR ENROLLEES WHO RECEIVE SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY SUCH OFFICE. THIS ASSESSMENT SHALL INCLUDE, BUT NOT BE LIMITED TO, AN EVALUATION OF THE MEDICAL, SOCIAL, HABILITATIVE AND ENVIRONMENTAL NEEDS OF EACH PROSPECTIVE ENROLLEE AS SUCH NEEDS RELATE TO EACH INDIVIDUAL'S HEALTH, SAFETY, LIVING ENVIRONMENT AND WISHES, TO THE EXTENT THAT SUCH WISHES ARE KNOWN. THIS ASSESSMENT SHALL ALSO SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR THE ENROLLEE. SUCH PLAN OF CARE SHALL BE FOCUSED ON THE ACHIEVEMENT OF PERSON-CENTERED OUTCOMES AND SHALL BE CONSISTENT WITH AND HELP INFORM ANY OTHER PERSON-CENTERED PLAN REQUIRED FOR THE ENROLLEE BY THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES. THE INITIAL ASSESSMENT SHALL BE COMPLETED BY SUCH OFFICE OR A DESIGNEE OTHER THAN THE PLAN AND SHALL BE COMPLETED IN CONSULTATION WITH THE PROSPECTIVE ENROLLEE'S HEALTH CARE PRACTITIONER AS NECESSARY. REASSESSMENTS SHALL BE COMPLETED BY SUCH OFFICE OR ITS DESIGNEE, WHICH MAY BE THE MANAGED LONG TERM CARE PLAN IN WHICH THE PERSON IS ENROLLED OR PROPOSES TO ENROLL. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL PRESCRIBE THE FORMS ON WHICH THE ASSESSMENT SHALL BE MADE.

(F-1) THE PLAN SHALL PROVIDE THE DEPARTMENT AND THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES WITH A DESCRIPTION OF THE PROPOSED MARKETING PLAN AND HOW MARKETING MATERIALS WILL BE PRESENTED TO PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR AUTHORIZED DECISION MAKERS FOR THE PURPOSES OF ENABLING THEM TO MAKE AN INFORMED CHOICE.

(G) PLANS PROVIDING SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL BE SUBJECT TO ALL REQUIREMENTS APPLICABLE TO DISCOS OPERATING UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THIS ARTICLE WITH RESPECT TO QUALITY ASSURANCE, GRIEVANCES AND APPEALS, INFORMED CHOICE, PARTICIPATION IN DEVELOPMENT OF PLANS OF CARE AND REQUIREMENTS WITH RESPECT TO MARKETING, TO THE EXTENT THAT SUCH REQUIREMENTS ARE NOT INCONSISTENT WITH THIS SECTION.

(H) NO PERSON WITH A DEVELOPMENTAL DISABILITY SHALL BE REQUIRED TO ENROLL IN A MANAGED LONG TERM CARE PLAN AS A CONDITION OF RECEIVING MEDICAL ASSISTANCE AND SERVICES OPERATED, CERTIFIED, FUNDED, AUTHORIZED OR APPROVED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES UNTIL PROGRAM FEATURES AND REIMBURSEMENT RATES ARE APPROVED BY THE COMMISSIONER AND THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND UNTIL SUCH COMMISSIONERS DETERMINE THAT THERE ARE A SUFFICIENT NUMBER OF PLANS AUTHORIZED TO COORDINATE CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES PURSUANT TO THIS ARTICLE OPERATING IN THE PERSON'S COUNTY OF RESIDENCE TO MEET THE NEEDS OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AND THAT SUCH PLANS MEET THE STANDARDS OF THIS SECTION.

13. NOTWITHSTANDING ANY INCONSISTENT PROVISION TO THE CONTRARY, THE COMMISSIONER MAY ISSUE A CERTIFICATE OF AUTHORITY TO NO MORE THAN THREE ELIGIBLE APPLICANTS WHO ARE ELIGIBLE FOR MEDICARE AND MEDICAL ASSISTANCE TO OPERATE MANAGED LONG TERM CARE PLANS THAT ARE AUTHORIZED TO EXCLUSIVELY ENROLL PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW. THE COMMISSIONER MAY ONLY ISSUE CERTIFICATES OF AUTHORITY PURSUANT TO THIS SUBDIVISION IF, AND TO THE EXTENT THAT, THE DEPARTMENT HAS RECEIVED FEDERAL APPROVAL TO OPERATE A FULLY INTEGRATED DUALS ADVANTAGE PROGRAM FOR THE INTEGRATION OF SERVICES FOR PERSONS ENROLLED IN MEDICARE AND MEDICAL ASSISTANCE. THE COMMISSIONER MAY WAIVE ANY OF THE DEPARTMENT'S REGULATIONS AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, DEEMS NECESSARY TO ALLOW SUCH MANAGED LONG TERM CARE PLANS TO PROVIDE OR ARRANGE FOR SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES THAT ARE ADEQUATE AND APPROPRIATE TO MEET THE NEEDS OF SUCH INDIVIDUALS AND THAT WILL ENSURE THEIR HEALTH AND SAFETY.

14. THE PROVISIONS OF SUBDIVISIONS TWELVE AND THIRTEEN OF THIS SECTION SHALL ONLY BE EFFECTIVE IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR THE COSTS OF SERVICES PROVIDED THEREUNDER TO RECIPIENTS OF MEDICAL ASSISTANCE PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW. THE COMMISSIONER SHALL MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THE SOCIAL SERVICES LAW, AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT, AS MAY BE NECESSARY TO ENSURE SUCH FEDERAL FINANCIAL PARTICIPATION. TO THE EXTENT THAT THE PROVISIONS OF SUBDIVISION TWELVE AND THIRTEEN OF THIS SECTION ARE INCONSISTENT WITH OTHER PROVISIONS OF THIS ARTICLE OR WITH THE PROVISIONS OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, THE PROVISIONS OF THIS SUBDIVISION SHALL PREVAIL.

S 77. Subparagraph (ii) of paragraph (b) of subdivision 1 of section 364-j of the social services law, as amended by chapter 433 of the laws of 1997, is amended and a new subparagraph (iii) is added to read as follows:

(ii) is authorized as a partially capitated program pursuant to section three hundred sixty-four-f of this title or section forty-four hundred three-e of the public health law or section 1915b of the social security act[.]; OR

(III) IS AUTHORIZED TO OPERATE UNDER SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

S 78. Section 364-j of the social services law is amended by adding a new subdivision 28 to read as follows:

28. TO THE EXTENT THAT ANY PROVISION OF THIS SECTION IS INCONSISTENT WITH ANY PROVISION OF SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW, SUCH PROVISION OF THIS SECTION SHALL NOT APPLY TO AN ENTITY AUTHORIZED TO OPERATE PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW.

S 79. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (aa) to read as follows:

(AA) CARE AND SERVICES FURNISHED BY A DEVELOPMENTAL DISABILITY INDIVIDUAL SUPPORT AND CARE COORDINATION ORGANIZATION (DISCO) THAT HAS RECEIVED A CERTIFICATE OF AUTHORITY PURSUANT TO SECTION FORTY-FOUR HUNDRED THREE-G OF THE PUBLIC HEALTH LAW TO ELIGIBLE INDIVIDUALS RESIDING IN THE GEOGRAPHIC AREA SERVED BY SUCH ENTITY, WHEN SUCH SERVICES ARE FURNISHED IN ACCORDANCE WITH AN AGREEMENT APPROVED BY THE DEPARTMENT OF HEALTH WHICH MEETS THE REQUIREMENTS OF FEDERAL LAW AND REGULATIONS.

S 80. The commissioner of health shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act and to require medical assistance recipients with developmental disabilities who require home and community-based services, as specified by the commissioner, to receive such services through an available organization certified pursuant to article 44 of the public health law. Copies of such original waiver applications and amendments thereto shall be provided to the chairs of the senate finance committee, the assembly ways and means committee and the senate and assembly health committees simultaneously with their submission to the federal government.

S 80-a. Section 364-jj of the social services law, as added by chapter 649 of the laws of 1996, is amended to read as follows:

S 364-jj. Special advisory review panel on Medicaid managed care. (a) There is hereby established a special advisory review panel on Medicaid managed care. The panel shall consist of [nine] TWELVE members who shall be appointed as follows: [three] FOUR by the governor, one of which shall serve as the chair; [two] THREE 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. [All members shall be appointed no later than September first, nineteen hundred ninety-six.] 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. 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; [and]

(vii) 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) examine other issues as it deems appropriate.

(c) Commencing January first, nineteen hundred ninety-seven and quarterly thereafter the panel shall submit a report regarding the status of Medicaid managed care in the state and provide recommendations if it deems appropriate to the governor, the temporary president and the minority leader of the senate, and the speaker and the minority leader of the assembly.

S 81. 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 82. 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 83. 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 84. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013 provided that:

1. section thirty-three-a of this act shall take effect January 1, 2014;

1-a. sections seventy-three through eighty-a shall expire and be deemed repealed September 30, 2019

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

2-a. Notwithstanding any inconsistent provision of the state administrative procedure act, the commissioner of health and the commissioner of developmental disabilities are authorized to promulgate on an emergency basis any regulation he or she determines necessary to implement any provision of sections seventy-two through seventy-nine of this act upon its effective date;

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

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

5. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of 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;

6. 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;

7. the amendments to section 364-j of the social services law made by sections seven, twelve, thirteen, thirty-five-a, thirty-six, thirty-seven, thirty-eight, thirty-nine, forty, forty-one, forty-two, forty-three, forty-four, seventy-two, seventy-seven and seventy-eight of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

8. section forty-eight-a of this act shall expire and be deemed repealed March 31, 2016;

9. the amendments to section 4403-f of the public health law made by sections seven-a, forty-eight, fifty-four, seventy-five and seventy-six of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

10. the provisions of this act shall apply to any pending cause of action brought pursuant to article 13 of the state finance law, and shall further apply to claims, records, statements or obligations, as

defined by section 188 of the state finance law, that were made, used, or existing prior to, on or after April 1, 2007.

PART B

Section 1. Subdivision (f) of section 129 of part C of chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, is amended to read as follows:

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [2013] 2016;

S 2. Paragraph (a) of subdivision 1 of section 212 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, as amended by section 2 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, effective beginning August 1, 1996, for the period April 1, 1997 through March 31, 1998, April 1, 1998 for the period April 1, 1998 through March 31, 1999, August 1, 1999, for the period April 1, 1999 through March 31, 2000, April 1, 2000, for the period April 1, 2000 through March 31, 2001, April 1, 2001, for the period April 1, 2001 through March 31, 2002, April 1, 2002, for the period April 1, 2002 through March 31, 2003, and for the state fiscal year beginning April 1, 2005 through March 31, 2006, and for the state fiscal year beginning April 1, 2006 through March 31, 2007, and for the state fiscal year beginning April 1, 2007 through March 31, 2008, and for the state fiscal year beginning April 1, 2008 through March 31, 2009, and for the state fiscal year beginning April 1, 2009 through March 31, 2010, and for the state fiscal year beginning April 1, 2010 through March 31, [2013] 2016, the department of health is authorized to pay public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, operated by the state of New York or by the state university of New York or by a county, which shall not include a city with a population of over one million, of the state of New York, and those public general hospitals located in the county of Westchester, the county of Erie or the county of Nassau, additional payments for inpatient hospital services as medical assistance payments pursuant to title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance pursuant to the federal laws and regulations governing disproportionate share payments to hospitals up to one hundred percent of each such public general hospital's medical assistance and uninsured patient losses after all other medical assistance, including disproportionate share payments to such public general hospital for 1996, 1997, 1998, and 1999, based initially for 1996 on reported 1994 reconciled data as further reconciled to actual reported 1996 reconciled data, and for 1997 based initially on reported 1995 reconciled data as further reconciled to actual reported 1997 reconciled data, for 1998 based initially on reported 1995 reconciled data as further reconciled to actual reported 1998 reconciled data, for 1999 based initially on reported 1995 reconciled data as further reconciled to actual reported 1999 reconciled data, for 2000 based initially on reported 1995 reconciled data as further reconciled to actual reported 2000 data, for 2001 based initially on reported 1995 reconciled data as further reconciled to actual reported 2001 data, for 2002 based initially on reported 2000 reconciled data as further reconciled to actual reported 2002 data, and

for state fiscal years beginning on April 1, 2005, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2005, and for state fiscal years beginning on April 1, 2006, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2006, for state fiscal years beginning on and after April 1, 2007 through March 31, 2009, based initially on reported 2000 reconciled data as further reconciled to actual reported data for 2007 and 2008, respectively, for state fiscal years beginning on and after April 1, 2009, based initially on reported 2007 reconciled data, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and as further reconciled to actual reported data for 2009, for state fiscal years beginning on and after April 1, 2010, based initially on reported reconciled data from the base year two years prior to the payment year, adjusted for authorized Medicaid rate changes applicable to the state fiscal year, and further reconciled to actual reported data from such payment year, and to actual reported data for each respective succeeding year. The payments may be added to rates of payment or made as aggregate payments to an eligible public general hospital.

S 3. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 3 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

S 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [2013] 2015, and

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

S 4. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 4 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, [2013] 2015;

S 5. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 102 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day

services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, AND FURTHER PROVIDED THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN SUCH ASSESSMENT SHALL BE SIX PERCENT.

S 6. Section 88 of chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, as amended by chapter 446 of the laws of 2011, is amended to read as follows:

S 88. Notwithstanding any provision of law to the contrary, all operating demonstrations, as such term is defined in paragraph (c) of subdivision 1 of section 4403-f of the public health law as added by section eighty-two of this act, due to expire prior to January 1, 2001 shall be deemed to expire on December 31, [2013] 2015.

S 7. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 2 of part G of chapter 56 of the laws of 2012, 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 [thirteen] FOURTEEN, 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 [thirteen] FOURTEEN and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [thirteen] FOURTEEN; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [thirteen] FOURTEEN, 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 8. Subdivision 2 of section 93 of part C of chapter 58 of the laws of 2007 amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 fiscal year, as amended by section 10 of part B of chapter 58 of the laws of 2009, is amended to read as follows:

2. section two of this act shall expire and be deemed repealed on March 31, [2013] 2014;

S 8-a. Subdivision 8 of section 364-l of the social services law, as added by section 2 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

8. The commissioner of health shall provide a report to the governor and the legislature no later than January first, two thousand [ten] FOURTEEN. The report shall include findings as to the demonstration projects' effectiveness in managing the care needs and improving the health of program participants, an evaluation as to the programs' cost-effectiveness as measured against traditional medicaid care models, and recommendations as to whether the programs should be extended, modified, eliminated, or made permanent.

S 9. Section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 9 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

S 194. 1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

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

S 10. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 10 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015 for inpatient and

outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

S 11. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, [and] February 1, 2013 AND FEBRUARY 1, 2014 AND FEBRUARY 1, 2015 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide target percentage respectively.

S 12. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013; 2014 AND 2015 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

S 13. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as

amended by section 13 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 reduction amount.

S 14. Paragraph (b) of subdivision 5 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 14 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(b) The 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 statewide aggregate reduction amounts shall for each year be allocated by the commissioner of health among residential health care facilities that are eligible to provide services to beneficiaries of title XVIII of the federal social security act (medicare) and residents eligible for payments pursuant to title 11 of article 5 of the social services law on the basis of the extent of each facility's failure to achieve a two percentage points increase in the 1996 target percentage, a three percentage point increase in the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 target percentage and a two and one-quarter percentage point increase in the 1999 target percentage for each year, compared to the base percentage, calculated on a facility specific basis for this purpose, compared to the statewide total of the extent of each facility's failure to achieve a two percentage points increase in the 1996 and a three percentage point increase in the 1997 and a three percentage point increase in the 1998 and a two and one-quarter percentage point increase in the 1999 target percentage and a three percentage point increase in the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 target percentage compared to the base percentage. These amounts shall be called the 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 facility specific reduction amounts respectively.

S 14-a. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 14-a of part D of chapter 59 of the laws of 2011, is amended to read as follows:

S 228. 1. Definitions. (a) Regions, for purposes of this section, shall mean a downstate region to consist of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region to consist of all other New York state counties. A certified home health agency or long term home health care program shall be located in the same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law.

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

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

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

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean January 1, 2013 through November 30, 2013, AND THE 2014 TARGET PERIOD SHALL MEAN JANUARY 1, 2014 THROUGH NOVEMBER 30, 2014 AND THE 2015 TARGET PERIOD SHALL MEAN JANUARY 1, 2015 THROUGH NOVEMBER 30, 2015.

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

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012 [and], prior to February 1, 2013, PRIOR TO FEBRUARY 1, 2014 AND PRIOR TO FEBRUARY 1, 2015 for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

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

4. (a) For each regional group, the 1996 target medicaid revenue percentage shall be calculated by subtracting the 1996 medicaid revenue reduction percentages from the base period medicaid revenue percentages. The 1996 medicaid revenue reduction percentage, taking into account

regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:
(i) one and one-tenth percentage points for CHHAs located within the downstate region;
(ii) six-tenths of one percentage point for CHHAs located within the upstate region;
(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and
(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.
(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:
(i) one and one-tenth percentage points for CHHAs located within the downstate region;
(ii) six-tenths of one percentage point for CHHAs located within the upstate region;
(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and
(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.
(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:
(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;
(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;
(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPs located within the downstate region; and
(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPs located within the upstate region.
5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.
(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage

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

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

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

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

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

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

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

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional group's applicable state share reduction amount for such respective year:

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

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

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

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

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

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

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

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

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

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

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

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage, calculated on a

provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the 1996 target medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount calculation pursuant to paragraph (a) of subdivision 6 of this section. This amount shall be called the 1996 provider specific state share reduction amount.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

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

(b) The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, [and] 2013, 2014 AND 2015 respectively, shall be due to the state from each CHHA and LTHHCP and each year the amount due for such year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

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

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

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

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

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

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

S 15. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 15 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015;

S 16. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 16 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

S 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, AND ON AND AFTER APRIL 1, 2013 THROUGH MARCH 31, 2015.

S 17. Subdivision 1 of section 20 of chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, as amended by section 17 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [2013] 2015;

S 18. The opening paragraph of subdivision 7-a of section 3614 of the public health law, as amended by section 18 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two

thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen AND ON AND AFTER APRIL FIRST, TWO THOUSAND THIRTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

S 19. Intentionally omitted.

S 20. Subdivision 6-a of section 93 of part C of chapter 58 of the laws of 2007 amending the social services law and the public health law relating to adjustments of rates, as amended by section 40 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

6-a. section fifty-seven of this act shall expire and be deemed repealed on December 31, [2013] 2018; provided that the amendments made by such section to subdivision 4 of section 366-c of the social services law shall apply with respect to determining initial and continuing eligibility for medical assistance, including the continued eligibility of recipients originally determined eligible prior to the effective date of this act, and provided further that such amendments shall not apply to any person or group of persons if it is subsequently determined by the Centers for Medicare and Medicaid services or by a court of competent jurisdiction that medical assistance with federal financial participation is available for the costs of services provided to such person or persons under the provisions of subdivision 4 of section 366-c of the social services law in effect immediately prior to the effective date of this act.

S 21. Subdivision 12 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 23 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

12. Sections one hundred five-b through one hundred five-f of this act shall expire March 31, [2013] 2015.

S 22. Section 5 of chapter 426 of the laws of 1983, amending the public health law relating to professional misconduct proceedings, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

S 5. This act shall take effect June 1, 1983 and shall remain in full force and effect until March 31, [2013] 2018.

S 23. Section 5 of chapter 582 of the laws of 1984, amending the public health law relating to regulating activities of physicians, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

S 5. This act shall take effect immediately, provided however that the provisions of this act shall remain in full force and effect until March 31, [2013] 2018 at which time the provisions of this act shall be deemed to be repealed.

S 24. Subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law, as amended by chapter 36 of the laws of 2008, is amended to read as follows:

(ii) Participation and membership during a three year demonstration period in a physician committee of the Medical Society of the State of

New York or the New York State Osteopathic Society whose purpose is to confront and refer to treatment physicians who are thought to be suffering from alcoholism, drug abuse or mental illness. Such demonstration period shall commence on April first, nineteen hundred eighty and terminate on May thirty-first, nineteen hundred eighty-three. An additional demonstration period shall commence on June first, nineteen hundred eighty-three and terminate on March thirty-first, nineteen hundred eighty-six. An additional demonstration period shall commence on April first, nineteen hundred eighty-six and terminate on March thirty-first, nineteen hundred eighty-nine. An additional demonstration period shall commence April first, nineteen hundred eighty-nine and terminate March thirty-first, nineteen hundred ninety-two. An additional demonstration period shall commence April first, nineteen hundred ninety-two and terminate March thirty-first, nineteen hundred ninety-five. An additional demonstration period shall commence on April first, nineteen hundred ninety-five and terminate on March thirty-first, nineteen hundred ninety-eight. An additional demonstration period shall commence on April first, nineteen hundred ninety-eight and terminate on March thirty-first, two thousand three. An additional demonstration period shall commence on April first, two thousand three and terminate on March thirty-first, two thousand thirteen[;]. AN ADDITIONAL DEMONSTRATION PERIOD SHALL COMMENCE APRIL FIRST, TWO THOUSAND THIRTEEN AND TERMINATE ON MARCH THIRTY-FIRST, TWO THOUSAND EIGHTEEN provided, however, that the commissioner may prescribe requirements for the continuation of such demonstration program, including periodic reviews of such programs and submission of any reports and data necessary to permit such reviews. During these additional periods, the provisions of this subparagraph shall also apply to a physician committee of a county medical society.

S 25. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 27 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 4. This act shall take effect immediately; provided that the provisions of section one of this act shall be deemed to have been in full force and effect on and after April 1, 2003, and shall expire March 31, [2013] 2015 when upon such date the provisions of such section shall be deemed repealed.

S 25-a. Section 3 of chapter 906 of the laws of 1984, amending the social services law relating to expanding medical assistance eligibility and the scope of services available to certain persons with disabilities, as amended by section 69-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

S 3. This act shall take effect on the thirtieth day after it shall have become a law and shall be of no further force and effect after December 31, [2013] 2018, at which time the provisions of this act shall be deemed to be repealed.

S 26. 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 27. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of

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

S 28. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013; provided that the amendments to subparagraph (ii) of paragraph (c) of subdivision 11 of section 230 of the public health law made by section twenty-four of this act shall not affect the expiration of such subparagraph and shall expire therewith.

PART C

Section 1. Section 2807-k of the public health law is amended by adding a new subdivision 5-d to read as follows:

5-D. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE OR ANY OTHER CONTRARY PROVISION OF LAW, AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN, THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN, ALL FUNDS AVAILABLE FOR DISTRIBUTION PURSUANT TO THIS SECTION, EXCEPT FOR FUNDS DISTRIBUTED PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH (B) OF SUBDIVISION FIVE-B OF THIS SECTION, AND ALL FUNDS AVAILABLE FOR DISTRIBUTION PURSUANT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE, SHALL BE RESERVED AND SET ASIDE AND DISTRIBUTED IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBDIVISION.

(B) THE COMMISSIONER SHALL PROMULGATE REGULATIONS, AND MAY PROMULGATE EMERGENCY REGULATIONS, ESTABLISHING METHODOLOGIES FOR THE DISTRIBUTION OF FUNDS AS DESCRIBED IN PARAGRAPH (A) OF THIS SUBDIVISION AND SUCH REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING:

(I) SUCH REGULATIONS SHALL ESTABLISH METHODOLOGIES FOR DETERMINING EACH FACILITY'S RELATIVE UNCOMPENSATED CARE NEED AMOUNT BASED ON UNINSURED INPATIENT AND OUTPATIENT UNITS OF SERVICE FROM THE COST REPORTING YEAR TWO YEARS PRIOR TO THE DISTRIBUTION YEAR, MULTIPLIED BY THE APPLICABLE MEDICAID RATES IN EFFECT JANUARY FIRST OF THE DISTRIBUTION YEAR, AS SUMMED AND ADJUSTED BY A STATEWIDE COST ADJUSTMENT FACTOR AND REDUCED BY THE SUM OF ALL PAYMENT AMOUNTS COLLECTED FROM SUCH UNINSURED PATIENTS, AND AS FURTHER ADJUSTED BY APPLICATION OF A NOMINAL NEED COMPUTATION THAT SHALL TAKE INTO ACCOUNT EACH FACILITY'S MEDICAID INPATIENT SHARE.

(II) ANNUAL DISTRIBUTIONS PURSUANT TO SUCH REGULATIONS FOR THE TWO THOUSAND THIRTEEN THROUGH TWO THOUSAND FIFTEEN CALENDAR YEARS SHALL BE IN ACCORD WITH THE FOLLOWING:

(A) ONE HUNDRED THIRTY-NINE MILLION FOUR HUNDRED THOUSAND DOLLARS SHALL BE DISTRIBUTED AS MEDICAID DISPROPORTIONATE SHARE HOSPITAL ("DSH") PAYMENTS TO MAJOR PUBLIC GENERAL HOSPITALS; AND

(B) NINE HUNDRED NINETY-FOUR MILLION NINE HUNDRED THOUSAND DOLLARS AS MEDICAID DSH PAYMENTS TO ELIGIBLE GENERAL HOSPITALS, OTHER THAN MAJOR PUBLIC GENERAL HOSPITALS.

(III)(A) SUCH REGULATIONS SHALL ESTABLISH TRANSITION ADJUSTMENTS TO THE DISTRIBUTIONS MADE PURSUANT TO CLAUSES (A) AND (B) OF SUBPARAGRAPH (II) OF THIS PARAGRAPH SUCH THAT NO FACILITY EXPERIENCES A REDUCTION IN INDIGENT CARE POOL PAYMENTS PURSUANT TO THIS SUBDIVISION THAT IS GREATER

THAN THE PERCENTAGES, AS SPECIFIED IN CLAUSE (C) OF THIS SUBPARAGRAPH AS COMPARED TO THE AVERAGE DISTRIBUTION THAT EACH SUCH FACILITY RECEIVED FOR THE THREE CALENDAR YEARS PRIOR TO TWO THOUSAND THIRTEEN PURSUANT TO THIS SECTION AND SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE.

(B) SUCH REGULATIONS SHALL ALSO ESTABLISH ADJUSTMENTS LIMITING THE INCREASES IN INDIGENT CARE POOL PAYMENTS EXPERIENCED BY FACILITIES PURSUANT TO THIS SUBDIVISION BY AN AMOUNT THAT WILL BE, AS DETERMINED BY THE COMMISSIONER AND IN CONJUNCTION WITH SUCH OTHER FUNDING AS MAY BE AVAILABLE FOR THIS PURPOSE, SUFFICIENT TO ENSURE FULL FUNDING FOR THE TRANSITION ADJUSTMENT PAYMENTS AUTHORIZED BY CLAUSE (A) OF THIS SUBPARAGRAPH.

(C) NO FACILITY SHALL EXPERIENCE A REDUCTION IN INDIGENT CARE POOL PAYMENTS PURSUANT TO THIS SUBDIVISION THAT: FOR THE CALENDAR YEAR BEGINNING JANUARY FIRST, TWO THOUSAND THIRTEEN, IS GREATER THAN TWO AND ONE-HALF PERCENT; FOR THE CALENDAR YEAR BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, IS GREATER THAN FIVE PERCENT; AND, FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND FIFTEEN, IS GREATER THAN SEVEN AND ONE-HALF PERCENT.

(IV) SUCH REGULATIONS SHALL RESERVE ONE PERCENT OF THE FUNDS AVAILABLE FOR DISTRIBUTION IN THE TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN CALENDAR YEARS PURSUANT TO THIS SUBDIVISION, SUBDIVISION FOURTEEN-F OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE, AND SECTIONS TWO HUNDRED ELEVEN AND TWO HUNDRED TWELVE OF CHAPTER FOUR HUNDRED SEVENTY-FOUR OF THE LAWS OF NINETEEN HUNDRED NINETY-SIX, IN A "FINANCIAL ASSISTANCE COMPLIANCE POOL" AND SHALL ESTABLISH METHODOLOGIES FOR THE DISTRIBUTION OF SUCH POOL FUNDS TO FACILITIES BASED ON THEIR LEVEL OF COMPLIANCE, AS DETERMINED BY THE COMMISSIONER, WITH THE PROVISIONS OF SUBDIVISION NINE-A OF THIS SECTION.

(C) THE COMMISSIONER SHALL ANNUALLY REPORT TO THE GOVERNOR AND THE LEGISLATURE ON THE DISTRIBUTION OF FUNDS UNDER THIS SUBDIVISION INCLUDING, BUT NOT LIMITED TO:

(I) THE IMPACT ON SAFETY NET PROVIDERS, INCLUDING COMMUNITY PROVIDERS, RURAL GENERAL HOSPITALS AND MAJOR PUBLIC GENERAL HOSPITALS;

(II) THE PROVISION OF INDIGENT CARE BY UNITS OF SERVICES AND FUNDS DISTRIBUTED BY GENERAL HOSPITALS; AND

(III) THE EXTENT TO WHICH ACCESS TO CARE HAS BEEN ENHANCED.

S 2. Subdivision 14-f of section 2807-c of the public health law, as amended by chapter 1 of the laws of 1999, is amended to read as follows:

14-f. Public general hospital indigent care adjustment. Notwithstanding any inconsistent provision of this section AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, payment for inpatient hospital services for persons eligible for payments made by state governmental agencies for the period January first, nineteen hundred ninety-seven through December thirty-first, nineteen hundred ninety-nine and periods on and after January first, two thousand applicable to patients eligible for federal financial participation under title XIX of the federal social security act in medical assistance provided pursuant to title eleven of article five of the social services law determined in accordance with this section shall include for eligible public general hospitals a public general hospital indigent care adjustment equal to the aggregate amount of the adjustments provided for such public general hospital for the period January first, nineteen hundred ninety-six through December thirty-first, nineteen hundred ninety-six pursuant to subdivisions fourteen-a and fourteen-d of this section on an annualized basis, [provided all federal approvals necessary by federal law and regulation for federal financial participation in payments made for

beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the adjustment provided herein as a component of such payments are granted] PROVIDED, HOWEVER, THAT FOR PERIODS ON AND AFTER JANUARY FIRST, TWO THOUSAND THIRTEEN AN ANNUAL AMOUNT OF FOUR HUNDRED TWELVE MILLION DOLLARS SHALL BE ALLOCATED TO ELIGIBLE MAJOR PUBLIC HOSPITALS BASED ON EACH HOSPITAL'S PROPORTIONATE SHARE OF MEDICAID AND UNINSURED LOSSES TO TOTAL MEDICAID AND UNINSURED LOSSES FOR ALL ELIGIBLE MAJOR PUBLIC HOSPITALS, NET OF ANY DISPROPORTIONATE SHARE HOSPITAL PAYMENTS RECEIVED PURSUANT TO SECTIONS TWENTY-EIGHT HUNDRED SEVEN-K AND TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE. The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.

S 3. Paragraph (i) of subdivision 2-a of section 2807 of the public health law, as amended by section 16 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND ONE HUNDRED FIFTY-THREE MILLION DOLLARS FOR STATE FISCAL YEAR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND THIRTEEN, provided, however, that for periods on and after April first, two thousand nine, such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the two thousand seven calendar year to the applicable rate year, and provided further, however, that funds made available as a result of any such decreases may be utilized by the commissioner to increase capitation rates paid to Medicaid managed care plans and family health plus plans to cover increased payments to health care providers for ambulatory care services and to increase such other ambulatory care payment rates as the commissioner determines necessary to facilitate access to quality ambulatory care services.

S 4. The opening paragraph of subparagraph (i) of paragraph (i) of subdivision 35 of section 2807-c of the public health law, as added by section 3-a of part B of chapter 109 of the laws of 2010, is amended to read as follows:

Notwithstanding any inconsistent provision of this subdivision or any other contrary provision of law and subject to the availability of federal financial participation, for the period July first, two thousand ten through March thirty-first, two thousand eleven, and each state fiscal year period thereafter, the commissioner shall make additional inpatient hospital payments up to the aggregate upper payment limit for inpatient hospital services after all other medical assistance payments, but not to exceed two hundred thirty-five million five hundred thousand dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven [and], three hundred fourteen million dollars for each state fiscal year BEGINNING APRIL FIRST, TWO THOUSAND ELEVEN, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND THIRTEEN, AND NO LESS THAN THREE HUNDRED THIRTY-NINE MILLION DOLLARS FOR EACH STATE FISCAL YEAR thereafter, to general hospitals, other than major public general

hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. Such payments shall be made as medical assistance payments for fee-for-service inpatient hospital services pursuant to title eleven of article five of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act and in accordance with the following:

S 5. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013 provided that:

a. sections one, two and four of this act shall be deemed to have been in full force and effect on and after January 1, 2013; and

b. the amendments to subdivision 14-f of section 2807-c of the public health law made by section two of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith.

PART D

Section 1. Subdivision 1 of section 366 of the social services law is REPEALED and a new subdivision 1 is added to read as follows:

1. (A) DEFINITIONS. FOR PURPOSES OF THIS SECTION:

(1) "BENCHMARK COVERAGE" REFERS TO MEDICAL ASSISTANCE COVERAGE DEFINED IN SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE;

(2) "CARETAKER RELATIVE" MEANS A RELATIVE OF A DEPENDENT CHILD BY BLOOD, ADOPTION, OR MARRIAGE WITH WHOM THE CHILD IS LIVING, WHO ASSUMES PRIMARY RESPONSIBILITY FOR THE CHILD'S CARE AND WHO IS ONE OF THE FOLLOWING:

(I) THE CHILD'S FATHER, MOTHER, GRANDFATHER, GRANDMOTHER, BROTHER, SISTER, STEPFATHER, STEPMOTHER, STEPBROTHER, STEPSISTER, UNCLE, AUNT, FIRST COUSIN, NEPHEW, OR NIECE; OR

(II) THE SPOUSE OF SUCH PARENT OR RELATIVE, EVEN AFTER THE MARRIAGE IS TERMINATED BY DEATH OR DIVORCE;

(3) "FAMILY SIZE" MEANS THE NUMBER OF PERSONS COUNTED AS MEMBERS OF AN INDIVIDUAL'S HOUSEHOLD; WITH RESPECT TO INDIVIDUALS WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, IN DETERMINING THE FAMILY SIZE OF A PREGNANT WOMAN, OR OF OTHER INDIVIDUALS WHO HAVE A PREGNANT WOMAN IN THEIR HOUSEHOLD, THE PREGNANT WOMAN IS COUNTED AS HERSELF PLUS THE NUMBER OF CHILDREN SHE IS EXPECTED TO DELIVER;

(4) "FEDERAL POVERTY LINE" MEANS THE POVERTY LINE DEFINED AND ANNUALLY REVISED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES;

(5) "HOUSEHOLD", FOR PURPOSES OF DETERMINING THE FINANCIAL ELIGIBILITY OF INDIVIDUALS WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, SHALL MEAN:

(I) BASIC RULE FOR TAXPAYERS NOT CLAIMED AS A TAX DEPENDENT. IN THE CASE OF AN INDIVIDUAL WHO EXPECTS TO FILE A TAX RETURN FOR THE TAXABLE YEAR IN WHICH AN INITIAL DETERMINATION OR RENEWAL OF ELIGIBILITY IS

BEING MADE, AND WHO DOES NOT EXPECT TO BE CLAIMED AS A TAX DEPENDENT BY ANOTHER TAXPAYER, THE HOUSEHOLD CONSISTS OF THE TAXPAYER AND, SUBJECT TO CLAUSE (V) OF THIS SUBPARAGRAPH, ALL PERSONS WHOM SUCH INDIVIDUAL EXPECTS TO CLAIM AS A TAX DEPENDENT;

(II) BASIC RULE FOR INDIVIDUALS CLAIMED AS A TAX DEPENDENT. IN THE CASE OF AN INDIVIDUAL WHO EXPECTS TO BE CLAIMED AS A TAX DEPENDENT BY ANOTHER TAXPAYER FOR THE TAXABLE YEAR IN WHICH AN INITIAL DETERMINATION OR RENEWAL OF ELIGIBILITY IS BEING MADE, THE HOUSEHOLD IS THE HOUSEHOLD OF THE TAXPAYER CLAIMING SUCH INDIVIDUAL AS A TAX DEPENDENT, EXCEPT THAT THE HOUSEHOLD MUST BE DETERMINED IN ACCORDANCE WITH CLAUSE (III) OF THIS SUBPARAGRAPH IN THE CASE OF:

(A) INDIVIDUALS OTHER THAN A SPOUSE OR CHILD WHO EXPECT TO BE CLAIMED AS A TAX DEPENDENT BY ANOTHER TAXPAYER; AND

(B) INDIVIDUALS UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT, WHO EXPECT TO BE CLAIMED BY ONE PARENT AS A TAX DEPENDENT AND ARE LIVING WITH BOTH PARENTS BUT WHOSE PARENTS DO NOT EXPECT TO FILE A JOINT TAX RETURN; AND

(C) INDIVIDUALS UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT, WHO EXPECT TO BE CLAIMED AS A TAX DEPENDENT BY A NON-CUSTODIAL PARENT. FOR PURPOSES OF THIS SUBCLAUSE:

(1) A COURT ORDER OR BINDING SEPARATION, DIVORCE, OR CUSTODY AGREEMENT ESTABLISHING PHYSICAL CUSTODY CONTROLS; OR

(2) IF THERE IS NO SUCH ORDER OR AGREEMENT OR IN THE EVENT OF A SHARED CUSTODY AGREEMENT, THE CUSTODIAL PARENT IS THE PARENT WITH WHOM THE CHILD SPENDS MOST NIGHTS;

(III) RULES FOR INDIVIDUALS WHO NEITHER FILE A TAX RETURN NOR ARE CLAIMED AS A TAX DEPENDENT. IN THE CASE OF INDIVIDUALS WHO DO NOT EXPECT TO FILE A FEDERAL TAX RETURN AND DO NOT EXPECT TO BE CLAIMED AS A TAX DEPENDENT FOR THE TAXABLE YEAR IN WHICH AN INITIAL DETERMINATION OR RENEWAL OF ELIGIBILITY IS BEING MADE, OR WHO ARE DESCRIBED IN SUBCLAUSES (A), (B), OR (C) OF CLAUSE (II) OF THIS SUBPARAGRAPH, THE HOUSEHOLD CONSISTS OF THE INDIVIDUAL AND, IF LIVING WITH THE INDIVIDUAL:

(A) THE INDIVIDUAL'S SPOUSE;

(B) THE INDIVIDUAL'S CHILDREN UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT; AND

(C) IN THE CASE OF AN INDIVIDUAL UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT, THE INDIVIDUAL'S PARENTS AND THE INDIVIDUAL'S SIBLINGS UNDER NINETEEN YEARS OF AGE, OR UNDER TWENTY-ONE YEARS OF AGE IF A FULL-TIME STUDENT;

(IV) MARRIED COUPLES. IN THE CASE OF A MARRIED COUPLE LIVING TOGETHER, EACH SPOUSE WILL BE INCLUDED IN THE HOUSEHOLD OF THE OTHER SPOUSE, REGARDLESS OF WHETHER THEY EXPECT TO FILE A JOINT TAX RETURN UNDER SECTION SIX THOUSAND THIRTEEN OF THE INTERNAL REVENUE CODE OR WHETHER ONE SPOUSE EXPECTS TO BE CLAIMED AS A TAX DEPENDENT BY THE OTHER SPOUSE.

(V) FOR PURPOSES OF CLAUSE (I) OF THIS SUBPARAGRAPH, IF A TAXPAYER CANNOT REASONABLY ESTABLISH THAT ANOTHER INDIVIDUAL IS A TAX DEPENDENT OF THE TAXPAYER FOR THE TAX YEAR IN WHICH MEDICAID IS SOUGHT, THE INCLUSION OF SUCH INDIVIDUAL IN THE HOUSEHOLD OF THE TAXPAYER IS DETERMINED IN ACCORDANCE WITH CLAUSE (III) OF THIS SUBPARAGRAPH.

(6) "MAGI" MEANS MODIFIED ADJUSTED GROSS INCOME;

(7) "MAGI-BASED INCOME" MEANS INCOME CALCULATED USING THE SAME METHODOLOGIES USED TO DETERMINE MAGI UNDER SECTION 36B(D)(2)(B) OF THE INTERNAL REVENUE CODE, WITH THE EXCEPTION OF LUMP SUM PAYMENTS, CERTAIN EDUCATIONAL SCHOLARSHIPS, AND CERTAIN AMERICAN INDIAN AND ALASKA NATIVE INCOME, AS SPECIFIED BY THE COMMISSIONER OF HEALTH CONSISTENT WITH FEDERAL REGULATION AT 42 CFR 435.603 OR ANY SUCCESSOR REGULATION;

(8) "MAGI HOUSEHOLD INCOME" MEANS, WITH RESPECT TO AN INDIVIDUAL WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, THE SUM OF THE MAGI-BASED INCOME OF EVERY PERSON INCLUDED IN THE INDIVIDUAL'S MAGI HOUSEHOLD, EXCEPT THAT IT SHALL NOT INCLUDE THE MAGI-BASED INCOME OF THE FOLLOWING PERSONS IF SUCH PERSONS ARE NOT EXPECTED TO BE REQUIRED TO FILE A TAX RETURN IN THE TAXABLE YEAR IN WHICH ELIGIBILITY FOR MEDICAL ASSISTANCE IS BEING DETERMINED:

(I) A BIOLOGICAL, ADOPTED, OR STEP CHILD WHO IS INCLUDED IN THE INDIVIDUAL'S MAGI HOUSEHOLD; OR

(II) A PERSON, OTHER THAN A SPOUSE OR A BIOLOGICAL, ADOPTED, OR STEP CHILD, WHO IS EXPECTED TO BE CLAIMED AS A TAX DEPENDENT BY THE INDIVIDUAL;

(9) "STANDARD COVERAGE" REFERS TO MEDICAL ASSISTANCE COVERAGE DEFINED IN SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE.

(B) MAGI ELIGIBILITY GROUPS. INDIVIDUALS LISTED IN THIS PARAGRAPH ARE ELIGIBLE FOR MEDICAL ASSISTANCE BASED ON MODIFIED ADJUSTED GROSS INCOME. IN DETERMINING THE ELIGIBILITY OF AN INDIVIDUAL FOR THE MAGI ELIGIBILITY GROUP WITH THE HIGHEST INCOME STANDARD UNDER WHICH THE INDIVIDUAL MAY QUALIFY, AN AMOUNT EQUIVALENT TO FIVE PERCENTAGE POINTS OF THE FEDERAL POVERTY LEVEL FOR THE APPLICABLE FAMILY SIZE WILL BE DEDUCTED FROM THE HOUSEHOLD INCOME.

(1) AN INDIVIDUAL IS ELIGIBLE FOR BENCHMARK COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE AND HE OR SHE IS:

(I) AGE NINETEEN OR OLDER AND UNDER AGE SIXTY-FIVE; AND

(II) NOT PREGNANT; AND

(III) NOT ENTITLED TO OR ENROLLED FOR BENEFITS UNDER PARTS A OR B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT; AND

(IV) NOT OTHERWISE ELIGIBLE FOR AND RECEIVING COVERAGE UNDER SUBPARAGRAPHS TWO AND THREE OF THIS PARAGRAPH; AND

(V) NOT A PARENT OR OTHER CARETAKER RELATIVE OF A DEPENDENT CHILD UNDER TWENTY-ONE YEARS OF AGE AND LIVING WITH SUCH CHILD, UNLESS SUCH CHILD IS RECEIVING BENEFITS UNDER THIS TITLE OR UNDER TITLE 1-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW, OR OTHERWISE IS ENROLLED IN MINIMUM ESSENTIAL COVERAGE.

(2) A PREGNANT WOMAN OR AN INFANT YOUNGER THAN ONE YEAR OF AGE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR AN INFANT YOUNGER THAN ONE YEAR OF AGE WHO MEETS THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(3) A CHILD WHO IS AT LEAST ONE YEAR OF AGE BUT YOUNGER THAN NINETEEN YEARS OF AGE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, OR A CHILD WHO IS AT LEAST ONE YEAR OF AGE BUT YOUNGER THAN NINETEEN YEARS OF AGE WHO MEETS THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FOUR OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(4) AN INDIVIDUAL WHO IS A PREGNANT WOMAN OR IS A MEMBER OF A FAMILY THAT CONTAINS A DEPENDENT CHILD LIVING WITH A PARENT OR OTHER CARETAKER

RELATIVE IS ELIGIBLE FOR STANDARD COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME 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, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; FOR PURPOSES OF THIS SUBPARAGRAPH, THE TERM DEPENDENT CHILD MEANS A PERSON WHO IS UNDER EIGHTEEN YEARS OF AGE, OR IS EIGHTEEN YEARS OF AGE AND A FULL-TIME STUDENT, WHO IS DEPRIVED OF PARENTAL SUPPORT OR CARE BY REASON OF THE DEATH, CONTINUED ABSENCE, OR PHYSICAL OR MENTAL INCAPACITY OF A PARENT, OR BY REASON OF THE UNEMPLOYMENT OF THE PARENT, AS DEFINED BY THE DEPARTMENT OF HEALTH.

(5) A CHILD WHO IS UNDER TWENTY-ONE YEARS OF AGE AND WHO WAS IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE ON HIS OR HER EIGHTEENTH BIRTHDAY IS ELIGIBLE FOR STANDARD COVERAGE; NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE PROVISIONS OF THIS SUBPARAGRAPH SHALL BE EFFECTIVE ONLY IF AND FOR SO LONG AS FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE IN THE COSTS OF MEDICAL ASSISTANCE FURNISHED HEREUNDER.

(6) AN INDIVIDUAL WHO IS NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS SECTION IS ELIGIBLE FOR COVERAGE OF FAMILY PLANNING SERVICES REIMBURSED BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT, AND FOR COVERAGE OF THOSE SERVICES IDENTIFIED BY THE COMMISSIONER OF HEALTH AS SERVICES GENERALLY PERFORMED AS PART OF OR AS A FOLLOW-UP TO A SERVICE ELIGIBLE FOR SUCH NINETY PERCENT REIMBURSEMENT, INCLUDING TREATMENT FOR SEXUALLY TRANSMITTED DISEASES, IF HIS OR HER INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE, WHICH SHALL BE CALCULATED IN ACCORDANCE WITH GUIDANCE ISSUED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(7) A CHILD WHO IS NINETEEN OR TWENTY YEARS OF AGE LIVING WITH HIS OR HER PARENT WILL BE ELIGIBLE FOR STANDARD COVERAGE IF THE SUM OF THE MAGI-BASED INCOME OF EVERY PERSON INCLUDED IN THE CHILD'S MAGI HOUSEHOLD EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT, BUT DOES NOT EXCEED ONE HUNDRED FIFTY PERCENT, OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE.

(7-A) AN INDIVIDUAL IS ELIGIBLE FOR BENCHMARK COVERAGE IF HIS OR HER MAGI HOUSEHOLD INCOME EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE AND HE OR SHE:

(I) WAS ELIGIBLE OR WOULD HAVE BEEN ELIGIBLE FOR THE FAMILY HEALTH PLUS PROGRAM WITHOUT FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF MEDICAL CARE AND SERVICES UNDER SUCH PROGRAM; AND

(II) IS NOT ELIGIBLE TO ENROLL IN A QUALIFIED HEALTH PLAN OFFERED THROUGH THE STATE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152).

(C) NON-MAGI ELIGIBILITY GROUPS. INDIVIDUALS LISTED IN THIS PARAGRAPH ARE ELIGIBLE FOR STANDARD COVERAGE. WHERE A FINANCIAL ELIGIBILITY DETERMINATION MUST BE MADE BY THE MEDICAL ASSISTANCE PROGRAM FOR INDIVIDUALS IN THESE GROUPS, SUCH FINANCIAL ELIGIBILITY WILL BE DETERMINED IN ACCORDANCE WITH SUBDIVISION TWO OF THIS SECTION.

(1) AN INDIVIDUAL RECEIVING OR ELIGIBLE TO RECEIVE FEDERAL SUPPLEMENTAL SECURITY INCOME PAYMENTS AND/OR ADDITIONAL STATE PAYMENTS PURSUANT TO TITLE SIX OF THIS ARTICLE; ANY INCONSISTENT PROVISION OF THIS

CHAPTER OR OTHER LAW NOTWITHSTANDING, THE DEPARTMENT MAY DESIGNATE THE OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE AS ITS AGENT TO DISCHARGE ITS RESPONSIBILITY, OR SO MUCH OF ITS RESPONSIBILITY AS IS PERMITTED BY FEDERAL LAW, FOR DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE WITH RESPECT TO PERSONS WHO ARE NOT ELIGIBLE TO RECEIVE FEDERAL SUPPLEMENTAL SECURITY INCOME PAYMENTS BUT WHO ARE RECEIVING A STATE ADMINISTERED SUPPLEMENTARY PAYMENT OR MANDATORY MINIMUM SUPPLEMENT IN ACCORDANCE WITH THE PROVISIONS OF SUBDIVISION ONE OF SECTION TWO HUNDRED TWELVE OF THIS ARTICLE.

(2) AN INDIVIDUAL WHO, ALTHOUGH NOT RECEIVING PUBLIC ASSISTANCE OR CARE FOR HIS OR HER MAINTENANCE UNDER OTHER PROVISIONS OF THIS CHAPTER, HAS INCOME AND RESOURCES, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE RELATIVES, THAT DOES NOT EXCEED THE AMOUNTS SET FORTH IN PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION, AND IS (I) SIXTY-FIVE YEARS OF AGE OR OLDER, OR CERTIFIED BLIND OR CERTIFIED DISABLED OR (II) FOR REASONS OTHER THAN INCOME OR RESOURCES, IS ELIGIBLE FOR FEDERAL SUPPLEMENTAL SECURITY INCOME BENEFITS AND/OR ADDITIONAL STATE PAYMENTS.

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

(4) A CHILD IN FOSTER CARE, OR A CHILD DESCRIBED IN SECTION FOUR HUNDRED FIFTY-FOUR OR FOUR HUNDRED FIFTY-EIGHT-D OF THIS CHAPTER.

(5) A DISABLED INDIVIDUAL AT LEAST SIXTEEN YEARS OF AGE, BUT UNDER THE AGE OF SIXTY-FIVE, WHO: WOULD BE ELIGIBLE FOR BENEFITS UNDER THE SUPPLEMENTAL SECURITY INCOME PROGRAM BUT FOR EARNINGS IN EXCESS OF THE ALLOWABLE LIMIT; HAS NET AVAILABLE INCOME THAT DOES NOT EXCEED TWO HUNDRED FIFTY PERCENT OF THE APPLICABLE FEDERAL INCOME OFFICIAL POVERTY LINE, AS DEFINED AND UPDATED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, FOR A ONE-PERSON OR TWO-PERSON HOUSEHOLD, AS DEFINED BY THE COMMISSIONER IN REGULATION; HAS HOUSEHOLD RESOURCES, AS DEFINED IN PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-SIX-C OF THIS TITLE, OTHER THAN RETIREMENT ACCOUNTS, THAT DO NOT EXCEED TWENTY THOUSAND DOLLARS FOR A ONE-PERSON HOUSEHOLD OR THIRTY THOUSAND DOLLARS FOR A TWO-PERSON HOUSEHOLD, AS DEFINED BY THE COMMISSIONER IN REGULATION; AND CONTRIBUTES TO THE COST OF MEDICAL ASSISTANCE PROVIDED PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH SUBDIVISION TWELVE OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THIS TITLE; FOR PURPOSES OF THIS SUBPARAGRAPH, DISABLED MEANS HAVING A MEDICALLY DETERMINABLE IMPAIRMENT OF SUFFICIENT SEVERITY AND DURATION TO QUALIFY FOR BENEFITS UNDER SECTION 1902(A)(10)(A)(II)(XV) OF THE SOCIAL SECURITY ACT.

(6) AN INDIVIDUAL AT LEAST SIXTEEN YEARS OF AGE, BUT UNDER THE AGE OF SIXTY-FIVE, WHO: IS EMPLOYED; CEASES TO BE IN RECEIPT OF MEDICAL ASSISTANCE UNDER SUBPARAGRAPH FIVE OF THIS PARAGRAPH BECAUSE THE PERSON, BY REASON OF MEDICAL IMPROVEMENT, IS DETERMINED AT THE TIME OF A REGULARLY SCHEDULED CONTINUING DISABILITY REVIEW TO NO LONGER BE ELIGIBLE FOR SUPPLEMENTAL SECURITY INCOME PROGRAM BENEFITS OR DISABILITY INSURANCE BENEFITS UNDER THE SOCIAL SECURITY ACT; CONTINUES TO HAVE A SEVERE MEDICALLY DETERMINABLE IMPAIRMENT, TO BE DETERMINED IN ACCORDANCE WITH

APPLICABLE FEDERAL REGULATIONS; AND CONTRIBUTES TO THE COST OF MEDICAL ASSISTANCE PROVIDED PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH SUBDIVISION TWELVE OF SECTION THREE HUNDRED SIXTY-SEVEN-A OF THIS TITLE; FOR PURPOSES OF THIS SUBPARAGRAPH, A PERSON IS CONSIDERED TO BE EMPLOYED IF THE PERSON IS EARNING AT LEAST THE APPLICABLE MINIMUM WAGE UNDER SECTION SIX OF THE FEDERAL FAIR LABOR STANDARDS ACT AND WORKING AT LEAST FORTY HOURS PER MONTH; OR

(7) AN INDIVIDUAL RECEIVING TREATMENT FOR BREAST OR CERVICAL CANCER WHO MEETS THE ELIGIBILITY REQUIREMENTS OF PARAGRAPH (D) OF SUBDIVISION FOUR OF THIS SECTION OR THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(8) AN INDIVIDUAL RECEIVING TREATMENT FOR COLON OR PROSTATE CANCER WHO MEETS THE ELIGIBILITY REQUIREMENTS OF PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION OR THE PRESUMPTIVE ELIGIBILITY REQUIREMENTS OF SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(9) AN INDIVIDUAL WHO:

(I) IS UNDER TWENTY-SIX YEARS OF AGE; AND

(II) WAS IN FOSTER CARE UNDER THE RESPONSIBILITY OF THE STATE ON HIS OR HER EIGHTEENTH BIRTHDAY; AND

(III) WAS IN RECEIPT OF MEDICAL ASSISTANCE UNDER THIS TITLE WHILE IN FOSTER CARE; AND

(IV) IS NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE.

(10) A RESIDENT OF A HOME FOR ADULTS OPERATED BY A SOCIAL SERVICES DISTRICT, OR A RESIDENTIAL CARE CENTER FOR ADULTS OR COMMUNITY RESIDENCE OPERATED OR CERTIFIED BY THE OFFICE OF MENTAL HEALTH, AND HAS NOT, ACCORDING TO CRITERIA PROMULGATED BY THE DEPARTMENT CONSISTENT WITH THIS TITLE, SUFFICIENT INCOME, OR IN THE CASE OF A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER, CERTIFIED BLIND, OR CERTIFIED DISABLED, SUFFICIENT INCOME AND RESOURCES, INCLUDING AVAILABLE SUPPORT FROM RESPONSIBLE RELATIVES, TO MEET ALL THE COSTS OF REQUIRED MEDICAL CARE AND SERVICES AVAILABLE UNDER THIS TITLE.

(D) CONDITIONS OF ELIGIBILITY. A PERSON SHALL NOT BE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE UNLESS HE OR SHE:

(1) IS A RESIDENT OF THE STATE, OR, WHILE TEMPORARILY IN THE STATE, REQUIRES IMMEDIATE MEDICAL CARE WHICH IS NOT OTHERWISE AVAILABLE, PROVIDED THAT SUCH PERSON DID NOT ENTER THE STATE FOR THE PURPOSE OF OBTAINING SUCH MEDICAL CARE; AND

(2) ASSIGNS TO THE APPROPRIATE SOCIAL SERVICES OFFICIAL OR TO THE DEPARTMENT, IN ACCORDANCE WITH DEPARTMENT REGULATIONS: (I) ANY BENEFITS WHICH ARE AVAILABLE TO HIM OR HER INDIVIDUALLY FROM ANY THIRD PARTY FOR CARE OR OTHER MEDICAL BENEFITS AVAILABLE UNDER THIS TITLE AND WHICH ARE OTHERWISE ASSIGNABLE PURSUANT TO A CONTRACT OR ANY AGREEMENT WITH SUCH THIRD PARTY; OR (II) ANY RIGHTS, OF THE INDIVIDUAL OR OF ANY OTHER PERSON WHO IS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE AND ON WHOSE BEHALF THE INDIVIDUAL HAS THE LEGAL AUTHORITY TO EXECUTE AN ASSIGNMENT OF SUCH RIGHTS, TO SUPPORT SPECIFIED AS SUPPORT FOR THE PURPOSE OF MEDICAL CARE BY A COURT OR ADMINISTRATIVE ORDER; AND

(3) COOPERATES WITH THE APPROPRIATE SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT IN ESTABLISHING PATERNITY OR IN ESTABLISHING, MODIFYING, OR ENFORCING A SUPPORT ORDER WITH RESPECT TO HIS OR HER CHILD; PROVIDED, HOWEVER, THAT NOTHING HEREIN CONTAINED SHALL BE CONSTRUED TO REQUIRE A PAYMENT UNDER THIS TITLE FOR CARE OR SERVICES, THE COST OF WHICH MAY BE MET IN WHOLE OR IN PART BY A THIRD PARTY; NOTWITHSTANDING THE FOREGOING, A SOCIAL SERVICES OFFICIAL SHALL NOT REQUIRE SUCH COOPERATION IF THE SOCIAL SERVICES OFFICIAL OR THE DEPARTMENT DETERMINES THAT SUCH ACTIONS

WOULD BE DETRIMENTAL TO THE BEST INTEREST OF THE CHILD, APPLICANT, OR RECIPIENT, OR WITH RESPECT TO PREGNANT WOMEN DURING PREGNANCY AND DURING THE SIXTY-DAY PERIOD BEGINNING ON THE LAST DAY OF PREGNANCY, IN ACCORDANCE WITH PROCEDURES AND CRITERIA ESTABLISHED BY REGULATIONS OF THE DEPARTMENT CONSISTENT WITH FEDERAL LAW; AND

(4) APPLIES FOR AND UTILIZES GROUP HEALTH INSURANCE BENEFITS AVAILABLE THROUGH A CURRENT OR FORMER EMPLOYER, INCLUDING BENEFITS FOR A SPOUSE AND DEPENDENT CHILDREN, IN ACCORDANCE WITH THE REGULATIONS OF THE DEPARTMENT.

(E) CONDITIONS OF COVERAGE. AN OTHERWISE ELIGIBLE PERSON SHALL NOT BE ENTITLED TO MEDICAL ASSISTANCE COVERAGE OF CARE, SERVICES, AND SUPPLIES UNDER THIS TITLE WHILE HE OR SHE:

(1) IS AN INMATE OR PATIENT IN AN INSTITUTION OR FACILITY WHEREIN MEDICAL ASSISTANCE MAY NOT BE PROVIDED IN ACCORDANCE WITH APPLICABLE FEDERAL OR STATE REQUIREMENTS, EXCEPT FOR PERSONS DESCRIBED IN SUBPARAGRAPH TEN OF PARAGRAPH (C) OF THIS SUBDIVISION OR SUBDIVISION ONE-A OR SUBDIVISION ONE-B OF THIS SECTION; OR

(2) IS A PATIENT IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE TREATMENT OF TUBERCULOSIS OR CARE OF THE MENTALLY DISABLED, WITH THE EXCEPTION OF: (I) A PERSON SIXTY-FIVE YEARS OF AGE OR OLDER AND A PATIENT IN ANY SUCH INSTITUTION; (II) A PERSON UNDER TWENTY-ONE YEARS OF AGE AND RECEIVING IN-PATIENT PSYCHIATRIC SERVICES IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE CARE OF THE MENTALLY DISABLED; (III) A PATIENT IN A PUBLIC INSTITUTION OPERATED PRIMARILY FOR THE CARE OF THE MENTALLY RETARDED WHO IS RECEIVING MEDICAL CARE OR TREATMENT IN THAT PART OF SUCH INSTITUTION THAT HAS BEEN APPROVED PURSUANT TO LAW AS A HOSPITAL OR NURSING HOME; (IV) A PATIENT IN AN INSTITUTION OPERATED BY THE STATE DEPARTMENT OF MENTAL HYGIENE, WHILE UNDER CARE IN A HOSPITAL ON RELEASE FROM SUCH INSTITUTION FOR THE PURPOSE OF RECEIVING CARE IN SUCH HOSPITAL; OR (V) IS A PERSON RESIDING IN A COMMUNITY RESIDENCE OR A RESIDENTIAL CARE CENTER FOR ADULTS.

S 2. Subdivision 4 of section 366 of the social services law is REPEALED and a new subdivision 4 is added to read as follows:

4. SPECIAL ELIGIBILITY PROVISIONS.

(A) TRANSITIONAL MEDICAL ASSISTANCE.

(1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, EACH FAMILY WHICH WAS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION IN AT LEAST ONE OF THE SIX MONTHS IMMEDIATELY PRECEDING THE MONTH IN WHICH SUCH FAMILY BECAME INELIGIBLE FOR SUCH ASSISTANCE BECAUSE OF INCOME FROM THE EMPLOYMENT OF THE CARETAKER RELATIVE SHALL, WHILE SUCH FAMILY INCLUDES A DEPENDENT CHILD, REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE FOR TWELVE CALENDAR MONTHS IMMEDIATELY FOLLOWING THE MONTH IN WHICH SUCH FAMILY WOULD OTHERWISE BE DETERMINED TO BE INELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO THE PROVISIONS OF THIS TITLE AND THE REGULATIONS OF THE DEPARTMENT GOVERNING INCOME AND RESOURCE LIMITATIONS RELATING TO ELIGIBILITY DETERMINATIONS FOR FAMILIES DESCRIBED IN SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION.

(2) (I) UPON GIVING NOTICE OF TERMINATION OF MEDICAL ASSISTANCE PROVIDED PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION, THE DEPARTMENT SHALL NOTIFY EACH SUCH FAMILY OF ITS RIGHTS TO EXTENDED BENEFITS UNDER SUBPARAGRAPH ONE OF THIS PARAGRAPH AND DESCRIBE THE CONDITIONS UNDER WHICH SUCH EXTENSION MAY BE TERMINATED.

(II) THE DEPARTMENT SHALL PROMULGATE REGULATIONS IMPLEMENTING THE REQUIREMENTS OF THIS SUBPARAGRAPH AND SUBPARAGRAPH ONE OF THIS PARAGRAPH RELATING TO THE CONDITIONS UNDER WHICH EXTENDED COVERAGE HEREUNDER MAY

BE TERMINATED, THE SCOPE OF COVERAGE, AND THE CONDITIONS UNDER WHICH COVERAGE MAY BE EXTENDED PENDING A REDETERMINATION OF ELIGIBILITY. SUCH REGULATIONS SHALL, AT A MINIMUM, PROVIDE FOR: TERMINATION OF SUCH COVERAGE AT THE CLOSE OF THE FIRST MONTH IN WHICH THE FAMILY CEASES TO INCLUDE A DEPENDENT CHILD; NOTICE OF TERMINATION PRIOR TO THE EFFECTIVE DATE OF ANY TERMINATIONS; COVERAGE UNDER EMPLOYEE HEALTH PLANS AND HEALTH MAINTENANCE ORGANIZATIONS; AND DISQUALIFICATION OF PERSONS FOR EXTENDED COVERAGE BENEFITS UNDER THIS PARAGRAPH FOR FRAUD.

(3) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, EACH FAMILY WHICH WAS ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION IN AT LEAST THREE OF THE SIX MONTHS IMMEDIATELY PRECEDING THE MONTH IN WHICH SUCH FAMILY BECAME INELIGIBLE FOR SUCH ASSISTANCE AS A RESULT, WHOLLY OR PARTLY, OF THE COLLECTION OR INCREASED COLLECTION OF SPOUSAL SUPPORT PURSUANT TO PART D OF TITLE IV OF THE FEDERAL SOCIAL SECURITY ACT, SHALL, FOR PURPOSES OF MEDICAL ASSISTANCE ELIGIBILITY, BE CONSIDERED TO BE ELIGIBLE FOR MEDICAL ASSISTANCE PURSUANT TO SUBPARAGRAPH FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION FOR AN ADDITIONAL FOUR CALENDAR MONTHS BEGINNING WITH THE MONTH INELIGIBILITY FOR SUCH ASSISTANCE BEGINS.

(B) PREGNANT WOMEN AND CHILDREN.

(1) A PREGNANT WOMAN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUBPARAGRAPH TWO OR FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION ON ANY DAY OF HER PREGNANCY WILL CONTINUE TO BE ELIGIBLE FOR SUCH CARE AND SERVICES THROUGH THE END OF THE MONTH IN WHICH THE SIXTIETH DAY FOLLOWING THE END OF THE PREGNANCY OCCURS, WITHOUT REGARD TO ANY CHANGE IN THE INCOME OF THE FAMILY THAT INCLUDES THE PREGNANT WOMAN, EVEN IF SUCH CHANGE OTHERWISE WOULD HAVE RENDERED HER INELIGIBLE FOR MEDICAL ASSISTANCE.

(2) A CHILD BORN TO A WOMAN ELIGIBLE FOR AND RECEIVING MEDICAL ASSISTANCE ON THE DATE OF THE CHILD'S BIRTH SHALL BE DEEMED TO HAVE APPLIED FOR MEDICAL ASSISTANCE AND TO HAVE BEEN FOUND ELIGIBLE FOR SUCH ASSISTANCE ON THE DATE OF SUCH BIRTH AND TO REMAIN ELIGIBLE FOR SUCH ASSISTANCE FOR A PERIOD OF ONE YEAR, SO LONG AS THE CHILD IS A MEMBER OF THE WOMAN'S HOUSEHOLD AND THE WOMAN REMAINS ELIGIBLE FOR SUCH ASSISTANCE OR WOULD REMAIN ELIGIBLE FOR SUCH ASSISTANCE IF SHE WERE PREGNANT.

(3) A CHILD UNDER THE AGE OF NINETEEN WHO IS DETERMINED ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THE PROVISIONS OF THIS SECTION, SHALL, CONSISTENT WITH APPLICABLE FEDERAL REQUIREMENTS, REMAIN ELIGIBLE FOR SUCH ASSISTANCE UNTIL THE EARLIER OF:

(I) THE LAST DAY OF THE MONTH WHICH IS TWELVE MONTHS FOLLOWING THE DETERMINATION OR REDETERMINATION OF ELIGIBILITY FOR SUCH ASSISTANCE; OR

(II) THE LAST DAY OF THE MONTH IN WHICH THE CHILD REACHES THE AGE OF NINETEEN.

(4) AN INFANT ELIGIBLE UNDER SUBPARAGRAPH TWO OR FOUR OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE THE CHILD ATTAINS ONE YEAR OF AGE, AND WHO, BUT FOR ATTAINING SUCH AGE, WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER SUCH SUBPARAGRAPH, SHALL CONTINUE TO REMAIN ELIGIBLE UNTIL THE END OF THE STAY FOR WHICH IN-PATIENT SERVICES ARE BEING FURNISHED.

(5) A CHILD ELIGIBLE UNDER SUBPARAGRAPH THREE OF PARAGRAPH (B) OF SUBDIVISION ONE OF THIS SECTION WHO IS RECEIVING MEDICALLY NECESSARY IN-PATIENT SERVICES FOR WHICH MEDICAL ASSISTANCE IS PROVIDED ON THE DATE THE CHILD ATTAINS NINETEEN YEARS OF AGE, AND WHO, BUT FOR ATTAINING SUCH AGE, WOULD REMAIN ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH,

SHALL CONTINUE TO REMAIN ELIGIBLE UNTIL THE END OF THE STAY FOR WHICH IN-PATIENT SERVICES ARE BEING FURNISHED.

(6) A WOMAN WHO WAS PREGNANT WHILE IN RECEIPT OF MEDICAL ASSISTANCE WHO SUBSEQUENTLY LOSES HER ELIGIBILITY FOR MEDICAL ASSISTANCE SHALL HAVE HER ELIGIBILITY FOR MEDICAL ASSISTANCE CONTINUED FOR A PERIOD OF TWENTY-FOUR MONTHS FROM THE END OF THE MONTH IN WHICH THE SIXTIETH DAY FOLLOWING THE END OF HER PREGNANCY OCCURS, BUT ONLY FOR FEDERAL TITLE X SERVICES WHICH ARE ELIGIBLE FOR REIMBURSEMENT BY THE FEDERAL GOVERNMENT AT A RATE OF NINETY PERCENT; PROVIDED, HOWEVER, THAT SUCH NINETY PERCENT LIMITATION SHALL NOT APPLY TO THOSE SERVICES IDENTIFIED BY THE COMMISSIONER AS SERVICES, INCLUDING TREATMENT FOR SEXUALLY TRANSMITTED DISEASES, GENERALLY PERFORMED AS PART OF OR AS A FOLLOW-UP TO A SERVICE ELIGIBLE FOR SUCH NINETY PERCENT REIMBURSEMENT; AND PROVIDED FURTHER, HOWEVER, THAT NOTHING IN THIS PARAGRAPH SHALL BE DEEMED TO AFFECT PAYMENT FOR SUCH TITLE X SERVICES IF FEDERAL FINANCIAL PARTICIPATION IS NOT AVAILABLE FOR SUCH CARE, SERVICES AND SUPPLIES.

(C) CONTINUOUS COVERAGE FOR ADULTS. NOTWITHSTANDING ANY OTHER PROVISION OF LAW, A PERSON WHOSE ELIGIBILITY FOR MEDICAL ASSISTANCE IS BASED ON THE MODIFIED ADJUSTED GROSS INCOME OF THE PERSON OR THE PERSON'S HOUSEHOLD, AND WHO LOSES ELIGIBILITY FOR SUCH ASSISTANCE FOR A REASON OTHER THAN CITIZENSHIP STATUS, LACK OF STATE RESIDENCE, OR FAILURE TO PROVIDE A VALID SOCIAL SECURITY NUMBER, BEFORE THE END OF A TWELVE MONTH PERIOD BEGINNING ON THE EFFECTIVE DATE OF THE PERSON'S INITIAL ELIGIBILITY FOR SUCH ASSISTANCE, OR BEFORE THE END OF A TWELVE MONTH PERIOD BEGINNING ON THE DATE OF ANY SUBSEQUENT DETERMINATION OF ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME, SHALL HAVE HIS OR HER ELIGIBILITY FOR SUCH ASSISTANCE CONTINUED UNTIL THE END OF SUCH TWELVE MONTH PERIOD, PROVIDED THAT FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH ASSISTANCE IS AVAILABLE.

(D) BREAST AND CERVICAL CANCER TREATMENT.

(1) PERSONS WHO ARE NOT ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THE TERMS OF SECTION 1902(A)(10)(A)(I) OF THE FEDERAL SOCIAL SECURITY ACT ARE ELIGIBLE FOR MEDICAL ASSISTANCE COVERAGE DURING THE TREATMENT OF BREAST OR CERVICAL CANCER, SUBJECT TO THE PROVISIONS OF THIS PARAGRAPH.

(2) (I) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO ARE UNDER SIXTY-FIVE YEARS OF AGE, HAVE BEEN SCREENED FOR BREAST AND/OR CERVICAL CANCER UNDER THE CENTERS FOR DISEASE CONTROL AND PREVENTION BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM AND NEED TREATMENT FOR BREAST OR CERVICAL CANCER, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT; PROVIDED HOWEVER THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS CLAUSE ONLY TO THE EXTENT PERMITTED UNDER FEDERAL LAW, IF, FOR SO LONG AS, AND TO THE EXTENT THAT FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE THEREFOR.

(II) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO MEET THE REQUIREMENTS OF CLAUSE (I) OF THIS SUBPARAGRAPH BUT FOR THEIR AGE AND/OR GENDER, WHO HAVE BEEN SCREENED FOR BREAST AND/OR CERVICAL CANCER UNDER THE PROGRAM DESCRIBED IN TITLE ONE-A OF ARTICLE TWENTY-FOUR OF THE PUBLIC HEALTH LAW AND NEED TREATMENT FOR BREAST OR CERVICAL CANCER, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT; PROVIDED HOWEVER THAT MEDICAL ASSISTANCE SHALL BE FURNISHED PURSUANT TO THIS CLAUSE ONLY IF AND FOR SO LONG AS THE PROVISIONS OF CLAUSE (I) OF THIS SUBPARAGRAPH ARE IN EFFECT.

(3) MEDICAL ASSISTANCE PROVIDED TO A PERSON UNDER THIS PARAGRAPH SHALL BE LIMITED TO THE PERIOD IN WHICH SUCH PERSON REQUIRES TREATMENT FOR BREAST OR CERVICAL CANCER.

(4) (I) THE COMMISSIONER OF HEALTH SHALL PROMULGATE SUCH REGULATIONS AS MAY BE NECESSARY TO CARRY OUT THE PROVISIONS OF THIS PARAGRAPH. SUCH REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO: ELIGIBILITY REQUIREMENTS; A DESCRIPTION OF THE MEDICAL SERVICES WHICH ARE COVERED; AND A PROCESS FOR PROVIDING PRESUMPTIVE ELIGIBILITY WHEN A QUALIFIED ENTITY, AS DEFINED BY THE COMMISSIONER, DETERMINES ON THE BASIS OF PRELIMINARY INFORMATION THAT A PERSON MEETS THE REQUIREMENTS FOR ELIGIBILITY UNDER THIS PARAGRAPH.

(II) FOR PURPOSES OF DETERMINING ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH, RESOURCES AVAILABLE TO SUCH INDIVIDUAL SHALL NOT BE CONSIDERED NOR REQUIRED TO BE APPLIED TOWARD THE PAYMENT OR PART PAYMENT OF THE COST OF MEDICAL CARE, SERVICES AND SUPPLIES AVAILABLE UNDER THIS PARAGRAPH.

(III) AN INDIVIDUAL SHALL BE ELIGIBLE FOR PRESUMPTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH IN ACCORDANCE WITH SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(5) THE COMMISSIONER OF HEALTH SHALL, CONSISTENT WITH THIS TITLE, MAKE ANY NECESSARY AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE SUBMITTED PURSUANT TO SECTION THREE HUNDRED SIXTY-THREE-A OF THIS TITLE, IN ORDER TO ENSURE FEDERAL FINANCIAL PARTICIPATION IN EXPENDITURES UNDER THIS PARAGRAPH. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, THE PROVISIONS OF CLAUSE (I) OF SUBPARAGRAPH TWO OF THIS PARAGRAPH SHALL BE EFFECTIVE ONLY IF AND FOR SO LONG AS FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE IN THE COSTS OF MEDICAL ASSISTANCE FURNISHED THEREUNDER.

(E) COLON AND PROSTATE CANCER TREATMENT.

(1) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, A PERSON WHO HAS BEEN SCREENED OR REFERRED FOR SCREENING FOR COLON OR PROSTATE CANCER BY THE CANCER SERVICES SCREENING PROGRAM, AS ADMINISTERED BY THE DEPARTMENT OF HEALTH, AND HAS BEEN DIAGNOSED WITH COLON OR PROSTATE CANCER IS ELIGIBLE FOR MEDICAL ASSISTANCE FOR THE DURATION OF HIS OR HER TREATMENT FOR SUCH CANCER.

(2) PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH SHALL HAVE AN INCOME OF TWO HUNDRED FIFTY PERCENT OR LESS OF THE COMPARABLE FEDERAL INCOME OFFICIAL POVERTY LINE AS DEFINED AND ANNUALLY REVISED BY THE FEDERAL OFFICE OF MANAGEMENT AND BUDGET.

(3) AN INDIVIDUAL SHALL BE ELIGIBLE FOR PRESUMPTIVE ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS PARAGRAPH IN ACCORDANCE WITH SUBDIVISION FIVE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE.

(4) MEDICAL ASSISTANCE IS AVAILABLE UNDER THIS PARAGRAPH TO PERSONS WHO ARE UNDER SIXTY-FIVE YEARS OF AGE, AND ARE NOT OTHERWISE COVERED UNDER CREDITABLE COVERAGE AS DEFINED IN THE FEDERAL PUBLIC HEALTH SERVICE ACT.

S 3. Paragraph (a) of subdivision 4 of section 364-i of the social services law, as added by section 29-a of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law to the contrary, a child shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determine, on the basis of preliminary information, that the [net] MAGI household income of the child does not exceed the applicable level for eligibility as provided for pursuant to SUBPARAGRAPH TWO OR THREE OF paragraph [(u)] (B) of subdivision [four] ONE of section three hundred sixty-six of this title.

S 4. Paragraph (a) of subdivision 5 of section 364-i of the social services law, as added by chapter 176 of the laws of 2006, is amended to read as follows:

(a) An individual shall be presumed to be eligible for medical assistance under this title beginning on the date that a qualified entity, as defined in paragraph (c) of this subdivision, determines, on the basis of preliminary information, that the individual meets the requirements of paragraph [(v) or (v-1)] (D) OR (E) of subdivision four of section three hundred sixty-six of this title.

S 5. Subdivision 6 of section 364-i of the social services law, as added by chapter 484 of the laws of 2009 and paragraph (a-2) as added by section 76 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

6. (a) A pregnant woman shall be presumed to be eligible for [coverage of services described in paragraph (c) of this subdivision] MEDICAL ASSISTANCE UNDER THIS TITLE, EXCLUDING INPATIENT SERVICES AND INSTITUTIONAL LONG TERM CARE, beginning on the date that a prenatal care provider, licensed under article twenty-eight of the public health law or other prenatal care provider approved by the department of health determines, on the basis of preliminary information, that the pregnant woman's [family has: (i) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that does not exceed two hundred thirty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size, or (ii) in the absence of such approval, net income that does not exceed two hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size.] MAGI HOUSEHOLD INCOME DOES NOT EXCEED THE MAGI-EQUIVALENT OF TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE.

(a-2) At the time of application for presumptive eligibility pursuant to this subdivision, a pregnant woman who resides in a social services district that has implemented the state's managed care program pursuant to section three hundred sixty-four-j of this title must choose a managed care provider. If a managed care provider is not chosen at the time of application, the pregnant woman will be assigned to a managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of paragraph (f) of subdivision four of section three hundred sixty-four-j of this title.

(b) Such presumptive eligibility shall continue through the earlier of: the day on which eligibility is determined pursuant to this title; or the last day of the month following the month in which the provider makes preliminary determination, in the case of a pregnant woman who does not file an application for medical assistance on or before such day.

(c) [A presumptively eligible pregnant woman is eligible for coverage of:

(i) all medical care, services, and supplies available under the medical assistance program, excluding inpatient services and institutional long term care, if the woman's family has: (A) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that does not exceed one hundred twenty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size, or (B) in the absence of such approval, net income that does not

exceed one hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size; or

(ii) prenatal care services as described in subparagraph four of paragraph (o) of subdivision four of section three hundred sixty-six of this title, if the woman's family has: (A) subject to the approval of the federal Centers for Medicare and Medicaid Services, gross income that exceeds one hundred twenty percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for families of the same size, but does not exceed two hundred thirty percent of such federal poverty line, or (B) in the absence of such approval, net income that exceeds one hundred percent but does not exceed two hundred percent of the federal poverty line (as defined and annually revised by the United States department of health and human services) for a family of the same size.

(d)] The department of health shall provide prenatal care providers licensed under article twenty-eight of the public health law and other approved prenatal care providers with such forms as are necessary for a pregnant woman to apply and information on how to assist such women in completing and filing such forms. A qualified provider which determines that a pregnant woman is presumptively eligible shall notify the social services district in which the pregnant woman resides of the determination within five working days after the date on which such determination is made and shall inform the woman at the time the determination is made that she is required to make application by the last day of the month following the month in which the determination is made.

[(e)] (D) Notwithstanding any other provision of law, care that is furnished to a pregnant woman pursuant to this subdivision during a presumptive eligibility period shall be deemed as medical assistance for purposes of payment and state reimbursement.

[(f)] (E) Facilities licensed under article twenty-eight of the public health law providing prenatal care services shall perform presumptive eligibility determinations and assist women in submitting appropriate documentation to the social services district as required by the commissioner; provided, however, that a facility may apply to the commissioner for exemption from this requirement on the basis of undue hardship.

[(g)] (F) All prenatal care providers enrolled in the medicaid program must provide prenatal care services to eligible service recipients determined presumptively eligible for medical assistance but not yet enrolled in the medical assistance program, and assist women in submitting appropriate documentation to the social services district as required by the commissioner.

S 6. Subdivision 1 and the opening paragraph of subdivision 2 of section 365-a of the social services law, subdivision 1 as amended by chapter 110 of the laws of 1971 and the opening paragraph of subdivision 2 as amended by chapter 41 of the laws of 1992, are amended to read as follows:

[1.] The amount, nature and manner of providing medical assistance for needy persons shall be determined by the public welfare official with the advice of a physician and in accordance with the local medical plan, this title, and the regulations of the department.

1. "BENCHMARK COVERAGE" SHALL MEAN PAYMENT OF PART OR ALL OF THE COST OF MEDICALLY NECESSARY MEDICAL, DENTAL, AND REMEDIAL CARE, SERVICES, AND SUPPLIES DESCRIBED IN SUBDIVISION TWO OF THIS SECTION, AND TO THE EXTENT NOT INCLUDED THEREIN, ANY ESSENTIAL BENEFITS AS DEFINED IN 42 U.S.C. 18022(B), WITH THE EXCEPTION OF INSTITUTIONAL LONG TERM CARE SERVICES;

SUCH CARE, SERVICES AND SUPPLIES SHALL BE PROVIDED CONSISTENT WITH THE MANAGED CARE PROGRAM DESCRIBED IN SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE.

["Medical assistance"] "STANDARD COVERAGE" shall mean payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies, as authorized in this title or the regulations of the department, which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with this title and the regulations of the department. Such care, services and supplies shall include the following medical care, services and supplies, together with such medical care, services and supplies provided for in subdivisions three, four and five of this section, and such medical care, services and supplies as are authorized in the regulations of the department:

S 7. Subdivision 1 of section 366-a of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

1. Any person requesting medical assistance may make application therefor [in person, through another in his behalf or by mail] BY A WRITTEN APPLICATION to the social services official of the county[, city or town, or to the service officer of the city or town] in which the applicant resides or is found OR TO THE DEPARTMENT OF HEALTH OR ITS AGENT; A PHONE APPLICATION; OR AN ON-LINE APPLICATION. [In addition, in the case of a person who is sixty-five years of age or older and is a patient in a state hospital for tuberculosis or for the mentally disabled, applications may be made to the department or to a social services official designated as the agent of the department.] Notwithstanding any provision of law to the contrary, [a personal] AN IN-PERSON interview with the applicant or with the person who made application on his or her behalf shall not be required as part of a determination of initial or continuing eligibility pursuant to this title.

S 8. Paragraph (a) of subdivision 2 of section 366-a of the social services law, as amended by section 60 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

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

S 9. The opening paragraph of subdivision 3 of section 366-a of the social services law, as added by chapter 256 of the laws of 1966, is amended to read as follows:

Upon the receipt of such application, and after the completion of any investigation that shall be deemed necessary, the appropriate [public welfare] SOCIAL SERVICES official[,] or the department OF HEALTH or its agent [when the applicant is a patient in a state hospital for tuberculosis or for the mentally disabled,] shall

S 10. Paragraphs (b) and (c) of subdivision 5 of section 366-a of the social services law, as added by section 52 of part A of chapter 1 of the laws of 2002, are amended to read as follows:

(b) The commissioner shall develop a simplified statewide recertification form for use in redetermining eligibility under this title. The form [shall] MAY include requests only for such information that is:

(i) reasonably necessary to determine continued eligibility for medical assistance under this title; and

(ii) subject to change since the date of the recipient's initial application.

(c) [A personal] THE REGULATIONS REQUIRED BY PARAGRAPH (A) OF THIS SUBDIVISION SHALL PROVIDE THAT:

(I) THE REDETERMINATION OF ELIGIBILITY WILL BE MADE BASED ON RELIABLE INFORMATION POSSESSED OR AVAILABLE TO THE DEPARTMENT OF HEALTH OR ITS AGENT, INCLUDING INFORMATION ACCESSED FROM DATABASES PURSUANT TO SUBDIVISION EIGHT OF THIS SECTION;

(II) IF THE DEPARTMENT OF HEALTH OR ITS AGENT IS UNABLE TO RENEW ELIGIBILITY BASED ON AVAILABLE INFORMATION, THE RECIPIENT WILL BE REQUESTED TO SUPPLY ANY SUCH INFORMATION AS IS NECESSARY TO DETERMINE CONTINUED ELIGIBILITY FOR MEDICAL ASSISTANCE UNDER THIS TITLE; AND

(III) FOR PERSONS WHOSE MEDICAL ASSISTANCE ELIGIBILITY IS BASED ON MODIFIED ADJUSTED GROSS INCOME, ELIGIBILITY MUST BE RENEWED AT LEAST ONCE EVERY TWELVE MONTHS, UNLESS THE DEPARTMENT OF HEALTH OR ITS AGENT RECEIVES INFORMATION ABOUT A CHANGE IN A RECIPIENT'S CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY.

(D) AN IN-PERSON interview with the recipient shall not AUTOMATICALLY be required as part of a redetermination of eligibility pursuant to this subdivision UNLESS THE DEPARTMENT OF HEALTH DETERMINES OTHERWISE.

S 11. Paragraph (d) of subdivision 5 of section 366-a of the social services law is REPEALED.

S 12. Paragraph (e) of subdivision 5 of section 366-a of the social services law, as added by section 1 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

[(e)] (D) The commissioner of health shall verify the accuracy of the information provided by [the] AN APPLICANT OR recipient [pursuant to paragraph (d) of this subdivision] by matching it against information to which the commissioner of health has access, including under subdivision eight of this section. In the event [there is an inconsistency between] the information reported by the recipient [and] IS NOT REASONABLY COMPATIBLE WITH any information obtained by the commissioner of health from other sources and such [inconsistency] INCOMPATIBILITY is material to medical assistance eligibility, the commissioner of health shall request that the recipient provide adequate documentation to verify his or her place of residence or income, as applicable. In addition to the documentation of residence and income authorized by this paragraph, the commissioner of health is authorized to periodically require a reasonable sample of recipients to provide documentation of residence and income at recertification. The commissioner of health shall consult with

the medicaid inspector general regarding income and residence verification practices and procedures necessary to maintain program integrity and deter fraud and abuse.

S 13. Subdivision 11 of section 364-j of the social services law is REPEALED.

S 14. Clause (D) of subparagraph (v) of paragraph (a) of subdivision 2 of section 369-ee of the social services law, as amended by section 67 of part C of chapter 58 of the laws of 2009, is amended, and a new subparagraph (vi) is added to read as follows:

(D) is not described in clause (A), (B) or (C) of this subparagraph and has gross family income equal to or less than two hundred percent of the federal income official poverty line (as defined and updated by the United States Department of Health and Human Services) for a family of the same size; provided, however, that eligibility under this clause is subject to sources of federal and non-federal funding for such purpose described in section sixty-seven-a of [the] PART C OF chapter FIFTY-EIGHT of the laws of two thousand nine [that added this clause] or as may be available under the waiver agreement entered into with the federal government under section eleven hundred fifteen of the federal social security act, as jointly determined by the commissioner and the director of the division of the budget. In no case shall state funds be utilized to support the non-federal share of expenditures pursuant to this subparagraph, provided however that the commissioner may demonstrate to the United States department of health and human services the existence of non-federally participating state expenditures as necessary to secure federal funding under an eleven hundred fifteen waiver for the purposes herein. Eligibility under this clause may be provided to residents of all counties or, at the joint discretion of the commissioner and the director of the division of the budget, a subset of counties of the state[.]; AND

(VI) MAKES APPLICATION FOR BENEFITS PURSUANT TO THIS TITLE ON OR BEFORE DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN.

S 14-a. Subdivision 5 of section 369-ee of the social services law is amended by adding a new paragraph (d) to read as follows:

(D) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPH (A) OF THIS SUBDIVISION OR ANY OTHER PROVISION OF LAW, IN THE CASE OF A PERSON RECEIVING HEALTH CARE SERVICES PURSUANT TO THIS TITLE ON JANUARY FIRST, TWO THOUSAND FOURTEEN, SUCH PERSON'S ELIGIBILITY SHALL BE RECERTIFIED AS SOON AS PRACTICABLE THEREAFTER, AND SUCH PERSON'S COVERAGE UNDER THIS TITLE SHALL END ON THE EARLIEST OF: (I) THE DATE THE PERSON IS ENROLLED IN A QUALIFIED HEALTH PLAN OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTABLISHED IN ACCORDANCE WITH THE REQUIREMENTS OF THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION ACT OF 2010 (P.L. 111-152); (II) DECEMBER THIRTY-FIRST, TWO THOUSAND FOURTEEN; OR (III) THE DATE ON WHICH THE DEPARTMENT OF HEALTH CEASES TO HAVE ALL NECESSARY APPROVALS UNDER FEDERAL LAW AND REGULATION TO RECEIVE FEDERAL FINANCIAL PARTICIPATION, UNDER THE PROGRAM DESCRIBED IN TITLE ELEVEN OF THIS ARTICLE, IN THE COSTS OF HEALTH SERVICES PROVIDED PURSUANT TO THIS SECTION.

S 15. Section 369-ee of the social services law is REPEALED.

S 15-a. Section 369-ff of the social services law is REPEALED.

S 16. Subdivision 3 of section 367-a of the social services law is amended by adding a new paragraph (e) to read as follows:

(E) (1) PAYMENT OF PREMIUMS FOR ENROLLING INDIVIDUALS IN QUALIFIED HEALTH PLANS OFFERED THROUGH A HEALTH INSURANCE EXCHANGE ESTABLISHED PURSUANT TO THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L.

111-148), AS AMENDED BY THE FEDERAL HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152), SHALL BE AVAILABLE TO INDIVIDUALS WHO:

(I) IMMEDIATELY PRIOR TO BEING ENROLLED IN THE QUALIFIED HEALTH PLAN, WERE OR WOULD HAVE BEEN ELIGIBLE UNDER THE FAMILY HEALTH PLUS PROGRAM AS A PARENT OR STEPPARENT OF A CHILD UNDER THE AGE OF TWENTY-ONE, AND WHOSE MAGI HOUSEHOLD INCOME, AS DEFINED IN SUBPARAGRAPH EIGHT OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE, EXCEEDS ONE HUNDRED THIRTY-THREE PERCENT OF THE FEDERAL POVERTY LINE FOR THE APPLICABLE FAMILY SIZE;

(II) ARE NOT OTHERWISE ELIGIBLE FOR MEDICAL ASSISTANCE UNDER THIS TITLE; AND

(III) ARE ENROLLED IN A STANDARD HEALTH PLAN IN THE SILVER LEVEL, AS DEFINED IN 42 U.S.C. 18022.

(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.

(3) THE COMMISSIONER OF HEALTH SHALL SUBMIT AMENDMENTS TO THE STATE PLAN FOR MEDICAL ASSISTANCE AND/OR SUBMIT ONE OR MORE APPLICATIONS FOR WAIVERS OF THE FEDERAL SOCIAL SECURITY ACT AS MAY BE NECESSARY TO RECEIVE FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF PAYMENTS MADE PURSUANT TO THIS PARAGRAPH; PROVIDED FURTHER, HOWEVER, THAT NOTHING IN THIS SUBPARAGRAPH SHALL BE DEEMED TO AFFECT PAYMENTS FOR PREMIUMS PURSUANT TO THIS PARAGRAPH IF FEDERAL FINANCIAL PARTICIPATION IN THE COSTS OF SUCH PAYMENTS IS NOT AVAILABLE.

S 16-a. (a) The commissioner of health shall convene a workgroup to consider issues pertaining to the federal option to establish a basic health program for individuals who are not eligible for medical assistance under title eleven of article five of the social services law.

(b) The workgroup shall: evaluate federal guidance related to basic health programs; discuss fiscal, consumer, and health care impacts of a basic health program; and consider benefit package, premium and cost-sharing options for a basic health program.

S 17. Section 2510 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. "HOUSEHOLD INCOME" MEANS THE SUM OF THE MODIFIED ADJUSTED GROSS INCOME OF EVERY INDIVIDUAL INCLUDED IN A CHILD'S HOUSEHOLD CALCULATED IN ACCORDANCE WITH APPLICABLE FEDERAL LAW AND REGULATIONS, AS MAY BE AMENDED.

S 18. Section 2510 of the public health law is amended by adding two new subdivisions 14 and 15 to read as follows:

14. "STATE ENROLLMENT CENTER" MEANS THE CENTRALIZED SYSTEM AND OPERATION OF ELIGIBILITY DETERMINATIONS BY THE STATE OR ITS CONTRACTOR FOR ALL INSURANCE AFFORDABILITY PROGRAMS, INCLUDING THE CHILD HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO THIS TITLE.

15. "INSURANCE AFFORDABILITY PROGRAMS" MEANS THOSE PROGRAMS SET FORTH IN SECTION 435.4 OF TITLE 42 OF THE CODE OF FEDERAL REGULATIONS.

S 19. Subparagraphs (iv) and (vi) of paragraph (f) of subdivision 2 of section 2511 of the public health law, subparagraph (iv) as added by section 44 of part A of chapter 1 of the laws of 2002 and subparagraph (vi) as added by section 45-b of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(iv) In the event a household does not provide income documentation required by subparagraph (iii) of this paragraph within two months of the approved organization's OR STATE ENROLLMENT CENTER'S request, WHICHEVER IS APPLICABLE, the approved organization OR STATE ENROLLMENT CENTER shall disenroll the child at the end of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments made by the state on behalf of children enrolled during this two month period.

(vi) Any income verification response by the department of taxation and finance pursuant to subparagraphs (i) and (ii) of this paragraph shall not be a public record and shall not be released by the commissioner, the department of taxation and finance [or], an approved organization, OR THE STATE ENROLLMENT CENTER, except pursuant to this paragraph. Information disclosed pursuant to this paragraph shall be limited to information necessary for verification. Information so disclosed shall be kept confidential by the party receiving such information. Such information shall be expunged within a reasonable time to be determined by the commissioner and the department of taxation and finance.

S 20. Paragraph (j) of subdivision 2 of section 2511 of the public health law, as added by section 45 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(j) Where an application for recertification of coverage under this title contains insufficient information for a final determination of eligibility for continued coverage, a child shall be presumed eligible for a period not to exceed the earlier of two months beyond the preceding period of eligibility or the date upon which a final determination of eligibility is made based on the submission of additional data. In the event such additional information is not submitted within two months of the approved organization's OR STATE ENROLLMENT CENTER'S request, WHICHEVER IS APPLICABLE, the approved organization OR STATE ENROLLMENT CENTER shall disenroll the child following the expiration of such two month period. Except as provided in paragraph (c) of subdivision five-a of this section, approved organizations shall not be obligated to repay subsidy payments received on behalf of children enrolled during this two month period.

S 21. Subdivision 4 of section 2511 of the public health law, as amended by section 70 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

4. Households shall report to the approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, within thirty days, any changes in New York state residency or health care coverage under insurance that may make a child ineligible for subsidy payments pursuant to this section. Any individual who, with the intent to obtain benefits, willfully misstates income or residence to establish eligibility pursuant to subdivision two of this section or willfully fails to notify an approved organization OR STATE ENROLLMENT CENTER of a change in residence or health care coverage pursuant to this subdivision shall repay such subsidy to the commissioner. Individuals seeking to enroll children for coverage shall be informed that such willful misstatement or failure to notify shall result in such liability.

S 22. The subdivision heading and paragraphs (a) and (b) of subdivision 5-a of section 2511 of the public health law, the subdivision heading and paragraph (a) as added by chapter 170 of the laws of 1994 and paragraph (b) as amended by section 71 of part B of chapter 58 of the laws of 2005, are amended to read as follows:

Obligations of approved organizations OR THE STATE ENROLLMENT CENTER. (a) An approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, shall have the obligation to review all information provided pursuant to subdivision two of this section and shall not certify or recertify a child as eligible for a subsidy payment unless the child meets the eligibility criteria.

(b) An approved organization OR STATE ENROLLMENT CENTER, WHICHEVER IS APPLICABLE, shall promptly review all information relating to a potential change in eligibility based on information provided pursuant to subdivision four of this section. Within at least thirty days after receipt of such information, the approved organization OR STATE ENROLLMENT CENTER shall make a determination whether the child is still eligible for a subsidy payment and shall notify the household and the commissioner if it determines the child is not eligible for a subsidy payment.

S 23. Paragraph (a) of subdivision 11 of section 2511 of the public health law, as amended by section 37 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(a) An approved organization shall submit required reports and information to the commissioner in such form and at times, at least annually, as may be required by the commissioner and specified in contracts and official department of health administrative guidance, in order to evaluate the operations and results of the program and quality of care being provided by such organizations. Such reports and information shall include, but not be limited to, enrollee demographics (APPLICABLE ONLY UNTIL THE STATE ENROLLMENT CENTER IS IMPLEMENTED), program utilization and expense, patient care outcomes and patient specific medical information, including encounter data maintained by an approved organization for purposes of quality assurance and oversight. Any information or data collected pursuant to this paragraph shall be kept confidential in accordance with Title XXI of the federal social security act or any other applicable state or federal law.

S 24. Subdivision 12 of section 2511 of the public health law, as amended by chapter 2 of the laws of 1998, is amended to read as follows:

12. The commissioner shall, in consultation with the superintendent, establish procedures to coordinate the child health insurance plan with the medical assistance program, including but not limited to, procedures to maximize enrollment of eligible children under those programs by identification and transfer of children who are eligible or who become eligible to receive medical assistance and procedures to facilitate changes in enrollment status for children who are ineligible for subsidies under this section and for children who are no longer eligible for medical assistance in order to facilitate and ensure continuity of coverage. The commissioner shall review, on an annual basis, the eligibility verification and recertification procedures of approved organizations under this title to insure the appropriate enrollment of children. Such review shall include, but not be limited to, an audit of a statistically representative sample of cases from among all approved organizations AND SHALL BE APPLICABLE TO ANY PERIOD DURING WHICH AN APPROVED ORGANIZATION'S RESPONSIBILITIES INCLUDE DETERMINING ELIGIBILITY. In the event such review and audit reveals cases which do not meet the eligibility criteria for coverage set forth in this section, that information shall be forwarded to the approved organization and the commissioner for appropriate action.

S 25. Paragraph (e) of subdivision 12-a of section 2511 of the public health law, as added by chapter 2 of the laws of 1998, is amended and a new paragraph (f) is added to read as follows:

(e) standards and procedures for the imposition of penalties for substantial noncompliance, which may include, but not be limited to, financial penalties in addition to penalties set forth in section twelve of this chapter and consistent with applicable federal standards, as specified in contracts, and contract termination[.]; PROVIDED HOWEVER

(F) AUDIT STANDARDS AND PROCEDURES ESTABLISHED PURSUANT TO THIS SECTION, INCLUDING PENALTIES, SHALL BE APPLICABLE TO ELIGIBILITY DETERMINATIONS MADE BY APPROVED ORGANIZATIONS ONLY FOR PERIODS DURING WHICH AN APPROVED ORGANIZATION'S RESPONSIBILITIES INCLUDE MAKING SUCH ELIGIBILITY DETERMINATIONS.

S 26. Paragraph (e) and subparagraphs (i), (ii), (iii) and (v) of paragraph (f) of subdivision 2 of section 2511 of the public health law, paragraph (e) as added by chapter 170 of the laws of 1994 and relettered by chapter 2 of the laws of 1998, and subparagraphs (i) and (ii) of paragraph (f) as amended by section 6 of part B of chapter 58 of the laws of 2010, subparagraph (iii) of paragraph (f) as amended by chapter 535 of the laws of 2010, and subparagraph (v) of paragraph (f) as amended by section 7 of part J of chapter 82 of the laws of 2002, are amended to read as follows:

(e) is a resident of New York state. Such residency shall be [demonstrated by] ATTESTED TO BY THE APPLICANT FOR INSURANCE, PROVIDED HOWEVER, THE COMMISSIONER SHALL REQUIRE adequate proof[, as determined by the commissioner,] of a New York state street address IN CIRCUMSTANCES WHEN THERE IS AN INCONSISTENCY WITH RESIDENCY INFORMATION FROM OTHER DATA SOURCES. [If the child has no street address, such proof may include, but not be limited to, school records or other documentation determined by the commissioner.]

(i) In order to establish income eligibility under this subdivision at initial application, a household shall provide [such documentation specified in subparagraph (iii) of this paragraph, as necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title] THE SOCIAL SECURITY NUMBERS FOR EACH PARENT AND LEGALLY RESPONSIBLE ADULT WHO IS A MEMBER OF THE HOUSEHOLD, SUBJECT TO SUBPARAGRAPH (V) OF THIS PARAGRAPH. The commissioner [may verify the accuracy of such income information provided by the household by matching it against] SHALL DETERMINE ELIGIBILITY BASED ON income information contained in databases to which the commissioner has access, including the state's wage reporting system pursuant to subdivision five of section one hundred seventy-one-a of the tax law and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law. THE COMMISSIONER SHALL REQUIRE AN ATTESTATION BY THE HOUSEHOLD THAT THE INCOME INFORMATION OBTAINED FROM ELECTRONIC DATA SOURCES IS ACCURATE. SUCH ATTESTATION SHALL INCLUDE ANY OTHER HOUSEHOLD INCOME INFORMATION NOT OBTAINED FROM AN ELECTRONIC DATA SOURCE THAT IS NECESSARY TO DETERMINE A CHILD'S FINANCIAL ELIGIBILITY FOR A SUBSIDY PAYMENT UNDER THIS TITLE. IF THE ATTESTATION IS REASONABLY COMPATIBLE WITH INFORMATION OBTAINED FROM AVAILABLE DATA SOURCES, NO FURTHER INFORMATION OR DOCUMENTATION IS REQUIRED. IF THE ATTESTATION IS NOT REASONABLY COMPATIBLE WITH INFORMATION OBTAINED FROM AVAILABLE DATA SOURCES, DOCUMENTATION SHALL BE REQUIRED AS SPECIFIED IN SUBPARAGRAPH (III) OF THIS PARAGRAPH.

(ii) In order to establish income eligibility under this subdivision at recertification, [a household shall attest to all information regarding the household's income that is necessary and sufficient to determine a child's financial eligibility for a subsidy payment under this title

and shall provide the social security numbers for each parent and legally responsible adult who is a member of the household and whose income is available to the child, subject to subparagraph (v) of this paragraph. The] THE commissioner [may verify the accuracy of such income information provided by the household by matching it against income] MAY MAKE A REDETERMINATION OF ELIGIBILITY WITHOUT REQUIRING INFORMATION FROM THE INDIVIDUAL IF ABLE TO DO SO BASED ON RELIABLE INFORMATION CONTAINED IN THE INDIVIDUAL'S ENROLLMENT FILE OR OTHER MORE CURRENT information contained in databases to which the commissioner has access, including the state's wage reporting system and by means of an income verification performed pursuant to a cooperative agreement with the department of taxation and finance pursuant to subdivision four of section one hundred seventy-one-b of the tax law. THE COMMISSIONER SHALL REQUIRE AN ATTESTATION BY THE HOUSEHOLD THAT THE INCOME INFORMATION CONTAINED IN THE ENROLLMENT FILE OR OBTAINED FROM ELECTRONIC DATA SOURCES IS ACCURATE. SUCH ATTESTATION SHALL INCLUDE ANY OTHER HOUSEHOLD INCOME INFORMATION NOT OBTAINED FROM AN ELECTRONIC DATA SOURCE THAT IS NECESSARY TO REDETERMINE A CHILD'S FINANCIAL ELIGIBILITY FOR A SUBSIDY PAYMENT UNDER THIS TITLE. In the event that there is an inconsistency between the income information attested to by the household and any information obtained by the commissioner from other sources pursuant to this subparagraph, and such inconsistency is material to the household's eligibility for a subsidy payment under this title, the commissioner shall require the [approved organization to obtain] HOUSEHOLD TO PROVIDE income documentation [from the household] as specified in subparagraph (iii) of this paragraph.

(iii) IF THE ATTESTATION OF HOUSEHOLD INCOME REQUIRED BY SUBPARAGRAPHS (I) AND (II) OF THIS PARAGRAPH IS NOT REASONABLY COMPATIBLE WITH INFORMATION OBTAINED FROM DATA SOURCES, FURTHER INFORMATION, INCLUDING DOCUMENTATION, SHALL BE REQUIRED. Income documentation shall include, but not be limited to, one or more of the following for each parent and legally responsible adult who is a member of the household and whose income is available to the child;

(A) current annual income tax returns;

(B) paycheck stubs;

(C) written documentation of income from all employers; or

(D) written documentation of income eligibility of a child for free or reduced breakfast or lunch through the school meal program certified by the child's school, provided that:

(I) the commissioner may verify the accuracy of the information provided in the same manner and way as provided for in subparagraph (ii) of this paragraph; and

(II) such documentation may not be suitable proof of income in the event of a material inconsistency in income after the commissioner has performed verification pursuant to subparagraph (ii) of this paragraph; or

(E) other documentation of income (earned or unearned) as determined by the commissioner, provided, however, such documentation shall set forth the source of such income.

(v) In the event a household chooses not to provide the social security numbers required by [subparagraph] SUBPARAGRAPHS (I) AND (ii) of this paragraph, such household shall provide income documentation specified in subparagraph (iii) of this paragraph as a condition of the child's enrollment. Nothing in this paragraph shall be construed as obligating a household to provide social security numbers of parents or legally

responsible adults as a condition of a child's enrollment or eligibility for a subsidy payment under this title.

S 27. Subparagraph (ii) of paragraph (g) of subdivision 2 of section 2511 of the public health law, as amended by section 29 of part A of chapter 58 of the laws of 2007, is amended to read as follows:

(ii) Effective September first two thousand seven, THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FOURTEEN temporary enrollment pursuant to subparagraph (i) of this paragraph shall be provided only to children who apply for recertification of coverage under this title who appear to be eligible for medical assistance under title eleven of article five of the social services law.

S 28. Paragraph (a) of subdivision 2-b of section 2511 of the public health law, as added by section 5 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(a) [Effective October first, two thousand ten, for] FOR purposes of claiming federal financial participation under paragraph nine of subsection (c) of section twenty-one hundred five of the federal social security act, [for individuals declaring to be citizens at initial application,] a household shall provide:

(i) the social security number for the applicant to be verified by the commissioner in accordance with a process established by the social security administration pursuant to federal law, or

(ii) documentation of citizenship and identity of the applicant consistent with requirements under the medical assistance program, as specified by the commissioner on the initial application.

S 29. Paragraph (d) of subdivision 9 of section 2510 of the public health law, as added by section 72-a of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(d) for periods on or after July first, two thousand nine, amounts as follows:

(i) no payments are required for eligible children whose family [gross] household income is less than one hundred sixty percent of the non-farm federal poverty level and for eligible children who are American Indians or Alaskan Natives, as defined by the U.S. Department of Health and Human Services, whose family [gross] household income is less than two hundred fifty-one percent of the non-farm federal poverty level; and

(ii) nine dollars per month for each eligible child whose family [gross] household income is between one hundred sixty percent and two hundred twenty-two percent of the non-farm federal poverty level, but no more than twenty-seven dollars per month per family; and

(iii) fifteen dollars per month for each eligible child whose family [gross] household income is between two hundred twenty-three percent and two hundred fifty percent of the non-farm federal poverty level, but no more than forty-five dollars per month per family; and

(iv) thirty dollars per month for each eligible child whose family [gross] household income is between two hundred fifty-one percent and three hundred percent of the non-farm federal poverty level, but no more than ninety dollars per month per family;

(v) forty-five dollars per month for each eligible child whose family [gross] household income is between three hundred one percent and three hundred fifty percent of the non-farm federal poverty level, but no more than one hundred thirty-five dollars per month per family; and

(vi) sixty dollars per month for each eligible child whose family [gross] household income is between three hundred fifty-one percent and

four hundred percent of the non-farm federal poverty level, but no more than one hundred eighty dollars per month per family.

S 30. Subparagraph (iii) of paragraph (a) of subdivision 2 of section 2511 of the public health law, as amended by section 32 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

(iii) effective September first, two thousand eight, resides in a household having a [gross] household income at or below four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services);

S 31. Subparagraph (ii) of paragraph (d) of subdivision 2 of section 2511 of the public health law, as amended by section 33 of part A of chapter 58 of the laws of 2007, clause (B) as amended by section 3 of part OO of chapter 57 of the laws of 2008, is amended to read as follows:

(ii) (A) The implementation of this paragraph for a child residing in a household having a [gross] household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall take effect only upon the commissioner's finding that insurance provided under this title is substituting for coverage under group health plans in excess of a percentage specified by the secretary of the federal department of health and human services. The commissioner shall notify the legislature prior to implementation of this paragraph.

(B) The implementation of clauses (A), (B), (C), (D), (E), (F), (G) and (I) of subparagraph (i) of this paragraph for a child residing in a household having a [gross] household income between two hundred fifty-one and four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall take effect September first, two thousand eight; provided however, the entirety of subparagraph (i) of this paragraph shall take effect and be applied to such children on the date federal financial participation becomes available for such population in accordance with the state's Title XXI child health plan. The commissioner shall monitor the number of children who are subject to the waiting period established pursuant to this clause.

S 32. Clauses (A) and (B) of subparagraph (i) of paragraph (b) of subdivision 18 of section 2511 of the public health law, as added by section 31 of part A of chapter 58 of the laws of 2007, are amended to read as follows:

(A) participation in the program for a child who resides in a household having a [gross] household income at or below two hundred fifty percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) shall be voluntary and an eligible child may disenroll from the premium assistance program at any time and enroll in individual coverage under this title; and

(B) participation in the program for a child who resides in a household having a [gross] household income between two hundred fifty-one and four hundred percent of the non-farm federal poverty level (as defined and updated by the United States department of health and human services) and meets certain eligibility criteria shall be mandatory. A child in this income group who meets the criteria for enrollment in the premium assistance program shall not be eligible for individual coverage under this title;

S 33. Subparagraph (iv) of paragraph (b) and paragraph (d) of subdivision 9 of section 2511 of the public health law, as amended by section 18-a of 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, [including the conduct of personal interviews pursuant to section three hundred sixty-six-a of the social services law and personal interviews required upon recertification under such section 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) of subdivision two of section two thousand five hundred and eleven of this title; and

(d) Subject to the availability of funds therefor, training shall be provided for outstationed persons and employees of approved organizations to enable them to disseminate information, AND facilitate the completion of the application process under this subdivision[, and conduct personal interviews required by section three hundred sixty-six-a of the social services law and personal interviews required upon recertification under such section of the social services law].

S 33-a. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (s) to read as follows:

(S) ISSUE A READINESS REPORT TO THE LEGISLATURE, DETAILING THE STATUS OF THE STATEWIDE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER ESTABLISHED UNDER EXECUTIVE ORDER NUMBER FORTY-TWO OF TWO THOUSAND TWELVE, BY AUGUST THIRTIETH, TWO THOUSAND THIRTEEN. THE READINESS REPORT MAY BE PROVIDED IN ELECTRONIC FORMAT AND SHALL BE DISTRIBUTED TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE. THE READINESS REPORT SHALL OUTLINE THE PROGRESS AND PREPAREDNESS OF THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER AND DETAIL HOW THE EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL CARRY OUT THEIR RESPECTIVE FUNCTIONS INCLUDING BUT NOT LIMITED TO:

(I) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL BEGIN ACCEPTING APPLICATIONS ON OCTOBER FIRST, TWO THOUSAND THIRTEEN;

(II) THE PROCESS BY WHICH THE HEALTH BENEFIT EXCHANGE, STATE ENROLLMENT CENTER, AND STATE MEDICAID ENROLLMENT CENTER WILL CERTIFY QUALIFIED HEALTH PLANS;

(III) THE ANTICIPATED COST OF INDIVIDUAL AND SMALL GROUP PLANS BEING OFFERED IN THE HEALTH BENEFIT EXCHANGE;

(IV) THE NUMBER OF NAVIGATORS APPROVED;

(V) THE PLAN FOR FULL OPERATION BY JANUARY FIRST, TWO THOUSAND FOURTEEN; AND

(VI) THE PLAN TO BECOME FISCALLY SELF-SUSTAINING BY JANUARY FIRST, TWO THOUSAND FIFTEEN.

S 34. Paragraphs 9 and 10 of subsection (a) of section 2101 of the insurance law, as added by chapter 687 of the laws of 2003, are amended and a new paragraph 11 is added to read as follows:

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; [or]

(10) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission[.]; OR

(11) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, AS SUCH TERM IS USED IN 42 U.S.C. S 18031(I), PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031(I)(3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

S 35. Paragraphs 8 and 9 of subsection (c) of section 2101 of the insurance law, paragraph 8 as amended and paragraph 9 as added by section 5 of part I of chapter 61 of the laws of 2011, are amended and a new paragraph 10 is added to read as follows:

(8) a person who is not a resident of this state who sells, solicits or negotiates a contract for commercial property/casualty risks to an insured with risks located in more than one state insured under that contract, provided that such person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; [or]

(9) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state[.]; OR

(10) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, AS SUCH TERM IS USED IN 42 U.S.C. S 18031(I), INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031(I)(3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

S 36. Paragraphs 10 and 11 of subsection (k) of section 2101 of the insurance law, paragraph 10 as amended and paragraph 11 as added by section 6 of part I of chapter 61 of the laws of 2011, are amended and a new paragraph 12 is added to read as follows:

(10) any salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive a commission; [or]

(11) a person who is not a resident of this state who sells, solicits or negotiates a contract of property/casualty insurance, as defined in paragraph six of subsection (x) of this section, of an insurer not authorized to do business in this state, provided that: (A) the insured's home state is a state other than this state; and (B) such person is otherwise licensed to sell, solicit or negotiate excess line insurance in the insured's home state[.]; OR

(12) ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031 TO ACT AS A NAVIGATOR, AS SUCH TERM IS USED IN 42 U.S.C. S 18031(I), INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031 (I) (3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

S 37. Subsection (b) of section 2102 of the insurance law is amended by adding a new paragraph 5 to read as follows:

(5) PARAGRAPHS ONE AND THREE OF THIS SUBSECTION SHALL NOT APPLY TO ANY PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031 (I), INCLUDING PERSONS EMPLOYED BY CERTIFIED NAVIGATORS; PROVIDED THAT THE PERSON: (A) HAS COMPLETED THE TRAINING REQUIRED BY THE HEALTH BENEFIT EXCHANGE; (B) DOES NOT SELL INSURANCE; (C) DOES NOT ENGAGE IN ANY ACTIVITY WITH RESPECT TO INSURANCE NOT EXPRESSLY PERMITTED UNDER 42 U.S.C. S 18031 (I) (3) AND REGULATIONS THEREUNDER; AND (D) DOES NOT RECEIVE ANY COMPENSATION FOR ACTING AS A NAVIGATOR DIRECTLY OR INDIRECTLY FROM AN INSURED, INSURANCE PRODUCER, OR AN INSURER.

S 37-a. Subsections (a) and (d) of section 2123 of the insurance law, as amended by chapter 540 of the laws of 1996, paragraph 3 of subsection (a) as added by chapter 616 of the laws of 1997 and the opening paragraph of paragraph 3 of subsection (a) as amended by chapter 13 of the laws of 2002, are amended to read as follows:

(a) (1) No agent or representative of any insurer or health maintenance organization authorized to transact life, accident or health insurance or health maintenance organization business in this state [and no], insurance broker, [and no] PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, OR other person, firm, association or corporation, shall issue or circulate or cause or permit to be issued or circulated, any illustration, circular, statement or memorandum misrepresenting the terms, benefits or advantages of any policy or contract of life, accident or health insurance, any annuity contract or any health maintenance organization contract, delivered or issued for delivery or to be delivered or issued for delivery, in this state, or shall make any misleading estimate as to the dividends or share of surplus or additional amounts to be received

in the future on such policy or contract, or shall make any false or misleading statement as to the dividends or share of surplus or additional amounts previously paid by any such insurer or health maintenance organization on similar policies or contracts, or shall make any misleading representation, or any misrepresentation, as to the financial condition of any such insurer or health maintenance organization, or as to the legal reserve system upon which such insurer or health maintenance organization operates.

(2) No such person, firm, association or corporation shall make to any person or persons any incomplete comparison of any such policies or contracts of any insurer, insurers, or health maintenance organization, for the purpose of inducing, or tending to induce, such person or persons to lapse, forfeit or surrender any insurance policy or health maintenance organization contract.

(3) Any replacement of individual life insurance policies or individual annuity contracts of an insurer by an agent, representative of the same or different insurer or broker shall conform to standards promulgated by regulation by the superintendent. Such regulation shall:

(A) specify what constitutes the replacement of a life insurance policy or annuity contract and the proper disclosure and notification procedures to replace a policy or contract;

(B) require notification of the proposed replacement to the insurer whose policies or contracts are intended to be replaced;

(C) require the timely exchange of illustrative and cost information required by section three thousand two hundred nine of this chapter and necessary for completion of a comparison of the proposed and replaced coverage; and

(D) provide for a sixty-day period following issuance of the replacement policies or contracts during which the policy or contract owner may return the policies or contracts and reinstate the replaced policies or contracts.

(d) Any agent or representative of an insurer or health maintenance organization, [any] insurance broker [and], PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, OR any other person, firm, association or corporation who, or which, shall violate any of the provisions of this section and shall knowingly receive any compensation or commission for the SOLICITATION, sale OR NEGOTIATION of any insurance policy, health maintenance organization or annuity contract induced by a violation of this section shall also be liable for a civil penalty in the amount received by such violator as compensation or commission, which penalty may be sued for and recovered for his, HER, OR ITS own use and benefit by any person induced to purchase an insurance policy, health maintenance organization or annuity contract by such violation. In addition, such agent, representative, broker, person, firm, association or corporation violating this section shall be liable for a civil penalty in the amount of any compensation or commission lost by any agent, representative or broker as a result of a violation of this section or the making of such false or misleading statement, which penalty may be sued for and recovered for his, HER, OR ITS own use and benefit by such agent, representative or broker.

S 37-b. The insurance law is amended by adding a new section 2138 to read as follows:

S 2138. HEALTH BENEFIT EXCHANGE NAVIGATORS. A PERSON WHO HAS RECEIVED A GRANT FROM AND HAS BEEN CERTIFIED BY THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, TO ACT AS A NAVIGATOR, INCLUDING ANY PERSON EMPLOYED BY A CERTIFIED NAVIGATOR, SHALL NOT RECEIVE, COLLECT OR HOLD ANY FUNDS THAT WOULD CONSTITUTE FIDUCIARY FUNDS WITHIN THE MEANING OF SECTION TWO THOUSAND ONE HUNDRED TWENTY OF THIS ARTICLE.

S 38. Subparagraph (B) of paragraph 25 of subsection (i) of section 3216 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(B) Every policy [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the policy. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per POLICY OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 39. Subparagraph (B) of paragraph 17 of subsection (1) of section 3221 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(B) Every group or blanket policy [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this paragraph and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the policy because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the group or blanket policy. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per POLICY OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the group or blanket

policy, provided however that such policy shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 40. Paragraph 2 of subsection (ee) of section 4303 of the insurance law, as amended by chapter 596 of the laws of 2011, is amended to read as follows:

(2) Every contract [which] THAT provides physician services, medical, major medical or similar comprehensive-type coverage shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in accordance with this [subsection] PARAGRAPH and shall not exclude coverage for the screening, diagnosis or treatment of medical conditions otherwise covered by the contract because the individual is diagnosed with autism spectrum disorder. Such coverage may be subject to annual deductibles, copayments and coinsurance as may be deemed appropriate by the superintendent and shall be consistent with those imposed on other benefits under the contract. Coverage for applied behavior analysis shall be subject to a maximum benefit of [forty-five thousand dollars] SIX HUNDRED EIGHTY HOURS OF TREATMENT per CONTRACT OR CALENDAR year per covered individual [and such maximum annual benefit will increase by the amount calculated from the average ten year rolling average increase of the medical component of the consumer price index]. This paragraph shall not be construed as limiting the benefits that are otherwise available to an individual under the contract, provided however that such contract shall not contain any limitations on visits that are solely applied to the treatment of autism spectrum disorder. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. Coverage shall be subject to utilization review and external appeals of health care services pursuant to article forty-nine of this chapter as well as, case management, and other managed care provisions.

S 40-a. Paragraph 1 of subsection (d) of section 3221 of the insurance law is amended to read as follows:

(1) The superintendent may approve any form of certificate to be issued under a blanket accident and health insurance policy as defined in section four thousand two hundred thirty-seven of this chapter, which omits or modifies any of the provisions hereinbefore required, if [he] THE SUPERINTENDENT deems such omission or modification suitable for the character of such insurance and not unjust to the persons insured thereunder. CERTIFICATES ISSUED UNDER A POLICY OR CONTRACT OF STUDENT ACCIDENT AND HEALTH INSURANCE AS DEFINED IN SECTION THREE THOUSAND TWO HUNDRED FORTY OF THIS ARTICLE SHALL COMPLY WITH SUCH SECTION.

S 41. The insurance law is amended by adding a new section 3240 to read as follows:

S 3240. STUDENT ACCIDENT AND HEALTH INSURANCE. (A) IN THIS SECTION:

(1) "STUDENT ACCIDENT AND HEALTH INSURANCE" MEANS A POLICY OR CONTRACT OF HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BY AN INSURER OR A CORPORATION, TO AN INSTITUTION OF HIGHER

EDUCATION COVERING STUDENTS ENROLLED IN THE INSTITUTION AND THE STUDENTS' DEPENDENTS.

(2) "INSTITUTION OF HIGHER EDUCATION" OR "INSTITUTION" SHALL HAVE THE MEANING SET FORTH IN THE HIGHER EDUCATION ACT OF 1965, 20 U.S.C. S 1001.

(3) "INSURER" MEANS AN INSURER LICENSED TO WRITE ACCIDENT AND HEALTH INSURANCE PURSUANT TO THIS CHAPTER.

(4) "CORPORATION" MEANS A CORPORATION ORGANIZED IN ACCORDANCE WITH ARTICLE FORTY-THREE OF THIS CHAPTER.

(B) AN INSURER OR CORPORATION SHALL NOT IMPOSE ANY PRE-EXISTING CONDITION EXCLUSION IN A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT. AN INSURER OR CORPORATION SHALL NOT CONDITION ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, FOR A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT ON HEALTH STATUS, MEDICAL CONDITION, INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES, CLAIMS EXPERIENCE, RECEIPT OF HEALTH CARE, MEDICAL HISTORY, GENETIC INFORMATION, EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE, OR DISABILITY.

(C) AN INSURER OR CORPORATION SHALL CONDITION ELIGIBILITY INCLUDING CONTINUING ELIGIBILITY, ON THE COVERED INDIVIDUAL BEING ENROLLED AS A STUDENT IN AN INSTITUTION OF HIGHER EDUCATION TO WHICH THE STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT IS ISSUED.

(D) A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT SHALL PROVIDE COVERAGE FOR ESSENTIAL HEALTH BENEFITS AS DEFINED IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

(E) AN INSURER OR CORPORATION SHALL NOT REFUSE TO RENEW OR OTHERWISE TERMINATE A STUDENT ACCIDENT AND HEALTH INSURANCE POLICY OR CONTRACT EXCEPT FOR ONE OR MORE OF THE REASONS SET FORTH IN:

(1) SUBPARAGRAPHS (A), (B), (D) OR (G) OF PARAGRAPH TWO OF SUBSECTION (P) OF SECTION THREE THOUSAND TWO HUNDRED TWENTY-ONE OF THIS ARTICLE; OR

(2) SUBPARAGRAPHS (A), (B), (D) OR (G) OF PARAGRAPH TWO OF SUBSECTION (J) OF SECTION FOUR THOUSAND THREE HUNDRED FIVE OF THIS CHAPTER.

(F) OTHER THAN THE PROVISIONS HEREIN ALSO REQUIRED BY ARTICLE FORTY-THREE OF THIS CHAPTER, THIS SECTION SHALL NOT APPLY TO COVERAGE UNDER A STUDENT HEALTH PLAN ISSUED PURSUANT TO SECTION ONE THOUSAND ONE HUNDRED TWENTY-FOUR OF THIS CHAPTER.

(G) THE SUPERINTENDENT MAY PROMULGATE REGULATIONS REGARDING STUDENT ACCIDENT AND HEALTH INSURANCE, WHICH MAY INCLUDE MINIMUM STANDARDS FOR THE FORM, CONTENT AND SALE OF THE POLICIES AND CONTRACTS AND, NOTWITHSTANDING THE PROVISIONS OF SECTION THREE THOUSAND TWO HUNDRED THIRTY-ONE AND FOUR THOUSAND THREE HUNDRED EIGHT OF THIS CHAPTER, THE ESTABLISHMENT OF RATING METHODOLOGY TO BE APPLIED TO THE POLICIES AND CONTRACTS; PROVIDED THAT ANY SUCH REGULATIONS SHALL BE NO LESS FAVORABLE TO THE INSURED THAN THAT WHICH IS PROVIDED UNDER FEDERAL LAW AND STATE LAW APPLICABLE TO INDIVIDUAL INSURANCE.

(H) THE RATIO OF BENEFITS TO PREMIUMS SHALL BE NOT LESS THAN EIGHTY-TWO PERCENT AS CALCULATED IN A MANNER TO BE DETERMINED BY THE SUPERINTENDENT.

(I) EVERY INSURER OR CORPORATION SHALL REPORT TO THE SUPERINTENDENT ANNUALLY, ON A DATE SPECIFIED BY THE SUPERINTENDENT IN A REGULATION, CLAIMS EXPERIENCE AND OTHER DATA IN A MANNER ACCEPTABLE TO THE SUPERINTENDENT THAT SHALL DEMONSTRATE THE INSURER'S OR CORPORATION'S COMPLIANCE WITH THE APPLICABLE RULES AND REGULATIONS, INCLUDING THE MINIMUM LOSS RATIO REQUIRED BY SUBSECTION (H) OF THIS SECTION. FAILURE TO COMPLY WITH SUBSECTION (H) OF THIS SECTION IS SUBJECT TO CORRECTIVE ACTION, WHICH MAY INCLUDE THE SUBMISSION, TO THE SUPERINTENDENT, OF AN APPROPRIATE RATE FILING OR FORM AND RATE FILING TO REDUCE FUTURE PREMIUMS,

INCREASE BENEFITS, ISSUE DIVIDENDS, ISSUE PREMIUM REFUNDS OR CREDITS, OR ANY COMBINATION OF THESE SUCH THAT THE MINIMUM LOSS RATIO CAN REASONABLY BE EXPECTED TO BE ACHIEVED.

S 42. Subsection (1) of section 3216 of the insurance law is REPEALED and a new subsection (l) is added to read as follows:

(L) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, AN INSURER SHALL NOT OFFER INDIVIDUAL HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE POLICIES UNLESS THE POLICIES MEET THE REQUIREMENTS OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER. SUCH POLICIES THAT ARE OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER, ALSO SHALL MEET ANY REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE.

S 43. Subsection (1) of section 4304 of the insurance law is REPEALED and a new subsection (1) is added to read as follows:

(1) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, A CORPORATION SHALL NOT OFFER INDIVIDUAL HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE CONTRACTS UNLESS THE CONTRACTS MEET THE REQUIREMENTS OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS ARTICLE. SUCH CONTRACTS THAT ARE OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER, ALSO SHALL MEET ANY REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE. TO THE EXTENT THAT A HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW OFFERS INDIVIDUAL HOSPITAL, MEDICAL, OR SURGICAL EXPENSE INSURANCE CONTRACTS, THE CONTRACTS SHALL MEET THE REQUIREMENTS OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS ARTICLE.

S 43-a. Item (i) of subparagraph (C) of paragraph 2 of subsection (c) of section 4304 of the insurance law, as amended by section 9 of part A of chapter 1 of the laws of 2002, is amended to read as follows:

(i) Discontinuance of a class of contract upon not less than five months' prior written notice[, except for subscribers to direct pay major medical or similar comprehensive-type coverage issued by a corporation organized pursuant to this article, or any successor corporation organized through a conversion pursuant to subsection (j) of section four thousand three hundred one of this article, and in effect prior to January first, nineteen hundred ninety-six who are ineligible to purchase policies offered after such date pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this article due to the provisions of 42 U.S.C. 1395ss in effect on the effective date of this item. In the event any such subscriber becomes eligible to purchase policies offered pursuant to section four thousand three hundred twenty-one or four thousand three hundred twenty-two of this article, then such subscriber may be discontinued upon not less than five months' prior written notice]. In exercising the option to discontinue coverage pursuant to this item, the corporation must act uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage and must offer to subscribers or group remitting agents, as may be appropriate, the option to purchase all other individual health insurance coverage currently being offered by the corporation to applicants in that market.

S 44. The section heading and subsection (a) of section 4321 of the insurance law, the section heading as added by chapter 504 of the laws

of 1995 and subsection (a) as amended by chapter 342 of the laws of 2004, are amended to read as follows:

Standardization of individual enrollee direct payment contracts offered by health maintenance organizations PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. (a) On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer a standardized individual enrollee contract on an open enrollment basis as prescribed by section forty-three hundred seventeen of this article and section forty-four hundred six of the public health law, and regulations promulgated thereunder, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, the enrollee contracts issued pursuant to this section and section four thousand three hundred twenty-two of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-two of this article shall also be the only contracts issued by health maintenance organizations for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prevent health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

S 45. The section heading and subsection (a) of section 4322 of the insurance law, the section heading as added by chapter 504 of the laws of 1995 and subsection (a) as amended by chapter 342 of the laws of 2004, are amended and a new subsection (i) is added to read as follows:

Standardization of individual enrollee direct payment contracts offered by health maintenance organizations which provide out-of-plan benefits PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. (a) On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, all health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article shall offer to individuals, in addition to the standardized contract required by section four thousand three hundred twenty-one of this article, a standardized individual enrollee direct payment contract on an open enrollment basis as prescribed by section four thousand three hundred seventeen of this article and section four thousand four hundred six of the public health law, and regulations promulgated thereunder, with an out-of-plan benefit

system, provided, however, that such requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. The out-of-plan benefit system shall either be provided by the health maintenance organization pursuant to subdivision two of section four thousand four hundred six of the public health law or through an accompanying insurance contract providing out-of-plan benefits offered by a company appropriately licensed pursuant to this chapter. On and after January first, nineteen hundred ninety-six, AND UNTIL SEPTEMBER THIRTIETH, TWO THOUSAND THIRTEEN, the contracts issued pursuant to this section and section four thousand three hundred twenty-one of this article shall be the only contracts offered by health maintenance organizations to individuals. The enrollee contracts issued by a health maintenance organization under this section and section four thousand three hundred twenty-one of this article shall also be the only contracts issued by the health maintenance organization for purposes of conversion pursuant to sections four thousand three hundred four and four thousand three hundred five of this article. However, nothing in this section shall be deemed to require health maintenance organizations to terminate individual direct payment contracts issued prior to January first, nineteen hundred ninety-six or prohibit health maintenance organizations from terminating individual direct payment contracts issued prior to January first, nineteen hundred ninety-six.

(I) ON AND AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, EACH CONTRACT THAT IS NOT A GRANDFATHERED HEALTH PLAN SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE. FOR PURPOSES OF THIS SUBSECTION:

(1) "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A); AND

(2) "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

S 46. The insurance law is amended by adding a new section 4328 to read as follows:

S 4328. INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS OFFERED BY HEALTH MAINTENANCE ORGANIZATION ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN. (A) ON AND AFTER OCTOBER FIRST, TWO THOUSAND THIRTEEN, EVERY HEALTH MAINTENANCE ORGANIZATION ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTICLE SHALL OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT IN ACCORDANCE WITH THE REQUIREMENTS OF THIS SECTION; PROVIDED, HOWEVER, THAT THIS REQUIREMENT SHALL NOT APPLY TO A HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW, EXCEPT AS OTHERWISE REQUIRED UNDER SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS

ARTICLE, OR A HEALTH MAINTENANCE ORGANIZATION EXCLUSIVELY SERVING INDIVIDUALS ENROLLED PURSUANT TO TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, TITLE ELEVEN-D OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, TITLE ONE-A OF ARTICLE TWENTY-FIVE OF THE PUBLIC HEALTH LAW OR TITLE EIGHTEEN OF THE FEDERAL SOCIAL SECURITY ACT. THE SUPERINTENDENT MAY, AFTER GIVING CONSIDERATION TO THE PUBLIC INTEREST, EXEMPT A HEALTH MAINTENANCE ORGANIZATION FROM THE REQUIREMENTS OF THIS SECTION PROVIDED THAT ANOTHER HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S 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 LICENSED UNDER THIS ARTICLE, OFFERS AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT THAT, AT A MINIMUM, COMPLIES WITH THIS SECTION AND PROVIDES ALL OF THE CONSUMER PROTECTIONS REQUIRED TO BE PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION PURSUANT TO THE PUBLIC HEALTH LAW AND REGULATIONS, INCLUDING THOSE CONSUMER PROTECTIONS CONTAINED IN SECTIONS FOUR THOUSAND FOUR HUNDRED THREE AND FOUR THOUSAND FOUR HUNDRED EIGHT-A OF THE PUBLIC HEALTH LAW. THE ENROLLEE CONTRACTS ISSUED BY A HEALTH MAINTENANCE ORGANIZATION UNDER THIS SECTION ALSO SHALL BE THE ONLY CONTRACTS ISSUED BY THE HEALTH MAINTENANCE ORGANIZATION FOR PURPOSES OF CONVERSION PURSUANT TO SECTIONS FOUR THOUSAND THREE HUNDRED FOUR AND FOUR THOUSAND THREE HUNDRED FIVE OF THIS ARTICLE.

(B) (1) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS PARAGRAPH, "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A).

(2) A HEALTH MAINTENANCE ORGANIZATION SHALL OFFER AT LEAST ONE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). A HEALTH MAINTENANCE ORGANIZATION ALSO SHALL OFFER ONE CHILD-ONLY PLAN AT EACH LEVEL OF COVERAGE AS REQUIRED IN SECTION 2707(C) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(C).

(3) WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, A HEALTH MAINTENANCE ORGANIZATION MAY OFFER AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT THAT IS A CATASTROPHIC HEALTH PLAN AS DEFINED IN SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), OR ANY REGULATIONS PROMULGATED THEREUNDER.

(4) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL HAVE THE SAME ENROLLMENT PERIODS, INCLUDING SPECIAL ENROLLMENT PERIODS, AS REQUIRED FOR AN INDIVIDUAL DIRECT PAYMENT CONTRACT OFFERED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER.

(5) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL BE ISSUED WITHOUT REGARD TO EVIDENCE OF INSURABILITY AND WITHOUT AN EXCLUSION FOR PRE-EXISTING CONDITIONS.

(6) A HEALTH MAINTENANCE ORGANIZATION OFFERING AN INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT PURSUANT TO THIS SECTION SHALL NOT ESTABLISH RULES FOR ELIGIBILITY, INCLUDING CONTINUED ELIGIBILITY, OF ANY INDIVIDUAL OR DEPENDENT OF THE INDIVIDUAL TO ENROLL UNDER THE CONTRACT BASED ON ANY OF THE FOLLOWING HEALTH STATUS-RELATED FACTORS:

(A) HEALTH STATUS;

(B) MEDICAL CONDITION, INCLUDING BOTH PHYSICAL AND MENTAL ILLNESSES;

(C) CLAIMS EXPERIENCE;
(D) RECEIPT OF HEALTH CARE;
(E) MEDICAL HISTORY;
(F) GENETIC INFORMATION;
(G) EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS OF DOMESTIC VIOLENCE; OR
(H) DISABILITY.

(7) THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT OFFERED PURSUANT TO THIS SECTION SHALL BE COMMUNITY RATED. FOR PURPOSES OF THIS PARAGRAPH, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUM FOR ALL PERSONS COVERED BY A CONTRACT FORM IS THE SAME, BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS, WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE, OR OCCUPATION.

(8) A HEALTH MAINTENANCE ORGANIZATION SHALL MAKE AVAILABLE AT LEAST ONE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT THE PLATINUM LEVEL OF COVERAGE, AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 USC S 18022(D), THAT INCLUDES AN OUT-OF-PLAN BENEFITS OPTION TO ENROLLEES COVERED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN, BY THE HEALTH MAINTENANCE ORGANIZATION UNDER CONTRACTS SUBJECT TO SECTION FOUR THOUSAND THREE HUNDRED TWENTY-TWO OF THIS ARTICLE. THE HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE THE PLATINUM LEVEL OF COVERAGE WITH AN OUT-OF-PLAN BENEFIT RIDER TO ANY ENROLLEE THAT ELECTS THE COVERAGE. ENROLLEES WHO TERMINATE THE RIDER OR ARE TERMINATED FOLLOWING THE EFFECTIVE DATE OF THIS PARAGRAPH SHALL BE INELIGIBLE TO PURCHASE SUCH RIDER FOLLOWING THE TERMINATION. NOTHING IN THIS PARAGRAPH SHALL REQUIRE A HEALTH MAINTENANCE ORGANIZATION TO OFFER AN OUT-OF-PLAN BENEFIT TO ANY OTHER ENROLLEE, INCLUDING THROUGH THE HEALTH BENEFIT EXCHANGE. A HEALTH MAINTENANCE ORGANIZATION SHALL PROVIDE NOTICE OF THE AVAILABILITY OF THE OUT-OF-PLAN BENEFITS PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN OR SHALL INCORPORATE NOTICE OF SUCH AVAILABILITY INTO DISCONTINUANCE NOTICES ISSUED PURSUANT TO SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS ARTICLE.

(C) IN ADDITION TO OR IN LIEU OF THE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS REQUIRED UNDER THIS SECTION, ALL HEALTH MAINTENANCE ORGANIZATIONS ISSUED A CERTIFICATE OF AUTHORITY UNDER ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW OR LICENSED UNDER THIS ARTICLE MAY OFFER INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, OR ANY REGULATIONS PROMULGATED THEREUNDER, SUBJECT TO ANY REQUIREMENTS ESTABLISHED BY THE HEALTH BENEFIT EXCHANGE. IF A HEALTH MAINTENANCE ORGANIZATION SATISFIES THE REQUIREMENTS OF SUBSECTION (A) OF THIS SECTION BY OFFERING INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS, ONLY WITHIN THE HEALTH BENEFIT EXCHANGE, THE HEALTH MAINTENANCE ORGANIZATION, NOT INCLUDING A HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW, SHALL ALSO OFFER AT LEAST ONE INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACT AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302 (D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022 (D), OUTSIDE THE HEALTH BENEFIT EXCHANGE.

(D)(1) NOTHING IN THIS SECTION SHALL BE DEEMED TO REQUIRE HEALTH MAINTENANCE ORGANIZATIONS TO DISCONTINUE INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN OR PREVENT HEALTH MAINTENANCE ORGANIZATIONS FROM DISCONTINUING INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN. IF A HEALTH MAINTENANCE ORGANIZATION DISCONTINUES INDIVIDUAL DIRECT PAYMENT CONTRACTS ISSUED PRIOR TO OCTOBER FIRST, TWO THOUSAND THIRTEEN, REGARD-

LESS OF WHETHER IT IS A GRANDFATHERED HEALTH PLAN, THEN THE HEALTH MAINTENANCE ORGANIZATION SHALL COMPLY WITH THE REQUIREMENTS OF SUBSECTION (C) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR OF THIS ARTICLE.

(2) FOR PURPOSES OF THIS SUBSECTION, "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E).

(E) THE SUPERINTENDENT MAY PROMULGATE REGULATIONS IMPLEMENTING THE REQUIREMENTS OF THIS SECTION, INCLUDING REGULATIONS THAT MODIFY OR ADD ADDITIONAL STANDARDIZED INDIVIDUAL ENROLLEE DIRECT PAYMENT CONTRACTS IF THE SUPERINTENDENT DETERMINES ADDITIONAL CONTRACTS WITH DIFFERENT LEVELS OF COVERAGE ARE NECESSARY TO MEET THE NEEDS OF THE PUBLIC.

S 46-a. Subdivision 1 of section 4406 of the public health law, as amended by chapter 342 of the laws of 2004, is amended as follows:

1. The contract between a health maintenance organization and an enrollee shall be subject to regulation by the superintendent as if it were a health insurance subscriber contract, and shall include, but not be limited to, all mandated benefits required by article forty-three of the insurance law. Such contract shall fully and clearly state the benefits and limitations therein provided or imposed, so as to facilitate understanding and comparisons, and to exclude provisions which may be misleading or unreasonably confusing. Such contract shall be issued to any individual and dependents of such individual and any group of fifty or fewer employees or members, exclusive of spouses and dependents, or any employee or member of the group, including dependents, applying for such contract at any time throughout the year, and may include a pre-existing condition provision as provided for in section four thousand three hundred eighteen of the insurance law, provided, however, that [such], THE SUPERINTENDENT MAY, AFTER GIVING CONSIDERATION TO THE PUBLIC INTEREST, EXEMPT A HEALTH MAINTENANCE ORGANIZATION FROM THE REQUIREMENTS OF THIS SECTION PROVIDED THAT ANOTHER HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION WITHIN THE HEALTH MAINTENANCE ORGANIZATION'S SAME HOLDING COMPANY SYSTEM, AS DEFINED IN ARTICLE FIFTEEN OF THE INSURANCE LAW, INCLUDING A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A LINE OF BUSINESS OF A HEALTH SERVICE CORPORATION LICENSED UNDER ARTICLE FORTY-THREE OF THE INSURANCE LAW, OFFERS COVERAGE THAT, AT A MINIMUM, COMPLIES WITH THIS SECTION AND PROVIDES ALL OF THE CONSUMER PROTECTIONS REQUIRED TO BE PROVIDED BY A HEALTH MAINTENANCE ORGANIZATION PURSUANT TO THIS CHAPTER AND REGULATIONS, INCLUDING THOSE CONSUMER PROTECTIONS CONTAINED IN SECTIONS FOUR THOUSAND FOUR HUNDRED THREE AND FOUR THOUSAND FOUR HUNDRED EIGHT-A OF THIS CHAPTER. THE requirements shall not apply to a health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four. Subject to the creditable coverage requirements of subsection (a) of section four thousand three hundred eighteen of the insurance law, the organization may, as an alternative to the use of a pre-existing condi-

tion provision, elect to offer contracts without a pre-existing condition provision to such groups but may require that coverage shall not become effective until after a specified affiliation period of not more than sixty days after the application for coverage is submitted. The organization is not required to provide health care services or benefits during such period and no premium shall be charged for any coverage during the period. After January first, nineteen hundred ninety-six, all individual direct payment contracts shall be issued only pursuant to sections four thousand three hundred twenty-one and four thousand three hundred twenty-two of the insurance law. Such contracts may not, with respect to an eligible individual (as defined in section 2741(b) of the federal Public Health Service Act, 42 U.S.C. S 300gg-41(b), impose any pre-existing condition exclusion.

S 46-b. Paragraph 5 of subsection (c) of section 3216 of the insurance law is amended to read as follows:

(5) (A) Any family policy providing hospital or surgical expense insurance (but not including such insurance against accidental injury only) shall provide that, in the event such insurance on any person, other than the policyholder, is terminated because the person is no longer within the definition of the family as set forth in the policy but before such person has attained the limiting age, if any, for coverage of adults specified in the policy, such person shall be entitled to have issued to [him] THAT PERSON by the insurer, without evidence of insurability, upon application therefor and payment of the first premium, within [thirty-one] SIXTY days after such insurance shall have terminated, an individual conversion policy THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER. THE INSURER SHALL OFFER ONE POLICY AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). THE INDIVIDUAL MAY CHOOSE ANY SUCH POLICY OFFERED BY THE INSURER. The conversion privilege afforded herein shall also be available upon the divorce or annulment of the marriage of the policyholder to the former spouse of such policyholder.

(B) Written notice of entitlement to a conversion policy shall be given by the insurer to the policyholder at least fifteen and not more than sixty days prior to the termination of coverage due to the initial limiting age of the covered dependent. Such notice shall include an explanation of the rights of the dependent with respect to [his] THE DEPENDENT being enrolled in an accredited institution of learning or his incapacity for self-sustaining employment by reason of mental illness, developmental disability or mental retardation as defined in the mental hygiene law or physical handicap.

(C) Such individual conversion policy shall be subject to the following terms and conditions:

(i) The premium shall be that applicable to the [class of risk to which such person belongs, to the age of such person and to the] form and amount of insurance therefor.

(ii) [Such policy shall provide, on a basis specified in the family policy, the same or substantially the same benefits as those provided in the family policy or such benefits as are provided in a policy specifically approved as an individual conversion policy by the superintendent.

(iii)] The benefits provided under such policy shall become effective upon the date that such person was no longer eligible under the family policy.

[(iv) The policy may exclude any condition excluded by the family policy for such person at the time of the termination of his insurance thereunder. The policy shall not exclude any other pre-existing conditions, but the benefits paid under such policy may be reduced by the amount of any such benefits payable under the family policy after the termination of such person's insurance thereunder and, during the first policy year of the conversion policy, the benefits payable under the policy may be reduced so that they are not in excess of those that would have been payable had such person's insurance under the family policy remained in force and effect.

(v)] (III) No insurer shall be required to issue a conversion policy if it appears that the person applying for such policy shall have at that time in force another insurance policy or hospital service or medical expense indemnity contract providing similar benefits or is covered by or is eligible for coverage by a group insurance policy or contract providing similar benefits or shall be covered by similar benefits required by any statute or provided by any welfare plan or program, which together with the conversion policy would result in over insurance or duplication of benefits according to standards on file with the superintendent relating to individual policies.

[(vi) The policy may include a provision whereby the insurer may request information at any premium due date of the policy of the person covered thereunder as to whether he is then covered by another policy or hospital service or medical expense indemnity corporation subscriber contract providing similar benefits or is then covered by a group contract or policy providing similar benefits or is then provided with similar benefits required by any statute or provided by any welfare plan or program. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits payable under the conversion policy may be based on the hospital surgical or medical expenses actually incurred after excluding expenses to the extent they are payable under such other coverage or provided under such statute, plan, or program.]

S 47. Paragraphs 4, 6, 9 and 10 of subsection (e) of section 3221 of the insurance law are REPEALED, paragraphs 5, 7, 8, 11 and 12 are renumbered paragraphs 4, 5, 6, 7 and 8 and paragraph 1, as amended by chapter 306 of the laws of 1987, is amended to read as follows:

(1) A group policy providing hospital, MEDICAL or surgical expense insurance for other than specific diseases or accident only, shall provide that if the insurance on an employee or member insured under the group policy ceases because of termination of [(I)] (A) employment or of membership in the class or classes eligible for coverage under the policy or [(II)] (B) the policy, for any reason whatsoever, unless the policyholder has replaced the group policy with similar and continuous coverage for the same group whether insured or self-insured, such employee or member who has been insured under the group policy [for at least three months] shall be entitled to have issued to [him] THE INSURED by the insurer without evidence of insurability upon application made to the insurer within [forty-five] SIXTY days after such termination, and payment of the quarterly, or, at the option of the employee or member, a less frequent premium applicable to the [class of risk to which the person belongs, the age of such person, and the] form and amount of insurance, an individual policy of insurance. The insurer may, at its option elect to provide the insurance coverage under a group insurance policy, delivered in this state, in lieu of the issuance of a converted individual policy of insurance. Such individual policy, or

group policy, as the case may be is hereafter referred to as the converted policy. The benefits provided under the converted policy shall be those required by subsection (f)[,] AND (g)[, (h) or (i) hereof] OF THIS SECTION, [whichever is applicable and,] in the event of termination of the converted group policy of insurance, each insured thereunder shall have a right of conversion to a converted individual policy of insurance.

S 48. Paragraph 3 of subsection (e) of section 3221 of the insurance law, as separately amended by chapters 370 and 869 of the laws of 1984, is amended to read as follows:

(3) The converted policy shall, at the option of the employee or member, provide identical coverage for the dependents of such employee or member who were covered under the group policy. Provided, however, that if the employee or member chooses the option of dependent coverage then dependents acquired after the permitted time to convert stated in paragraph one of this subsection shall be added to the converted family policy in accordance with the provisions of subsection (c) of section thirty-two hundred sixteen of this article and any regulations promulgated or guidelines issued by the superintendent. [The converted policy need not provide benefits in excess of those provided for such persons under the group policy from which conversion is made and may contain any exclusion or benefit limitation contained in the group policy or customarily used in individual policies.] The effective date of the individual's coverage under the converted policy shall be the date of the termination of the individual's insurance under the group policy as to those persons covered under the group policy.

S 49. Subsections (f) and (g) of section 3221 of the insurance law are REPEALED and two new subsections (f) and (g) are added to read as follows:

(F) IF THE GROUP INSURANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE, OR IF THE GROUP INSURANCE POLICY INSURES THE EMPLOYEE OR MEMBER FOR MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, THEN THE CONVERSION PRIVILEGE SHALL ENTITLE THE EMPLOYEE OR MEMBER TO OBTAIN COVERAGE UNDER A CONVERTED POLICY PROVIDING, AT THE INSURED'S OPTION, COVERAGE UNDER ANY ONE OF THE PLANS DESCRIBED IN SUBSECTION (G) OF THIS SECTION ON AN EXPENSE INCURRED BASIS.

(G) FOR CONVERSION PURPOSES, AN INSURER SHALL OFFER TO THE EMPLOYEE OR MEMBER A POLICY AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D) THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER.

S 50. Subparagraph (D) of paragraph 4 of subsection (l) of section 3221 of the insurance law, as amended by chapter 230 of the laws of 2004, is amended to read as follows:

(D) In addition to the requirements of subparagraph (A) of this paragraph, every insurer issuing a group policy for delivery in this state [which] WHERE THE policy provides reimbursement to insureds for psychiatric or psychological services or for the diagnosis and treatment of mental, nervous or emotional disorders and ailments, however defined in such policy, by physicians, psychiatrists or psychologists, [must] SHALL provide the same coverage to insureds for such services when performed by a licensed clinical social worker, within the lawful scope of his or her practice, who is licensed pursuant to subdivision two of section seven thousand seven hundred four of the education law and in addition shall have either: (i) three or more additional years experience in

psychotherapy, which for the purposes of this subparagraph shall mean the use of verbal methods in interpersonal relationships with the intent of assisting a person or persons to modify attitudes and behavior [which] THAT are intellectually, socially or emotionally maladaptive, under supervision, satisfactory to the state board for social work, in a facility, licensed or incorporated by an appropriate governmental department, providing services for diagnosis or treatment of mental, nervous or emotional disorders or ailments[, or]; (ii) three or more additional years experience in psychotherapy under the supervision, satisfactory to the state board for social work, of a psychiatrist, a licensed and registered psychologist or a licensed clinical social worker qualified for reimbursement pursuant to subsection [(h)] (E) of this section, or (iii) a combination of the experience specified in items (i) and (ii) OF THIS SUBPARAGRAPH totaling three years, satisfactory to the state board for social work.

(E) The state board for social work shall maintain a list of all licensed clinical social workers qualified for reimbursement under [this] subparagraph (D) OF THIS PARAGRAPH.

S 51. Paragraph 3 of subsection (e) of section 4304 of the insurance law is REPEALED and paragraphs 4 and 5 are renumbered paragraphs 3 and 4, and paragraphs 1 and 2 of such subsection (e), paragraph 1 as amended by chapter 661 of the laws of 1997, and as further amended by section 104 of part A of chapter 62 of the laws of 2011, are amended to read as follows:

(1) If any such contract is terminated in accordance with the provisions of paragraph one of subsection (c) [hereof] OF THIS SECTION, or any such contract is terminated because of a default by the remitting agent in the payment of premiums not cured within the grace period and the remitting agent has not replaced the contract with similar and continuous coverage for the same group whether insured or self-insured, or any such contract is terminated in accordance with the provisions of subparagraph (E) of paragraph two of subsection (c) [hereof] OF THIS SECTION, or if an individual other than the contract holder is no longer covered under a "family contract" because [he] THE INDIVIDUAL is no longer within the definition set forth in the contract, or a spouse is no longer covered under the contract because of divorce from the contract holder or annulment of the marriage, or any such contract is terminated because of the death of the contract holder, then such individual, former spouse, or in the case of the death of the contract holder the surviving spouse or other dependents of the deceased contract holder covered under the contract, as the case may be, shall be entitled to convert, without evidence of insurability, upon application therefor and the making of the first payment thereunder within [thirty-one] SIXTY days after the date of termination of such contract, to a contract [of a type which provides coverage most nearly comparable to the type of coverage under the contract from which the individual converted, which coverage shall be no less than the minimum standards for basic hospital, basic medical, or major medical as provided for in department of financial services regulation; provided, however, that if the corporation does not issue such a major medical contract, then to a comprehensive or comparable type of coverage which is most commonly being sold to group remitting agents. Notwithstanding the previous sentence, a corporation may elect to issue a standardized individual enrollee contract pursuant to section four thousand three hundred twenty-two of this article in lieu of a major medical contract, comprehensive or comparable type of coverage required to be offered upon conversion from an indemnity

contract] THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER. THE CORPORATION SHALL OFFER ONE CONTRACT AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). THE INDIVIDUAL MAY CHOOSE ANY SUCH CONTRACT OFFERED BY THE CORPORATION. The effective date of the coverage provided by the converted direct payment contract shall be the date of the termination of coverage under the contract from which conversion was made.

(2) The corporation shall not be required to issue any such converted individual direct payment contract if its issuance would result in over-insurance or duplication of benefits according to standards on file with the superintendent and approved by [him] THE SUPERINTENDENT with regard to such contracts. [The individual direct payment contract may include a provision whereby the corporation may request information when any payment is due under the contract of the person covered thereunder as to whether he is then covered by another individual contract providing similar benefits or is then covered by a group contract policy providing similar benefits or is then provided with similar benefits required by any statute or provided by any welfare plan or program which together with the converted individual direct payment contract would result in overinsurance or duplication of benefits according to the standards on file with the superintendent relating to individual contracts. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits provided under the converted individual direct payment contract may be based on the hospi-tal, surgical or medical expenses actually incurred after excluding expenses to the extent they are payable under such other coverage or provided under such statute, plan or program.]

S 52. Paragraphs 1 and 2 of subsection (d) of section 4305 of the insurance law, paragraph 1 as amended by chapter 504 of the laws of 1995 and paragraphs 1 and 2 as further amended by section 104 of part A of chapter 62 of the laws of 2011, are amended to read as follows:

(1) (A) A group contract issued pursuant to this section shall contain a provision to the effect that in case of a termination of coverage under such contract of any member of the group because of [(I)] (I) termination for any reason whatsoever of [his] THE MEMBER'S employment or membership, [if he has been covered under the group contract for at least three months,] or [(II)] (II) termination for any reason whatsoev-er of the group contract itself unless the group contract holder has replaced the group contract with similar and continuous coverage for the same group whether insured or self-insured, [he] THE MEMBER shall be entitled to have issued to [him] THE MEMBER by the corporation, without evidence of insurability, upon application therefor and payment of the first premium made to the corporation within [forty-five] SIXTY days after termination of the coverage, an individual direct payment contract, covering such member and [his] THE MEMBER'S eligible depen-dents who were covered by the group contract, which provides coverage [most nearly comparable to the type of coverage under the group contract, which coverage shall be no less than the minimum standards for basic hospital, basic medical, or major medical as provided for in department of financial services regulation; provided, however, that if the corporation does not issue such a major medical contract, then to a comprehensive or comparable type of coverage which is most commonly being sold to group remitting agents. Notwithstanding the previous sentence, a corporation may elect to issue a standardized individual enrollee contract pursuant to section four thousand three hundred twenty

two of this article in lieu of a major medical contract, comprehensive or comparable type of coverage required to be offered upon conversion from an indemnity contract] THAT CONTAINS THE BENEFITS DESCRIBED IN PARAGRAPH ONE OF SUBSECTION (B) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER. THE CORPORATION SHALL OFFER ONE CONTRACT AT EACH LEVEL OF COVERAGE AS DEFINED IN SECTION 1302(D) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(D). THE MEMBER MAY CHOOSE ANY SUCH CONTRACT OFFERED BY THE CORPORATION.

(B) The conversion privilege afforded [herein] IN THIS PARAGRAPH shall also be available: [(A)] (I) upon the divorce or annulment of the marriage of a member, to the divorced spouse or former spouse of such member[, (B)]; (II) upon the death of the member, to the surviving spouse and other dependents covered under the contract[,]; and [(C)] (III) to a dependent if no longer within the definition in the contract.

(2) The effective date of the coverage provided by the individual direct payment contract shall be the date of the termination of the individual's coverage under the group contract. [The individual direct payment converted contract may exclude any condition excluded by the group contract. The individual direct payment contract shall not exclude any other pre-existing conditions but the benefits provided under the individual direct payment converted contract may be reduced by the amount of any such benefits provided under the group contract after the termination of the individual's coverage thereunder and during the first contract year of such individual direct payment converted contract the benefits provided under the contract may be reduced so that they are not in excess of those that would have been provided had the individual's contract under the group contract remained in force and effect.] The corporation shall not be required to issue such individual direct payment converted contract covering any person if it appears that such person shall then be covered by another individual contract providing similar coverage or if it shall appear that such person is covered by or eligible to be covered by a group contract or policy providing similar benefits or is provided with similar benefits required by any statute or provided by any welfare plan or program, which together with the individual direct payment converted contract would result in over-insurance or duplication of benefits according to standards on file with the superintendent of financial services relating to individual contracts. [The individual direct payment converted contract may include a provision whereby the corporation may request information when any payment is due under the contract of any person covered thereunder as to whether he is then covered by another contract or by a policy providing similar benefits or is then covered by a group contract or policy providing similar benefits or is then provided with similar benefits required by any statute or provided by any welfare plan or program. If any such person is so covered or so provided and fails to furnish the details of such coverage when requested, the benefits payable under the individual direct payment converted contract may be based on the hospital, surgical or medical expenses actually incurred after excluding expenses to the extent they are payable under such other coverage or provided under such statute, plan or program.

In the event the benefits provided or payable are reduced in accordance with the provisions of this subsection the corporation shall return such portion of the premium paid as shall exceed the pro rata portion of the benefits thus determined.]

S 53. Section 3216 of the insurance law is amended by adding a new subsection (m) to read as follows:

(M) AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF THE BENEFITS MUST BE COVERED AS ESSENTIAL HEALTH BENEFITS. FOR ANY POLICY ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION. FOR PURPOSES OF THIS SUBSECTION, "ESSENTIAL HEALTH BENEFITS" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(B) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(B).

S 54. Subsections (h) and (i) of section 3221 of the insurance law are REPEALED and two new subsections (h) and (i) are added to read as follows:

(H) EVERY SMALL GROUP POLICY OR ASSOCIATION GROUP POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE AND IS NOT A GRANDFATHERED HEALTH PLAN SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS SUBSECTION:

(1) "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A);

(2) "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY AN INSURER IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E);

(3) "SMALL GROUP" MEANS A GROUP OF FIFTY OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; PROVIDED, HOWEVER, THAT BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN, "SMALL GROUP" MEANS A GROUP OF ONE HUNDRED OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; AND

(4) "ASSOCIATION GROUP" MEANS A GROUP DEFINED IN SUBPARAGRAPHS (B), (D), (H), (K), (L) OR (M) OF PARAGRAPH ONE OF SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, PROVIDED THAT:

(A) THE GROUP INCLUDES ONE OR MORE INDIVIDUAL MEMBERS; OR

(B) THE GROUP INCLUDES ONE OR MORE MEMBER EMPLOYERS OR OTHER MEMBER GROUPS THAT ARE SMALL GROUPS.

(I) AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF THE BENEFITS MUST BE COVERED PURSUANT TO SUBSECTION (H) OF THIS SECTION. FOR ANY POLICY ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, AN INSURER SHALL NOT BE REQUIRED TO OFFER THE POLICYHOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION.

S 55. Subsection (gg) of section 4303 of the insurance law, as added by chapter 536 of the laws of 2010, is relettered to be subsection (jj), subsection (hh), as added by chapter 597 of the laws of 2011, is relettered to be subsection (kk) and two new subsections (ll) and (mm) are added to read as follows:

(LL) EVERY SMALL GROUP CONTRACT OR ASSOCIATION GROUP CONTRACT DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE THAT PROVIDES COVERAGE FOR HOSPITAL, MEDICAL OR SURGICAL EXPENSE INSURANCE AND IS NOT A GRANDFATHERED HEALTH PLAN SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS SUBSECTION:

(1) "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A);

(2) "GRANDFATHERED HEALTH PLAN" MEANS COVERAGE PROVIDED BY A CORPORATION IN WHICH AN INDIVIDUAL WAS ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E); AND

(3) "SMALL GROUP" MEANS A GROUP OF FIFTY OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS. BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN, "SMALL GROUP" MEANS A GROUP OF ONE HUNDRED OR FEWER EMPLOYEES OR MEMBERS EXCLUSIVE OF SPOUSES AND DEPENDENTS; AND

(4) "ASSOCIATION GROUP" MEANS A GROUP DEFINED IN SUBPARAGRAPHS (B), (D), (H), (K), (L) OR (M) OF PARAGRAPH ONE OF SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, PROVIDED THAT:

(A) THE GROUP INCLUDES ONE OR MORE INDIVIDUAL MEMBERS; OR

(B) THE GROUP INCLUDES ONE OR MORE MEMBER EMPLOYERS OR OTHER MEMBER GROUPS THAT ARE SMALL GROUPS.

(MM) A CORPORATION SHALL NOT BE REQUIRED TO OFFER THE CONTRACT HOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION IF SUCH BENEFITS MUST BE COVERED PURSUANT TO SUBSECTION (KK) OF THIS SECTION. FOR ANY CONTRACT ISSUED WITHIN THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031, A CORPORATION SHALL NOT BE REQUIRED TO OFFER THE CONTRACT HOLDER ANY BENEFITS THAT MUST BE MADE AVAILABLE PURSUANT TO THIS SECTION.

S 55-a. Section 3221 of the insurance law is amended by adding a new subsection (s) to read as follows:

(S) AN INSURER SUBJECT TO THE PROVISIONS OF THIS ARTICLE OR AN INSURANCE PRODUCER SUBJECT TO THIS CHAPTER SHALL NOT PERMIT THE RENEWAL OF A SMALL GROUP POLICY THAT PROVIDES HOSPITAL, SURGICAL OR MEDICAL EXPENSE COVERAGE THAT RENEWS ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BUT BEFORE JULY FIRST, TWO THOUSAND FOURTEEN, SO AS TO RENEW THE SAME POLICY PRIOR TO THE POLICY'S ANNUAL RENEWAL DATE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT AND REGULATIONS PROMULGATED THEREUNDER WITH RESPECT TO SUCH POLICY. AN ISOLATED, INADVERTENT RENEWAL DATE CHANGE WHICH WAS NOT MADE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT SHALL NOT BE DEEMED A VIOLATION OF THIS SUBSECTION.

S 55-b. Section 4303 of the insurance law is amended by adding a new subsection (nn) to read as follows:

(NN) A CORPORATION SUBJECT TO THE PROVISIONS OF THIS ARTICLE OR AN INSURANCE PRODUCER SUBJECT TO THIS CHAPTER SHALL NOT PERMIT THE RENEWAL OF A SMALL GROUP POLICY WHICH PROVIDES HOSPITAL, SURGICAL OR MEDICAL EXPENSE COVERAGE THAT RENEWS ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, BUT BEFORE JULY FIRST, TWO THOUSAND FOURTEEN, SO AS TO RENEW THE SAME POLICY PRIOR TO THE POLICY'S ANNUAL RENEWAL DATE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT AND REGULATIONS PROMULGATED THEREUNDER WITH RESPECT TO SUCH POLICY. AN ISOLATED, INADVERTENT RENEWAL DATE CHANGE WHICH WAS NOT MADE FOR THE SOLE PURPOSE OF EVADING THE REQUIREMENTS OF THE AFFORDABLE CARE ACT SHALL NOT BE DEEMED A VIOLATION OF THIS SUBSECTION.

S 56. Section 4326 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (b) as amended by chapter 342 of the laws of 2004, subparagraph (A) of paragraph 1 and subparagraph (C) of paragraph 3 of subsection (c) as amended by chapter 419 of the laws of 2000, para-

graphs 13 and 14 of subsection (d), paragraphs 6 and 7 of subsection (e) and subsection (k) as amended and paragraph 15 of subsection (d) as added by chapter 219 of the laws of 2011 and subsections (d-1), (d-2) and (d-3) as added by chapter 645 of the laws of 2005, is amended to read as follows:

S 4326. Standardized health insurance contracts for qualifying small employers and individuals. (a) A program is hereby established for the purpose of making standardized health insurance contracts available to qualifying small employers [and qualifying individuals] as defined in this section. Such program is designed to encourage small employers to offer health insurance coverage to their employees [and to also make coverage available to uninsured employees whose employers do not provide group health insurance].

(b) Participation in the program established by this section and section four thousand three hundred twenty-seven of this article is limited to corporations or insurers organized or licensed under this article or article forty-two of this chapter and health maintenance organizations issued a certificate of authority under article forty-four of the public health law or licensed under this article. Participation by all health maintenance organizations is mandatory, provided, however, that such requirements shall not apply to a HOLDER OF A SPECIAL PURPOSE CERTIFICATE OF AUTHORITY ISSUED PURSUANT TO SECTION FOUR THOUSAND FOUR HUNDRED THREE-A OF THE PUBLIC HEALTH LAW OR A health maintenance organization exclusively serving individuals enrolled pursuant to title eleven of article five of the social services law, title eleven-D of article five of the social services law, title one-A of article twenty-five of the public health law or title eighteen of the federal Social Security Act[, and, further provided, that such health maintenance organization shall not discontinue a contract for an individual receiving comprehensive-type coverage in effect prior to January first, two thousand four who is ineligible to purchase policies offered after such date pursuant to this section or section four thousand three hundred twenty-two of this article due to the provision of 42 U.S.C. 1395ss in effect prior to January first, two thousand four]. On and after January first, two thousand one, all health maintenance organizations shall offer qualifying group health insurance contracts [and qualifying individual health insurance contracts] as defined in this section. For the purposes of this section and section four thousand three hundred twenty-seven of this article, article forty-three corporations or article forty-two insurers which voluntarily participate in compliance with the requirements of this program shall be eligible for reimbursement from the stop loss funds created pursuant to section four thousand three hundred twenty-seven of this article under the same terms and conditions as health maintenance organizations.

(c) The following definitions shall be applicable to the insurance contracts offered under the program established by this section:

(1) (A) A qualifying small employer is [an employer that is either:

(A) An individual proprietor who is the only employee of the business:

(i) without health insurance which provides benefits on an expense reimbursed or prepaid basis in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(ii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income;

(iii) except that the requirements set forth in item (i) of this subparagraph shall not be applicable where an individual proprietor had health insurance coverage during the previous twelve months and such coverage terminated due to one of the reasons set forth in items (i) through (viii) of subparagraph (C) of paragraph three of subsection (c) of this section; or

(B) An] AN employer with:

(i) not more than fifty [eligible] employees;

(ii) no group health insurance [which] THAT provides benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to application for a qualifying group health insurance contract under the program established by this section; and

(iii) at least thirty percent of its [eligible] employees receiving annual wages from the employer at a level equal to or less than thirty thousand dollars. The thirty thousand dollar figure shall be adjusted periodically pursuant to subparagraph [(F)] (D) of this paragraph.

[(C) The requirements set forth in item (i) of subparagraph (A) of this paragraph and in item (ii) of subparagraph (B) of this paragraph shall not be applicable where an individual proprietor or employer is transferring from a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or from health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(D)] (B) The twelve month period set forth [in item (i) of subparagraph (A) of this paragraph and] in item (ii) of subparagraph [(B)] (A) of this paragraph may be adjusted by the superintendent from twelve months to eighteen months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of [other health insurance contracts for] qualifying group health insurance contracts FOR OTHER HEALTH INSURANCE CONTRACTS.

[(E)] (C) An [individual proprietor or] employer shall cease to be a qualifying small employer if any health insurance [which] THAT provides benefits on an expense reimbursed or prepaid basis covering [the individual proprietor or] an employer's employees, other than qualifying group health insurance purchased pursuant to this section, is purchased or otherwise takes effect subsequent to purchase of qualifying group health insurance under the program established by this section.

[(F)] (D) The wage levels utilized in subparagraph [(B)] (A) of this paragraph shall be adjusted annually, beginning in two thousand two. The adjustment shall take effect on July first of each year. For July first, two thousand two, the adjustment shall be a percentage of the annual wage figure specified in subparagraph [(B)] (A) of this paragraph. For subsequent years, the adjustment shall be a percentage of the annual wage figure [which] THAT took effect on July first of the prior year. The percentage adjustment shall be the same percentage by which the current year's non-farm federal poverty level, as defined and updated by the federal department of health and human services, for a family unit of four persons for the forty-eight contiguous states and Washington, D.C., changed from the same level established for the prior year.

(2) A qualifying group health insurance contract is a group contract purchased from a health maintenance organization, corporation or insurer by a qualifying small employer [which] THAT provides the benefits set

forth in subsection (d) of this section. The contract must insure not less than fifty percent of the employees [eligible for coverage].

[(3)(A) A qualifying individual is an employed person:

(i) who does not have and has not had health insurance with benefits on an expense reimbursed or prepaid basis during the twelve month period prior to the individual's application for health insurance under the program established by this section;

(ii) whose employer does not provide group health insurance and has not provided group health insurance with benefits on an expense reimbursed or prepaid basis covering employees in effect during the twelve month period prior to the individual's application for health insurance under the program established by this section;

(iii) resides in a household having a net household income at or below two hundred eight percent of the non-farm federal poverty level (as defined and updated by the federal department of health and human services) or the gross equivalent of such net income; and

(iv) is ineligible for Medicare.

(B) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual is transferring from a health insurance contract issued pursuant to the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, a health insurance contract issued pursuant to the New York state small business health insurance partnership program established by section nine hundred twenty-two of the public health law or health care coverage issued pursuant to a regional pilot project for the uninsured established by section one thousand one hundred eighteen of this chapter.

(C) The requirements set forth in items (i) and (ii) of subparagraph (A) of this paragraph shall not be applicable where an individual had health insurance coverage during the previous twelve months and such coverage terminated due to:

(i) loss of employment due to factors other than voluntary separation;

(ii) death of a family member which results in termination of coverage under a health insurance contract under which the individual is covered;

(iii) change to a new employer that does not provide group health insurance with benefits on an expense reimbursed or prepaid basis;

(iv) change of residence so that no employer-based health insurance with benefits on an expense reimbursed or prepaid basis is available;

(v) discontinuation of a group health insurance contract with benefits on an expense reimbursed or prepaid basis covering the qualifying individual as an employee or dependent;

(vi) expiration of the coverage periods established by the continuation provisions of the Employee Retirement Income Security Act, 29 U.S.C. section 1161 et seq. and the Public Health Service Act, 42 U.S.C. section 300bb-1 et seq. established by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or the continuation provisions of subsection (m) of section three thousand two hundred twenty-one, subsection (k) of section four thousand three hundred four and subsection (e) of section four thousand three hundred five of this chapter;

(vii) legal separation, divorce or annulment which results in termination of coverage under a health insurance contract under which the individual is covered; or

(viii) loss of eligibility under a group health plan.

(D) The twelve month period set forth in items (i) and (ii) of subparagraph (A) of this paragraph may be adjusted by the superintendent from

twelve months to eighteen months if he determines that the twelve month period is insufficient to prevent inappropriate substitution of other health insurance contracts for qualifying individual health insurance contracts.

(4) A qualifying individual health insurance contract is an individual contract issued directly to a qualifying individual and which provides the benefits set forth in subsection (d) of this section. At the option of the qualifying individual, such contract may include coverage for dependents of the qualifying individual.]

(d) [The contracts issued pursuant to this section by health maintenance organizations, corporations or insurers and approved by the superintendent shall only provide in-plan benefits, except for emergency care or where services are not available through a plan provider. Covered services shall include only the following:

(1) inpatient hospital services consisting of daily room and board, general nursing care, special diets and miscellaneous hospital services and supplies;

(2) outpatient hospital services consisting of diagnostic and treatment services;

(3) physician services consisting of diagnostic and treatment services, consultant and referral services, surgical services (including breast reconstruction surgery after a mastectomy), anesthesia services, second surgical opinion, and a second opinion for cancer treatment;

(4) outpatient surgical facility charges related to a covered surgical procedure;

(5) preadmission testing;

(6) maternity care;

(7) adult preventive health services consisting of mammography screening; cervical cytology screening; periodic physical examinations no more than once every three years; and adult immunizations;

(8) preventive and primary health care services for dependent children including routine well-child visits and necessary immunizations;

(9) equipment, supplies and self-management education for the treatment of diabetes;

(10) diagnostic x-ray and laboratory services;

(11) emergency services;

(12) therapeutic services consisting of radiologic services, chemotherapy and hemodialysis;

(13) blood and blood products furnished in connection with surgery or inpatient hospital services;

(14) prescription drugs obtained at a participating pharmacy. In addition to providing coverage at a participating pharmacy, health maintenance organizations may utilize a mail order prescription drug program. Health maintenance organizations may provide prescription drugs pursuant to a drug formulary; however, health maintenance organizations must implement an appeals process so that the use of non-formulary prescription drugs may be requested by a physician; and

(15) for a contract that is not a grandfathered health plan, the following additional preventive health services:

(A) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;

(B) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(C) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the health resources and services administration; and

(D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this paragraph as provided for in comprehensive guidelines supported by the health resources and services administration.

(E) For purposes of this paragraph, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e)] A QUALIFYING GROUP HEALTH INSURANCE CONTRACT SHALL PROVIDE COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). FOR PURPOSES OF THIS SUBSECTION "ESSENTIAL HEALTH BENEFITS PACKAGE" SHALL HAVE THE MEANING SET FORTH IN SECTION 1302(A) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(A).

(d-1) Covered services shall not include drugs, procedures and supplies for the treatment of erectile dysfunction when provided to, or prescribed for use by, a person who is required to register as a sex offender pursuant to article six-C of the correction law, provided that: (1) any denial of coverage pursuant to this subsection shall provide the enrollee with the means of obtaining additional information concerning both the denial and the means of challenging such denial; (2) all drugs, procedures and supplies for the treatment of erectile dysfunction may be subject to prior authorization by corporations, insurers or health maintenance organizations for the purposes of implementing this subsection; and (3) the superintendent shall promulgate regulations to implement the denial of coverage pursuant to this subsection giving health maintenance organizations, corporations and insurers at least sixty days following promulgation of the regulations to implement their denial procedures pursuant to this subsection.

(d-2) No person or entity authorized to provide coverage under this section shall be subject to any civil or criminal liability for damages for any decision or action pursuant to subsection (d-1) of this section, made in the ordinary course of business if that authorized person or entity acted reasonably and in good faith with respect to such information.

(d-3) Notwithstanding any other provision of law, if the commissioner of health makes a finding pursuant to subdivision twenty-three of section two hundred six of the public health law, the superintendent is authorized to remove a drug, procedure or supply from the services covered by the standardized health insurance contract established by this section for those persons required to register as sex offenders pursuant to article six-C of the correction law.

(e) [The benefits provided in the contracts described in subsection (d) of this section shall be subject to the following deductibles and copayments:

(1) in-patient hospital services shall have a five hundred dollar copayment for each continuous hospital confinement;

(2) surgical services shall be subject to a copayment of the lesser of twenty percent of the cost of such services or two hundred dollars per occurrence;

(3) outpatient surgical facility charges shall be subject to a facility copayment charge of seventy-five dollars per occurrence;

(4) emergency services shall have a fifty dollar copayment which must be waived if hospital admission results from the emergency room visit;

(5) prescription drugs shall have a one hundred dollar calendar year deductible per individual. After the deductible is satisfied, each thirty-four day supply of a prescription drug will be subject to a copayment. The copayment will be ten dollars if the drug is generic. The copayment for a brand name drug will be twenty dollars plus the difference in cost between the brand name drug and the equivalent generic drug. If a mail order drug program is utilized, a twenty dollar copayment shall be imposed on a ninety day supply of generic prescription drugs. A forty dollar copayment plus the difference in cost between the brand name drug and the equivalent generic drug shall be imposed on a ninety day supply of brand name prescription drugs. In no event shall the copayment exceed the cost of the prescribed drug;

(6) (A) the maximum coverage for prescription drugs in an individual contract that is a grandfathered health plan shall be three thousand dollars per individual in a calendar year; and

(B) the maximum dollar amount on coverage for prescription drugs in an individual contract that is not a grandfathered health plan or in any group contract shall be consistent with section 2711 of the Public Health Service Act, 42 U.S.C. S 300gg-11 or any regulations thereunder.

(C) For purposes of this paragraph, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e); and

(7) all other services shall have a twenty dollar copayment with the exception of prenatal care which shall have a ten dollar copayment or preventive health services provided pursuant to paragraph fifteen of subsection (d) of this section, for which no copayment shall apply] A QUALIFYING GROUP HEALTH INSURANCE CONTRACT ISSUED TO A QUALIFYING SMALL EMPLOYER PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DOES NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A), SHALL BE DISCONTINUED, INCLUDING GRANDFATHERED HEALTH PLANS. FOR THE PURPOSES OF THIS PARAGRAPH, "GRANDFATHERED HEALTH PLANS" MEANS COVERAGE PROVIDED BY A CORPORATION TO INDIVIDUALS WHO WERE ENROLLED ON MARCH TWENTY-THIRD, TWO THOUSAND TEN FOR AS LONG AS THE COVERAGE MAINTAINS GRANDFATHERED STATUS IN ACCORDANCE WITH SECTION 1251(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18011(E). A QUALIFYING SMALL EMPLOYER SHALL BE TRANSITIONED TO A PLAN THAT PROVIDES: (1) A LEVEL OF COVERAGE THAT IS DESIGNED TO PROVIDE BENEFITS THAT ARE ACTUARIALLY EQUIVALENT TO EIGHTY PERCENT OF THE FULL ACTUARIAL VALUE OF THE BENEFITS PROVIDED UNDER THE PLAN; AND (2) COVERAGE FOR THE ESSENTIAL HEALTH BENEFIT PACKAGE AS REQUIRED IN SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A). THE SUPERINTENDENT SHALL STANDARDIZE THE BENEFIT PACKAGE AND COST SHARING REQUIREMENTS OF QUALIFIED GROUP HEALTH INSURANCE CONTRACTS CONSISTENT WITH COVERAGE OFFERED THROUGH THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031.

(f) [Except as included in the list of covered services in subsection (d) of this section, the] THE mandated and make-available benefits set forth in sections [three thousand two hundred sixteen,] three thousand two hundred twenty-one of this chapter and four thousand three hundred three of this article shall not be applicable to the contracts issued pursuant to this section. [Mandated benefits included in such contracts

shall be subject to the deductibles and copayments set forth in subsection (e) of this section.]

(g) [The superintendent shall be authorized to modify, by regulation, the copayment and deductible amounts described in this section if the superintendent determines such amendments are necessary to facilitate implementation of this section. On or after January first, two thousand two, the superintendent shall be authorized to establish, by regulation, one or more additional standardized health insurance benefit packages if the superintendent determines additional benefit packages with different levels of benefits are necessary to meet the needs of the public.

(h)] A health maintenance organization, corporation or insurer must offer the benefit package without change or additional benefits. [Qualifying] A QUALIFYING small [employers] EMPLOYER shall be issued the benefit package in a qualifying group health insurance contract. [Qualifying individuals shall be issued the benefit package in a qualifying individual health insurance contract.

(i)] (H) A health maintenance organization, corporation or insurer shall obtain from the employer [or individual] written certification at the time of initial application and annually thereafter ninety days prior to the contract renewal date that such employer [or individual] meets the requirements of a qualifying small employer [or a qualifying individual] pursuant to this section. A health maintenance organization, corporation or insurer may require the submission of appropriate documentation in support of the certification.

[(j)] (I) Applications for qualifying group health insurance contracts [and qualifying individual health insurance contracts] must be accepted from [any qualifying individual and] any qualifying small employer at all times throughout the year. The superintendent, by regulation, may require health maintenance organizations, corporations or insurers to give preference to qualifying small employers whose [eligible] employees have the lowest average salaries.

[(k) (1) All coverage under a qualifying group health insurance contract or a qualifying individual health insurance contract must be subject to a pre-existing condition limitation provision as set forth in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, including the crediting requirements thereunder. The underwriting of such contracts may not involve more than the imposition of a pre-existing condition limitation. However, as provided in sections three thousand two hundred thirty-two of this chapter and four thousand three hundred eighteen of this article, a corporation shall not impose a pre-existing condition limitation provision on any person under age nineteen, except may impose such a limitation on those persons covered by a qualifying individual health insurance contract that is a grandfathered health plan.

(2)] (J) Beginning January first, two thousand fourteen, pursuant to section 2704 of the Public Health Service Act, 42 U.S.C. S 300gg-3, a corporation shall not impose any pre-existing condition limitation in a qualifying group health insurance contract [or a qualifying individual health insurance contract except may impose such a limitation in a qualifying individual health insurance contract that is a grandfathered health plan].

[(3) For purposes of paragraphs one and two of this subsection, "grandfathered health plan" means coverage provided by a corporation in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. S 18011(e).

(l)] (K) A qualifying small employer shall elect whether to make coverage under the qualifying group health insurance contract available to dependents of employees. Any employee or dependent who is enrolled in Medicare is ineligible for coverage, unless required by federal law. Dependents of an employee who is enrolled in Medicare will be eligible for dependent coverage provided the dependent is not also enrolled in Medicare.

[(m)] (L) A qualifying small employer must pay at least fifty percent of the premium for employees covered under a qualifying group health insurance contract and must offer coverage to all employees receiving annual wages at a level of thirty thousand dollars or less, and at least one such employee shall accept such coverage. The thirty thousand dollar wage level shall be adjusted periodically in accordance with subparagraph [(F)] (D) of paragraph one of subsection (c) of this section. The employer premium contribution must be the same percentage for all covered employees.

[(n)] (M) Premium rate calculations for qualifying group health insurance contracts [and qualifying individual health insurance contracts] shall be subject to the following:

(1) coverage must be community rated and [include rate tiers for individuals, two adult families and at least one other family tier. The rate differences must be based upon the cost differences for the different family units and the rate tiers must be uniformly applied. The rate tier structure used by a health maintenance organization, corporation or insurer for the contracts issued to qualifying small employers and to qualifying individuals must be the same] THE SUPERINTENDENT SHALL SET STANDARD RATING TIERS FOR FAMILY UNITS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL CONTRACTS SUBJECT TO THIS SECTION; AND

(2) [if geographic rating areas are utilized, such geographic areas must be reasonable and in a given case may include a single county. The geographic areas utilized must be the same for the contracts issued to qualifying small employers and to qualifying individuals. The superintendent shall not require the inclusion of any specific geographic region within the proposed community rated region selected by the health maintenance organization, corporation or insurer so long as the health maintenance organization, corporation or insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the health maintenance organization, corporation or insurer's community rates.] BEGINNING JANUARY FIRST, TWO THOUSAND FOURTEEN, EVERY POLICY SUBJECT TO THIS SECTION SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTENDENT; AND

(3) claims experience under contracts issued to qualifying small employers [and to qualifying individuals] must be pooled WITH THE HEALTH MAINTENANCE ORGANIZATION, CORPORATION OR INSURER'S SMALL GROUP BUSINESS for rate setting purposes. [The premium rates for qualifying group health insurance contracts and qualifying individual health insurance contracts must be the same.

(o)] (N) A health maintenance organization, corporation or insurer shall submit reports to the superintendent in such form and at times as may be reasonably required in order to evaluate the operations and results of the standardized health insurance program established by this section.

[(p) Notwithstanding any other provision of law, all individuals and small businesses that are participating in or covered by insurance contracts or policies issued pursuant to the New York state small business health insurance partnership program established by section nine

hundred twenty-two of the public health law, the voucher insurance program established by section one thousand one hundred twenty-one of this chapter, or uninsured pilot programs established pursuant to chapter seven hundred three of the laws of nineteen hundred eighty-eight shall be eligible for participation in the standardized health insurance contracts established by this section, regardless of any of the eligibility requirements established pursuant to subsection (c) of this section.]

S 57. The insurance law is amended by adding a new section 4326-a to read as follows:

S 4326-A. TRANSITION OF HEALTHY NEW YORK ENROLLEES. (A) ON DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, COVERAGE ISSUED TO QUALIFYING INDIVIDUALS AND QUALIFYING SMALL EMPLOYERS WHO ARE SOLE PROPRIETORS AS DEFINED IN SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX SHALL END CONTINGENT UPON THE AVAILABILITY OF COVERAGE FOR INDIVIDUAL AND SOLE PROPRIETORS THROUGH THE HEALTH BENEFIT EXCHANGE.

(B) A HEALTH MAINTENANCE ORGANIZATION, CORPORATION, OR INSURER SHALL PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCONTINUANCE TO EACH ENROLLED INDIVIDUAL AND INDIVIDUAL PROPRIETOR AT LEAST ONE HUNDRED AND EIGHTY DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. EVERY NOTICE OF PROGRAM DISCONTINUANCE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION AS THE SUPERINTENDENT REQUIRES.

(C) QUALIFYING GROUP HEALTH INSURANCE CONTRACTS ISSUED TO QUALIFYING SMALL EMPLOYERS PRIOR TO JANUARY FIRST, TWO THOUSAND FOURTEEN THAT DO NOT INCLUDE ALL ESSENTIAL HEALTH BENEFITS REQUIRED PURSUANT TO SECTION 2707(A) OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6(A); SHALL BE DISCONTINUED. QUALIFYING SMALL EMPLOYERS THAT ARE IMPACTED BY THE DISCONTINUANCE SHALL BE TRANSITIONED TO A PLAN THAT MEETS THE REQUIREMENTS OF SUBSECTION (E) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-SIX OF THIS CHAPTER. A HEALTH MAINTENANCE ORGANIZATION, CORPORATION, OR INSURER SHALL PROVIDE WRITTEN NOTICE OF THE PROGRAM DISCONTINUANCE TO EACH ENROLLED QUALIFYING SMALL EMPLOYER AT LEAST ONE HUNDRED EIGHTY DAYS PRIOR TO THE DATE OF PROGRAM DISCONTINUANCE. EVERY NOTICE OF PROGRAM DISCONTINUANCE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION AS REQUIRED BY THE SUPERINTENDENT.

S 58. Section 4327 of the insurance law, as added by chapter 1 of the laws of 1999, subsection (h) as amended by chapter 419 of the laws of 2000, subsection (m-1) as added by section 12 of part B of chapter 58 of the laws of 2010, subsection (s) as amended and subsection (t) as added by chapter 441 of the laws of 2006, is amended to read as follows:

S 4327. Stop loss funds for standardized health insurance contracts issued to qualifying small employers and qualifying individuals. (a) The superintendent shall establish a fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying group health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article. This fund shall be known as the "small employer stop loss fund". [The superintendent shall establish a separate and distinct fund from which health maintenance organizations, corporations or insurers may receive reimbursement, to the extent of funds available therefor, for claims paid by such health maintenance organizations, corporations or insurers for members covered under qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twen-

ty-six of this article. This fund shall be known as the "qualifying individual stop loss fund".]

(b) [Commencing on January first, two thousand one, health] HEALTH maintenance organizations, corporations or insurers shall be eligible to receive reimbursement for ninety percent of claims paid between [thirty] FIVE thousand and [one hundred] SEVENTY-FIVE thousand dollars in a calendar year for any member covered under a standardized contract issued pursuant to section four thousand three hundred twenty-six of this article. Claims paid for members covered under qualifying group health insurance contracts shall be reimbursable from the small employer stop loss fund. [Claims paid for members covered under qualifying individual health insurance contracts shall be reimbursable from the qualifying individual stop loss fund.] For the purposes of this section, claims shall include health care claims paid by a health maintenance organization on behalf of a covered member pursuant to such standardized contracts.

(c) The superintendent shall promulgate regulations that set forth procedures for the operation of the small employer stop loss fund [and the qualifying individual stop loss fund] and distribution of monies therefrom.

(d) [The small employer stop loss fund shall operate separately from the qualifying individual stop loss fund. Except as specified in subsection (b) of this section with respect to calendar year two thousand one, the level of stop loss coverage for the qualifying group health insurance contracts and the qualifying individual health insurance contracts need not be the same. The two stop loss funds need not be structured or operated in the same manner, except as specified in this section. The monies available for distribution from the stop loss funds may be reallocated between the small employer stop loss fund and the qualifying individual stop loss fund if the superintendent determines that such reallocation is warranted due to enrollment trends.] THE SUPERINTENDENT MAY ADJUST THE LEVEL OF STOP LOSS COVERAGE SPECIFIED IN SUBSECTION (B) OF THIS SECTION.

(e) Claims shall be reported and funds shall be distributed from the small employer stop loss fund [and from the qualifying individual stop loss fund] on a calendar year basis. Claims shall be eligible for reimbursement only for the calendar year in which the claims are paid. Once claims paid on behalf of a covered member reach or exceed one hundred thousand dollars in a given calendar year, no further claims paid on behalf of such member in that calendar year shall be eligible for reimbursement.

(f) Each health maintenance organization, corporation or insurer shall submit a request for reimbursement from [each of] the stop loss [funds] FUND on forms prescribed by the superintendent. [Each of the] THE requests for reimbursement shall be submitted no later than April first following the end of the calendar year for which the reimbursement requests are being made. The superintendent may require health maintenance organizations, corporations or insurers to submit such claims data in connection with the reimbursement requests as he deems necessary to enable him to distribute monies and oversee the operation of the small employer [and qualifying individual] stop loss [funds] FUND. The superintendent may require that such data be submitted on a per member, aggregate and/or categorical basis. [Data shall be reported separately for qualifying group health insurance contracts and qualifying individual health insurance contracts issued pursuant to section four thousand three hundred twenty-six of this article.]

(g) For [each] THE stop loss fund, the superintendent shall calculate the total claims reimbursement amount for all health maintenance organizations, corporations or insurers for the calendar year for which claims are being reported.

(1) In the event that the total amount requested for reimbursement for a calendar year exceeds funds available for distribution for claims paid during that same calendar year, the superintendent shall provide for the pro-rata distribution of the available funds. Each health maintenance organization, corporation or insurer shall be eligible to receive only such proportionate amount of the available funds as the individual health maintenance organization's, corporation's or insurer's total eligible claims paid bears to the total eligible claims paid by all health maintenance organizations, corporations or insurers.

(2) In the event that funds available for distribution for claims paid by all health maintenance organizations, corporations or insurers during a calendar year exceeds the total amount requested for reimbursement by all health maintenance organizations, corporations or insurers during that same calendar year, any excess funds shall be carried forward and made available for distribution in the next calendar year. Such excess funds shall be in addition to the monies appropriated for the stop loss fund in the next calendar year.

(h) Upon the request of the superintendent, each health maintenance organization shall be required to furnish such data as the superintendent deems necessary to oversee the operation of the small employer [and qualifying individual] stop loss [funds] FUND. Such data shall be furnished in a form prescribed by the superintendent. Each health maintenance organization, corporation or insurer shall provide the superintendent with monthly reports of the total enrollment under the qualifying group health insurance contracts [and the qualifying individual health insurance contracts] issued pursuant to section four thousand three hundred twenty-six of this article. The reports shall be in a form prescribed by the superintendent.

(i) The superintendent shall separately estimate the per member annual cost of total claims reimbursement from each stop loss fund for [qualifying individual health insurance contracts and for] qualifying group health insurance contracts based upon available data and appropriate actuarial assumptions. Upon request, each health maintenance organization, corporation or insurer shall furnish to the superintendent claims experience data for use in such estimations.

(j) The superintendent shall determine total eligible enrollment under qualifying group health insurance contracts [and qualifying individual health insurance contracts]. [For qualifying group health insurance contracts, the] THE total eligible enrollment shall be determined by dividing the total funds available for distribution from the small employer stop loss fund by the estimated per member annual cost of total claims reimbursement from the small employer stop loss fund. [For qualifying individual health insurance contracts, the total eligible enrollment shall be determined by dividing the total funds available for distribution from the qualifying individual stop loss fund by the estimated per member annual cost of total claims reimbursement from the qualifying individual stop loss fund.]

(k) The superintendent shall suspend the enrollment of new employers under qualifying group health insurance contracts if [he] THE SUPERINTENDENT determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated

annual expenditures from the small employer stop loss fund in excess of the total funds available for distribution from such stop loss fund. [The superintendent shall suspend the enrollment of new individuals under qualifying individual health insurance contracts if he determines that the total enrollment reported by all health maintenance organizations, corporations or insurers under such contracts exceeds the total eligible enrollment, thereby resulting in anticipated annual expenditures from the qualifying individual stop loss fund in excess of the total funds available for distribution from such stop loss fund.]

(l) The superintendent shall provide the health maintenance organizations, corporations or insurers with notification of any enrollment suspensions as soon as practicable after receipt of all enrollment data. [The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.]

(m) If at any point during a suspension of enrollment of new qualifying small employers [and/or qualifying individuals], the superintendent determines that funds are sufficient to provide for the addition of new enrollments, the superintendent shall be authorized to reactivate new enrollments and to notify all health maintenance organizations, corporations or insurers that enrollment of new employers [and/or individuals] may again commence. [The superintendent's determination and notification shall be made separately for the qualifying group health insurance contracts and for the qualifying individual health insurance contracts.]

(m-1) In the event that the superintendent suspends the enrollment of new individuals for qualifying group health insurance contracts [or qualifying individual health insurance contracts], the superintendent shall ensure that small employers [or sole proprietors] seeking to enroll in a qualified group [or individual] health insurance contract pursuant to section forty-three hundred twenty-six of this article are provided information on and directed to [the family health plus employer partnership program under section three hundred sixty-nine-ff of the social services law] COVERAGE OPTIONS AVAILABLE THROUGH THE HEALTH BENEFIT EXCHANGE ESTABLISHED PURSUANT TO SECTION 1311 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18031.

(n) The suspension of issuance of qualifying group health insurance contracts to new qualifying small employers shall not preclude the addition of new employees of an employer already covered under such a contract or new dependents of employees already covered under such contracts.

(o) [The suspension of issuance of qualifying individual health insurance contracts to new qualifying individuals shall not preclude the addition of new dependents to an existing qualifying individual health insurance contract.

(p)] The premiums for qualifying group health insurance contracts must factor in the availability of reimbursement from the small employer stop loss fund. [The premiums for qualifying individual health insurance contracts must factor in the availability of reimbursement from the qualifying individual stop loss funds.

(q)] (P) The superintendent may obtain the services of an organization to administer the stop loss funds established by this section. [If the superintendent deems it appropriate, he or she may utilize a separate organization for administration of the small employer stop loss fund and the qualifying individual stop loss fund.] The superintendent shall establish guidelines for the submission of proposals by organizations

for the purposes of administering the funds. The superintendent shall make a determination whether to approve, disapprove or recommend modification to the proposal of an applicant to administer the funds. An organization approved to administer the funds shall submit reports to the superintendent in such form and at times as may be required by the superintendent in order to facilitate evaluation and ensure orderly operation of the funds, including[, but not limited to,] an annual report of the affairs and operations of the fund, such report to be delivered to the superintendent and to the chairs of the senate finance committee and the assembly ways and means committee. An organization approved to administer the funds shall maintain records in a form prescribed by the superintendent and which shall be available for inspection by or at the request of the superintendent. The superintendent shall determine the amount of compensation to be allocated to an approved organization as payment for fund administration. Compensation shall be payable from the stop loss coverage funds. An organization approved to administer the funds may be removed by the superintendent and must cooperate in the orderly transition of services to another approved organization or to the superintendent.

[(r)] (Q) If the superintendent deems it appropriate for the proper administration of the small employer stop loss fund [and/or the qualifying individual stop loss fund], the administrator of the fund, on behalf of and with the prior approval of the superintendent, shall be authorized to purchase stop loss insurance and/or reinsurance from an insurance company licensed to write such type of insurance in this state. Such stop loss insurance and/or reinsurance may be purchased to the extent of funds available therefor within such funds which are available for purposes of the stop loss funds established by this section.

[(s)] (R) The superintendent may access funding from the small employer stop loss fund [and/or the qualifying individual stop loss fund] for the purposes of developing and implementing public education, outreach and facilitated enrollment strategies targeted to small employers [and working adults] without health insurance. The superintendent may contract with marketing organizations to perform or provide assistance with such education, outreach, and enrollment strategies. The superintendent shall determine the amount of funding available for the purposes of this subsection which in no event shall exceed eight percent of the annual funding amounts for the small employer stop loss fund [and the qualifying individual stop loss fund].

[(t)] (S) Brooklyn healthworks pilot program and upstate healthworks pilot program. Commencing on July first, two thousand six, the superintendent shall access funding from the small employer stop loss fund [and the qualifying individual stop loss fund] for the purpose of support and expansion of the existing pilot program Brooklyn healthworks approved by the superintendent and for the establishment and operation of a pilot program to be located in upstate New York. For the purpose of this subsection, in no event shall the amount of funding available exceed two percent of the annual funding [amounts] AMOUNT for the small employer stop loss fund [and the qualifying individual stop loss fund].

S 59. Paragraph 1 of subsection (d) of section 4235 of the insurance law is amended to read as follows:

(1) In this section, for the purpose of insurance OTHER THAN FOR GROUP HOSPITAL, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF EXPENSE REIMBURSED INSURANCE hereunder: "employees" includes the officers, managers, employees and retired employees of the employer and of subsidiary or affiliated corporations of a corporate employer, and the

individual proprietors, partners, employees and retired employees of affiliated individuals and firms controlled by the insured employer through stock ownership, contract or otherwise; "employees" may be deemed to include the individual proprietor or partners if the employer is an individual proprietor or a partnership; and "employees" as used in subparagraph (A) of paragraph one of subsection (c) hereof may also include the directors of the employer and of subsidiary or affiliated corporations of a corporate employer.

S 60. Subsection (d) of section 4235 of the insurance law is amended by adding a new paragraph 3 to read as follows:

(3) IN THIS SECTION, FOR THE PURPOSE OF GROUP HOSPITAL, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPES OF EXPENSE REIMBURSED INSURANCE HEREUNDER:

(A) "EMPLOYEE" SHALL HAVE THE MEANING SET FORTH IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-91(D)(5) OR ANY REGULATIONS PROMULGATED THEREUNDER; AND

(B) "FULL-TIME EMPLOYEE" MEANS WITH RESPECT TO ANY MONTH, AN EMPLOYEE WHO IS EMPLOYED ON AVERAGE FOR AT LEAST THIRTY HOURS OF SERVICE PER WEEK AS SET FORTH IN SECTION 4980H(C)(4) OF THE INTERNAL REVENUE CODE, 26 U.S.C. S 4980H(C)(4), OR ANY REGULATIONS PROMULGATED THEREUNDER.

S 61. Subparagraph (B) of paragraph 1 of subsection (e) of section 3231 of the insurance law, as amended by chapter 107 of the laws of 2010, is amended to read as follows:

(B) The expected minimum loss ratio for a policy form subject to this section, for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance policy, or, with the approval of the superintendent, an aggregation of policy forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than [June thirtieth] JULY THIRTY-FIRST of each year, every insurer subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the insurer to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

S 62. Subparagraph (A) of paragraph 3 of subsection (c) of section 4308 of the insurance law, as added by chapter 107 of the laws of 2010, is amended to read as follows:

(A) The expected minimum loss ratio for a contract form subject to this subsection for which a rate filing or application is made pursuant to this paragraph, other than a medicare supplemental insurance contract, or, with the approval of the superintendent, an aggregation of contract forms that are combined into one community rating experience pool and rated consistent with community rating requirements, shall not be less than eighty-two percent. In reviewing a rate filing or application, the superintendent may modify the eighty-two percent expected minimum loss ratio requirement if the superintendent determines the modification to be in the interests of the people of this state or if the superintendent determines that a modification is necessary to maintain insurer solvency. No later than [June thirtieth] JULY THIRTY-FIRST

of each year, every corporation subject to this subparagraph shall annually report the actual loss ratio for the previous calendar year in a format acceptable to the superintendent. If an expected loss ratio is not met, the superintendent may direct the corporation to take corrective action, which may include the submission of a rate filing to reduce future premiums, or to issue dividends, premium refunds or credits, or any combination of these.

S 63. Section 3233 of the insurance law is amended by adding a new subsection (d) to read as follows:

(D) NOTWITHSTANDING ANY PROVISION OF THIS CHAPTER OR ANY OTHER CHAPTER, THE SUPERINTENDENT MAY SUSPEND OR TERMINATE, BY REGULATION, THE OPERATION, IN WHOLE OR IN PART, OF ANY MECHANISM ESTABLISHED AND OPERATING PURSUANT TO THE AUTHORITY OF THIS SECTION PROVIDED THAT THE SUPERINTENDENT DETERMINES THAT THE OBJECTIVES STATED IN SUBSECTION (A) OF THIS SECTION ARE MET BY THE OPERATION OF A MECHANISM OR MECHANISMS ESTABLISHED BY THE FEDERAL GOVERNMENT PURSUANT TO SECTION 1343 OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18063. NOTWITHSTANDING SUBSECTION (B) OF THIS SECTION, THE SUPERINTENDENT MAY EXERCISE THIS AUTHORITY WITHOUT CONVENING A TECHNICAL ADVISORY COMMITTEE.

S 64. Subparagraph (D) of paragraph 2 of subsection (p) of section 3221 of the insurance law, as added by chapter 661 of the laws of 1997, is amended to read as follows:

(D) The insurer is ceasing to offer group or blanket policies in a market in accordance with paragraph three OR SEVEN of this subsection.

S 65. Subsection (p) of section 3221 of the insurance law is amended by adding a new paragraph 7 to read as follows:

(7) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, AN INSURER MAY DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET POLICY OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL OR LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET POLICY OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42 U.S.C. 300GG-6 THAT BECOME APPLICABLE TO SUCH POLICY AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, PROVIDED THAT THE INSURER:

(A) DISCONTINUES THE EXISTING CLASS OF POLICY IN SUCH MARKET AS OF EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE POLICY RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS CHAPTER;

(B) PROVIDES WRITTEN NOTICE TO EACH POLICYHOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE. THE WRITTEN NOTICE SHALL BE IN A FORM SATISFACTORY TO THE SUPERINTENDENT;

(C) OFFERS TO EACH POLICYHOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE GROUP MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY THE INSURER TO A GROUP IN THAT MARKET;

(D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARAGRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE POLICYHOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR

SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

(E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCONTINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR OF THE INSURER THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE THE COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, S 42 U.S.C. 300GG-6 THAT BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN. THE WRITTEN NOTICE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION THE SUPERINTENDENT REQUIRES.

S 66. Item (iii) of subparagraph (C) of paragraph 2 of subsection (c) of section 4304 of the insurance law, as amended by chapter 661 of the laws of 1997, is amended to read as follows:

(iii) Discontinuance of all individual hospital, surgical or medical expense insurance contracts for which the premiums are paid by a remitting agent of a group, in the small group market, or the large group market, or both markets, in this state, in conjunction with a withdrawal from the small group market, or the large group market, or both markets, in this state. Withdrawal from the small group market, or the large group market, or both markets, shall be governed by the requirements of subparagraphs [(B)] (E) and [(C)] (F) of paragraph three of subsection (j) of section four thousand three hundred five of this article. For purposes of this item, "withdrawal" from a market means that no coverage is offered or maintained in such market under contracts issued pursuant to this section or contracts issued pursuant to section four thousand three hundred five of this article.

S 67. Subparagraph (D) of paragraph 2 of subsection (j) of section 4305 of the insurance law, as added by chapter 661 of the laws of 1997, is amended to read as follows:

(D) The corporation is ceasing to offer group or blanket contracts in a market in accordance with paragraph three OR PARAGRAPH SIX of this subsection.

S 68. Subsection (j) of section 4305 of the insurance law is amended by adding a new paragraph 6 to read as follows:

(6) NOTWITHSTANDING PARAGRAPH THREE OF THIS SUBSECTION, A CORPORATION MAY DISCONTINUE OFFERING A PARTICULAR CLASS OF GROUP OR BLANKET CONTRACT OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE OFFERED IN THE SMALL OR LARGE GROUP MARKET, AND INSTEAD OFFER A GROUP OR BLANKET CONTRACT OF HOSPITAL, SURGICAL OR MEDICAL EXPENSE INSURANCE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH CONTRACT AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, PROVIDED THAT THE CORPORATION:

(A) DISCONTINUES THE EXISTING CLASS OF CONTRACT IN SUCH MARKET AS OF EITHER DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN OR THE CONTRACT RENEWAL DATE OCCURRING IN TWO THOUSAND FOURTEEN IN ACCORDANCE WITH THIS CHAPTER;

(B) PROVIDES WRITTEN NOTICE TO EACH CONTRACT HOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET (AND TO ALL EMPLOYEES AND MEMBER INSUREDS COVERED UNDER SUCH COVERAGE) OF THE DISCONTINUANCE AT LEAST NINETY DAYS PRIOR TO THE DATE OF DISCONTINUANCE OF SUCH COVERAGE. THE WRITTEN NOTICE SHALL BE IN A FORM SATISFACTORY TO THE SUPERINTENDENT;

(C) OFFERS TO EACH CONTRACT HOLDER PROVIDED COVERAGE OF THE CLASS IN THE MARKET, THE OPTION TO PURCHASE ALL (OR, IN THE CASE OF THE LARGE GROUP MARKET, ANY) OTHER HOSPITAL, SURGICAL AND MEDICAL EXPENSE COVERAGE

THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME APPLICABLE TO SUCH COVERAGE AS OF JANUARY FIRST, TWO THOUSAND FOURTEEN, CURRENTLY BEING OFFERED BY THE CORPORATION TO A GROUP IN THAT MARKET;

(D) IN EXERCISING THE OPTION TO DISCONTINUE COVERAGE OF THE CLASS AND IN OFFERING THE OPTION OF COVERAGE UNDER SUBPARAGRAPH (C) OF THIS PARAGRAPH, ACTS UNIFORMLY WITHOUT REGARD TO THE CLAIMS EXPERIENCE OF THOSE CONTRACT HOLDERS OR ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY PARTICULAR COVERED EMPLOYEE, MEMBER INSURED OR DEPENDENT, OR PARTICULAR NEW EMPLOYEE, MEMBER INSURED, OR DEPENDENT WHO MAY BECOME ELIGIBLE FOR SUCH COVERAGE, AND DOES NOT DISCONTINUE THE COVERAGE OF THE CLASS WITH THE INTENT OR AS A PRETEXT TO DISCONTINUING THE COVERAGE OF ANY SUCH EMPLOYEE, MEMBER INSURED, OR DEPENDENT; AND

(E) AT LEAST ONE HUNDRED TWENTY DAYS PRIOR TO THE DATE OF THE DISCONTINUANCE OF SUCH COVERAGE, PROVIDES WRITTEN NOTICE TO THE SUPERINTENDENT OF THE DISCONTINUANCE, INCLUDING CERTIFICATION BY AN OFFICER OR DIRECTOR OF THE CORPORATION THAT THE REASON FOR THE DISCONTINUANCE IS TO REPLACE THE COVERAGE WITH NEW COVERAGE THAT COMPLIES WITH THE REQUIREMENTS OF SECTION 2707 OF THE PUBLIC HEALTH SERVICE ACT, 42 U.S.C. S 300GG-6 THAT BECOME EFFECTIVE JANUARY FIRST, TWO THOUSAND FOURTEEN. THE WRITTEN NOTICE SHALL BE IN SUCH FORM AND CONTAIN SUCH INFORMATION THE SUPERINTENDENT REQUIRES.

S 69. Subsections (a), (b) and (c) of section 3231 of the insurance law, subsection (a) as amended by chapter 661 of the laws of 1997, subsection (b) as amended by chapter 557 of the laws of 2002, subsection (c) as added by chapter 501 of the laws of 1992, are amended to read as follows:

(a) (1) No individual health insurance policy and no group health insurance policy covering between [two] ONE and fifty employees or members of the group OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR MEMBERS OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation [as] IF OTHERWISE permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual health insurance coverage, including medicare supplemental coverage, [or small group health insurance coverage, including medicare supplemental insurance,] OR SMALL GROUP HEALTH INSURANCE COVERAGE, INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVERAGE ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, SPECIFIED IN SUBSECTION (L) OF SECTION THREE THOUSAND TWO HUNDRED SIXTEEN, OF THIS ARTICLE must be accepted at all times throughout the year for any hospital and/or medical coverage offered by the insurer to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (g) of section three thousand two hundred sixteen or subsection (p) of section three thousand two hundred twenty-one of this article. Group hospital and/or medical coverage, including medicare supplemental insurance, obtained through an out-of-state trust covering a group of fifty or

fewer employees, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN, or participating persons who are residents of this state must be community rated regardless of the situs of delivery of the policy. Notwithstanding any other provisions of law, the underwriting of such policy may involve no more than the imposition of a pre-existing condition limitation [as] IF permitted by this article, and once accepted for coverage, an individual or small group cannot be terminated due to claims experience. Termination of an individual or small group shall be based only on one or more of the reasons set forth in subsection (p) of section three thousand two hundred twenty-one of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy [or contract] form is the same based on the experience of the entire pool of risks [covered by that policy or contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED BY THE INSURER without regard to age, sex, health status, TOBACCO USAGE or occupation, EXCLUDING THOSE INDIVIDUALS OR SMALL GROUPS COVERED BY MEDICARE SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE COVERAGE, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUMS FOR ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE SAME BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT POLICY OR CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE POLICIES ISSUED PURSUANT TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

(b) [Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL POLICIES SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY SET A STANDARD RELATIVITY APPLICABLE TO CHILD-ONLY POLICIES ISSUED PURSUANT TO SECTION 1302(F) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVITY FOR CHILD-ONLY POLICIES SHALL BE ACTUARIALLY JUSTIFIABLE USING THE AGGREGATE EXPERIENCE OF INSURERS TO PREVENT THE CHARGING OF UNJUSTIFIED PREMIUMS. THE SUPERINTENDENT MAY ADJUST SUCH PREMIUM TIERS AND RELATIVITIES PERIODICALLY BASED UPON THE AGGREGATE EXPERIENCE OF INSURERS. (2) AN INSURER SHALL ESTABLISH separate community rates for individuals as opposed to small groups. (3) If an insurer is required to issue a [contract] POLICY to individual proprietors pursuant to subsection (i) of this section, such policy shall be subject to subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the insurer in its rate filing so long as the insurer's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the insurer's community rates. (2) BEGINNING ON JANUARY FIRST, TWO THOUSAND FOURTEEN, FOR EVERY POLICY SUBJECT TO THIS SECTION THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENT PLANS, INSURERS SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTENDENT.

S 70. Subsection (g) of section 3231 of the insurance law, as added by chapter 501 of the laws of 1992, is amended to read as follows:

(g) (1) This section shall also apply to policies issued to a group defined in subsection (c) of section four thousand two hundred thirty-five, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have fifty or fewer employees or members exclusive of spouses and dependents. FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, IF THE GROUP INCLUDES ONE OR MORE MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR COVERAGE SUBJECT TO THIS SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE CLASSIFIED AS SMALL GROUPS FOR RATING PURPOSES AND THE REMAINING MEMBERS SHALL BE RATED CONSISTENT WITH THE RATING RULES APPLICABLE TO SUCH REMAINING MEMBERS PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION.

(2) IF A POLICY IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER, INCLUDING AN ASSOCIATION GROUP, THAT INCLUDES ONE OR MORE INDIVIDUAL OR INDIVIDUAL PROPRIETOR MEMBERS, FOR RATING PURPOSES THE INSURER SHALL INCLUDE SUCH MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING PREMIUM RATES FOR SUCH MEMBERS.

S 71. Paragraph 2 of subsection (i) of section 3231 of the insurance law, as amended by chapter 183 of the laws of 2011, is amended to read as follows:

(2) For coverage purchased pursuant to this subsection, THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand [fourteen] THIRTEEN, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. COVERAGE PURCHASED OR RENEWED PURSUANT TO THIS SUBSECTION ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SHALL BE CLASSIFIED IN THE INDIVIDUAL RATING CATEGORY.

S 72. Section 4317 of the insurance law, as added by chapter 501 of the laws of 1992, subsection (a) as amended by chapter 661 of the laws of 1997, subsection (b) as amended and subsection (f) as added by chapter 557 of the laws of 2002, subsection (d) as amended by section 2 of part A of chapter 494 of the laws of 2009, paragraph 2 of subsection (f) as amended by chapter 183 of the laws of 2011, is amended to read as follows:

S 4317. Rating of individual and small group health insurance contracts. (a) (1) No individual health insurance contract and no group health insurance contract covering between [two] ONE and fifty employees or members of the group, OR BETWEEN ONE AND ONE HUNDRED EMPLOYEES OR MEMBERS OF THE GROUP FOR POLICIES ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND SIXTEEN exclusive of spouses and dependents, including contracts for which the premiums are paid by a remitting agent for a group, hereinafter referred to as a small group, providing hospital and/or medical benefits, including Medicare supplemental insurance, shall be issued in this state unless such contract is community rated and, notwithstanding any other provisions of law, the underwriting of such contract involves no more than the imposition of a pre-existing condition limitation [as] IF OTHERWISE permitted by this article. (2) Any individual, and dependents of such individual, and any small group, including all employees or group members and dependents of employees or members, applying for individual or small group health insurance coverage INCLUDING MEDICARE SUPPLEMENTAL INSURANCE, BUT NOT INCLUDING COVERAGE ISSUED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SPECIFIED IN

SUBSECTION (L) OF SECTION FOUR THOUSAND THREE HUNDRED FOUR, AND SECTION FOUR THOUSAND THREE HUNDRED TWENTY-EIGHT OF THIS CHAPTER, must be accepted at all times throughout the year for any hospital and/or medical coverage[, including Medicare supplemental insurance,] offered by the corporation to individuals or small groups in this state. (3) Once accepted for coverage, an individual or small group cannot be terminated by the insurer due to claims experience. Termination of coverage for individuals or small groups may be based only on one or more of the reasons set forth in subsection (c) of section four thousand three hundred four or subsection (j) of section four thousand three hundred five of this article. (4) For the purposes of this section, "community rated" means a rating methodology in which the premium for all persons covered by a policy or contract form is the same, based on the experience of the entire pool of risks [covered by that policy or contract form] OF ALL INDIVIDUALS OR SMALL GROUPS COVERED BY THE CORPORATION without regard to age, sex, health status, TOBACCO USAGE or occupation EXCLUDING THOSE INDIVIDUALS OF SMALL GROUPS COVERED BY MEDICARE SUPPLEMENTAL INSURANCE. FOR MEDICARE SUPPLEMENTAL INSURANCE COVERAGE, "COMMUNITY RATED" MEANS A RATING METHODOLOGY IN WHICH THE PREMIUMS FOR ALL PERSONS COVERED BY A POLICY OR CONTRACT FORM IS THE SAME BASED ON THE EXPERIENCE OF THE ENTIRE POOL OF RISKS COVERED BY THAT POLICY OR CONTRACT FORM WITHOUT REGARD TO AGE, SEX, HEALTH STATUS, TOBACCO USAGE OR OCCUPATION. CATASTROPHIC HEALTH INSURANCE CONTRACTS ISSUED PURSUANT TO SECTION 1302(E) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(E), SHALL BE CLASSIFIED IN A DISTINCT COMMUNITY RATING POOL.

(b) [Nothing herein shall prohibit the use of premium rate structures to establish different premium rates for individuals as opposed to family units or] (1) THE SUPERINTENDENT MAY SET STANDARD PREMIUM TIERS AND STANDARD RATING RELATIVITIES BETWEEN TIERS APPLICABLE TO ALL CONTRACTS SUBJECT TO THIS SECTION. THE SUPERINTENDENT MAY ALSO SET A STANDARD RELATIVITY APPLICABLE TO CHILD-ONLY CONTRACTS ISSUED PURSUANT TO SECTION 1302(F) OF THE AFFORDABLE CARE ACT, 42 U.S.C. S 18022(F). THE RELATIVITY FOR CHILD-ONLY CONTRACTS MUST BE ACTUARIALLY JUSTIFIABLE USING THE AGGREGATE EXPERIENCE OF CORPORATIONS TO PREVENT THE CHARGING OF UNJUSTIFIED PREMIUMS. THE SUPERINTENDENT MAY ADJUST SUCH PREMIUM TIERS AND RELATIVITIES PERIODICALLY BASED UPON THE AGGREGATE EXPERIENCE OF CORPORATIONS ISSUING CONTRACT FORMS SUBJECT TO THIS SECTION. (2) A CORPORATION SHALL ESTABLISH separate community rates for individuals as opposed to small groups. (3) If a corporation is required to issue a contract to individual proprietors pursuant to subsection (f) of this section, such contract shall be subject to the requirements of subsection (a) of this section.

(c) (1) The superintendent shall permit the use of separate community rates for reasonable geographic regions, which may, in a given case, include a single county. The regions shall be approved by the superintendent as part of the rate filing. The superintendent shall not require the inclusion of any specific geographic regions within the proposed community rated regions selected by the corporation in its rate filing so long as the corporation's proposed regions do not contain configurations designed to avoid or segregate particular areas within a county covered by the corporation's community rates. (2) BEGINNING ON JANUARY FIRST, TWO THOUSAND FOURTEEN, FOR EVERY CONTRACT SUBJECT TO THIS SECTION THAT PROVIDES PHYSICIAN SERVICES, MEDICAL, MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE, EXCEPT FOR MEDICARE SUPPLEMENTAL INSURANCE, CORPORATIONS SHALL USE STANDARDIZED REGIONS ESTABLISHED BY THE SUPERINTENDENT.

(d) (1) This section shall also apply to [contracts] A CONTRACT issued to a group defined in subsection (c) of section four thousand two hundred thirty-five of this chapter, including but not limited to an association or trust of employers, if the group includes one or more member employers or other member groups which have fifty or fewer employees or members exclusive of spouses and dependents. FOR CONTRACTS ISSUED OR RENEWED ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN, IF THE GROUP INCLUDES ONE OR MORE MEMBER SMALL GROUP EMPLOYERS ELIGIBLE FOR COVERAGE SUBJECT TO THIS SECTION, THEN SUCH MEMBER EMPLOYERS SHALL BE CLASSIFIED AS SMALL GROUPS FOR RATING PURPOSES AND THE REMAINING MEMBERS SHALL BE RATED CONSISTENT WITH THE RATING RULES APPLICABLE TO SUCH REMAINING MEMBERS PURSUANT TO PARAGRAPH TWO OF THIS SUBSECTION.

(2) IF A CONTRACT IS ISSUED TO A GROUP DEFINED IN SUBSECTION (C) OF SECTION FOUR THOUSAND TWO HUNDRED THIRTY-FIVE OF THIS CHAPTER INCLUDING ASSOCIATION GROUPS, THAT INCLUDES ONE OR MORE INDIVIDUAL OR INDIVIDUAL PROPRIETOR MEMBERS, THEN FOR RATING PURPOSES THE CORPORATION SHALL INCLUDE SUCH MEMBERS IN ITS INDIVIDUAL POOL OF RISKS IN ESTABLISHING PREMIUM RATES FOR SUCH MEMBERS.

(3) A corporation shall provide specific claims experience to a municipal corporation, as defined in subsection (f) of section four thousand seven hundred two of this chapter, covered by the corporation under a community rated contract when the municipal corporation requests its claims experience for purposes of forming or joining a municipal cooperative health benefit plan certified pursuant to article forty-seven of this chapter. Notwithstanding the foregoing provisions, no corporation shall be required to provide more than three years' claims experience to a municipal corporation making this request.

(e) (1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section.

(2) This subsection shall not apply to coverage insuring a plan [which] THAT was in effect on or before December thirty-first, nineteen hundred ninety-one and was issued to a group [which] THAT includes member small employers or other member small groups, including but not limited to association groups, provided that (A) acceptance of additional small member employers (or other member groups comprised of fifty or fewer employees or members, exclusive of spouses and dependents) into the group on or after June first, nineteen hundred ninety-two and before April first, nineteen hundred ninety-four does not exceed an amount equal to ten percent per year of the total number of persons covered under the group as of June first, nineteen hundred ninety-two, but nothing in this subparagraph shall limit the addition of larger member employers; (B) (i) after April first, nineteen hundred ninety-four, the group thereafter accepts member small employers and member small groups without underwriting by any more than the imposition of a pre-existing condition limitation as permitted by this article and the cost for participation in the group for all persons covered shall be the same based on the experience of the entire pool of risks covered under the entire group, without regard to age, sex, health status or occupation; and; (ii) once accepted for coverage, an individual or small group cannot be terminated due to claims experience; (C) the [insurer] CORPO-

RATION has registered the names of such groups, including the total number of persons covered as of June first, nineteen hundred ninety-two, with the superintendent, in a form prescribed by the superintendent, on or before April first, nineteen hundred ninety-three and shall report annually thereafter until such groups comply with the provisions of subparagraph (B) of this paragraph; and (D) the types or categories of employers or groups eligible to join the association are not altered or expanded after June first, nineteen hundred ninety-two.

(3) A corporation may apply to the superintendent for an extension or extensions of time beyond April first, nineteen hundred ninety-four in which to implement the provisions of this subsection as they relate to groups registered with the superintendent pursuant to subparagraph (C) of paragraph two of this subsection; any such extension or extensions may not exceed two years in aggregate duration, and the ten percent per year limitation of subparagraph (A) of paragraph two of this subsection shall be reduced to five percent per year during the period of any such extension or extensions. Any application for an extension shall demonstrate that a significant financial hardship to such group would result from such implementation.

(f)(1) If the [insurer] CORPORATION issues coverage to an association group (including chambers of commerce), as defined in subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, THEN the [insurer must] CORPORATION SHALL issue the same coverage to individual proprietors [which] WHO purchase coverage through the association group as the [insurer] CORPORATION issues to groups [which] THAT purchase coverage through the association group; provided, however, that [an insurer which] A CORPORATION THAT, on the effective date of this subsection, is issuing coverage to individual proprietors not connected with an association group, may continue to issue such coverage provided that the coverage is otherwise in accordance with this subsection and all other applicable provisions of law.

(2) For coverage purchased pursuant to this subsection THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND THIRTEEN, individual proprietors shall be classified in their own community rating category, provided however, up to and including December thirty-first, two thousand [fourteen] THIRTEEN, the premium rate established for individual proprietors purchased pursuant to paragraph one of this subsection shall not be greater than one hundred fifteen percent of the rate established for the same coverage issued to groups. COVERAGE PURCHASED OR RENEWED PURSUANT TO THIS SUBSECTION ON OR AFTER JANUARY FIRST, TWO THOUSAND FOURTEEN SHALL BE CLASSIFIED IN THE INDIVIDUAL RATING CATEGORY.

(3) The [insurer] CORPORATION may require members of the association purchasing health insurance to verify that all employees electing health insurance are legitimate employees of the employers, as documented on New York state tax form NYS-45-ATT-MN or comparable documentation. In order to be eligible to purchase health insurance pursuant to this subsection and obtain the same group insurance products as are offered to groups, a sole employee of a corporation or a sole proprietor of an unincorporated business or entity must (A) work at least twenty hours per week, (B) if purchasing the coverage through an association group, be a member of the association for at least sixty days prior to the effective date of the insurance [policy] CONTRACT, and (C) present a copy of the following documentation to the [insurer] CORPORATION or health plan administrator on an annual basis:

(i) NYS tax form 45-ATT, or comparable documentation of active employee status;

(ii) for an unincorporated business, the prior year's federal income tax Schedule C for an incorporated business subject to Subchapter S with a sole employee, federal income tax Schedule E for other incorporated businesses with a sole employee, a W-2 annual wage statement, or federal tax form 1099 with federal income tax Schedule F; or

(iii) for a business in business for less than one year, a cancelled business check, a certificate of doing business, or appropriate tax documentation; and

(iv) such other documentation as may be reasonably required by the insurer as approved by the superintendent to verify eligibility of an individual to purchase health insurance pursuant to this subsection.

(4) Notwithstanding the provisions of item (I) of clause (i) of subparagraph (K) of paragraph one of subsection (c) of section four thousand two hundred thirty-five of this chapter, for purposes of this section, an association group shall include chambers of commerce with less than two hundred members and which are 501C3 or 501C6 organizations.

S 73. 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 74. 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 75. 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 76. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after January 1, 2013; provided that:

a. sections seventeen, thirty-eight, thirty-nine, forty, forty-a, forty-one, forty-six-a, forty-six-b forty-seven, forty-eight, forty-nine, fifty, fifty-one, fifty-two, fifty-three, fifty-four and fifty-five of this act shall take effect January 1, 2014, and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

b. sections forty-two, forty-three, forty-three-a, forty-four, forty-five and forty-six of this act shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after October 1, 2013;

b-1 paragraph 8 of subsection (b) of section 4328 of the insurance law, as added by section forty-six of this act shall expire and be deemed repealed on December 31, 2015;

c. section fifty-six of this act shall take effect January 1, 2014;

d. section fifty-seven of this act shall be deemed repealed January 1, 2014;

e. sections fifteen, fifty-eight, sixty-one and sixty-two of this act shall take effect January 1, 2015;

e-1. section fifteen-a of this act shall take effect January 1, 2014;

f. sections fifty-nine and sixty of this act shall take effect January 1, 2016 and shall apply to all policies and contracts issued, renewed, modified, altered, or amended on or after such date;

g. sections fourteen and fourteen-a of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013;

h. the amendments to paragraphs (e) and (f) of subdivision 2 of section 2511 of the public health law made by sections nineteen and twenty-six of this act shall take effect January 1, 2014 or a later date to be determined by the commissioner of health contingent upon the requirements of the Patient Protection and Affordable Care Act of 2010 being fully implemented by the state and as approved by the secretary of the department of health and human services; provided that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of the enactment of the legislation provided for in sections nineteen and twenty-six of this act in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

h-1. provided however, the amendments to subparagraph (ii) of paragraph (f) of subdivision 2 of section 2511 of the public health law made by section twenty-six of this act shall take effect April 1, 2014;

i. the amendments to subdivision 4 of section 2511 of the public health law made by section twenty-one of this act shall not affect the expiration and reversion of such subdivision and shall be deemed to expire therewith;

j. the amendments to subparagraph (ii) of paragraph (g) of subdivision 2 of section 2511 of the public health law made by section twenty-seven of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

j-1. the amendments to subparagraph (iii) of paragraph (a) of subdivision 2 of section 2511 of the public health law made by section thirty of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

j-2. the amendments to subparagraph (iv) of paragraph (b) and paragraph (d) of subdivision 9 of section 2511 of the public health law made by section thirty-three of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

j-3. the amendments to subdivision 5 of section 365-n of the social services law made by section thirty-three-a of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith;

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

l. 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;

m. 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;

n. 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;

o. 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; and

p. the amendments made to subparagraph (7) of paragraph (b) of subdivision 1 of section 366 of the social services law made by section one of this act shall expire and be deemed repealed October 1, 2019.

PART E

Section 1. Intentionally omitted.

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. Intentionally omitted.

S 9. Intentionally omitted.

S 10. Intentionally omitted.

S 11. Intentionally omitted.

S 12. Intentionally omitted.

S 13. Intentionally omitted.

S 14. Section 600 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 600. State aid; general requirements. In order to be eligible for state aid under this title, a municipality shall be required to do the following in accordance with the provisions of this article:

1. submit an application to the department for state aid WHICH IS APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH SECTION SIX HUNDRED ONE OF THIS TITLE;

[2. submit a municipal public health services plan to the department for approval;

3. implement and adhere to the municipal public health services plan, as approved;

4. submit a detailed report to the department of all expenditures on services funded by this title for the immediately preceding fiscal year of such municipality;

5. employ a person to supervise the provision of public health services in accordance with the provisions of section six hundred four of this chapter; and

6.] 2. PROVIDE CORE PUBLIC HEALTH SERVICES, AS DEFINED IN SECTION SIX HUNDRED TWO OF THIS TITLE, IN ACCORDANCE WITH AN APPLICATION FOR STATE AID SUBMITTED BY THE MUNICIPALITY AND APPROVED BY THE COMMISSIONER;

3. SUBMIT A COMMUNITY HEALTH ASSESSMENT IN ACCORDANCE WITH SECTION SIX HUNDRED TWO-A OF THIS TITLE;

4. ESTABLISH, COLLECT AND REPORT FEES AND REVENUE FOR SERVICES PROVIDED BY THE MUNICIPALITY, IN ACCORDANCE WITH SECTION SIX HUNDRED SIX OF THIS TITLE; AND

5. appropriate or otherwise make funds available to finance a prescribed share of the cost of public health services.

S 15. Section 601 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 601. Application for state aid. 1. The governing body of each municipality desiring to make application for state aid under this title shall annually, on such dates as may be fixed by the commissioner, submit an application for such aid.

2. The application shall be in such form as the commissioner shall prescribe, and shall include, but not be limited to:

(a) an organizational chart of the municipal health agency, AND A STATEMENT PROVIDING THE NUMBER OF EMPLOYEES, BY JOB TITLE, PROPOSED TO PROVIDE PUBLIC HEALTH SERVICES FUNDED BY THIS TITLE;

(b) a [detailed] budget of proposed expenditures for services funded by this title;

[(c) a description of proposed program activities for services funded by this title;

(d) a copy of the municipal public health services plan prepared and submitted pursuant to section six hundred two of this title;

(e) a certification by the chief executive officer of the municipality, or in those municipalities with no chief executive officer the chairman of the county legislature, that the proposed expenditures and program activities are consistent with the public health services plan; and

(f)] (C) A DESCRIPTION OF HOW THE MUNICIPALITY WILL PROVIDE PUBLIC HEALTH SERVICES;

(D) AN ATTESTATION BY THE CHIEF EXECUTIVE OFFICER OF THE MUNICIPALITY THAT SUFFICIENT FUNDS HAVE BEEN APPROPRIATED TO PROVIDE THE PUBLIC HEALTH SERVICES FOR WHICH THE MUNICIPALITY IS SEEKING STATE AID;

(E) AN ATTESTATION BY THE MUNICIPAL OFFICER IN CHARGE OF ADMINISTERING PUBLIC HEALTH THAT THE MUNICIPALITY HAS DILIGENTLY REVIEWED ITS STATE AID APPLICATION AND THAT THE APPLICATION SEEKS STATE AID ONLY FOR ELIGIBLE PUBLIC HEALTH SERVICES;

(F) A LIST OF PUBLIC HEALTH SERVICES PROVIDED BY THE MUNICIPALITY THAT ARE NOT ELIGIBLE FOR STATE AID, AND THE COST OF EACH SERVICE;

(G) A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR PUBLIC HEALTH SERVICES ELIGIBLE FOR STATE AID, IN ACCORDANCE WITH SECTION SIX HUNDRED SIX OF THIS TITLE; AND

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

3. THE COMMISSIONER SHALL APPROVE THE STATE AID APPLICATION TO THE EXTENT THAT IT IS CONSISTENT WITH THIS SECTION AND ANY OTHER CONDITIONS OR LIMITATIONS ESTABLISHED IN, OR REGULATIONS PROMULGATED PURSUANT TO, THIS ARTICLE.

4. A MUNICIPALITY MAY AMEND ITS STATE AID APPLICATION WITH THE APPROVAL OF THE COMMISSIONER, AND SUBJECT TO ANY RULES AND REGULATIONS THAT THE COMMISSIONER MAY ADOPT.

S 16. Section 602 of the public health law is REPEALED and a new section 602 is added to read as follows:

S 602. CORE PUBLIC HEALTH SERVICES. 1. TO BE ELIGIBLE FOR STATE AID, A MUNICIPALITY MUST PROVIDE THE FOLLOWING CORE PUBLIC HEALTH SERVICES:

(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.

(B) COMMUNICABLE DISEASE CONTROL, WHICH SHALL INCLUDE ACTIVITIES TO CONTROL AND MITIGATE THE EXTENT OF INFECTIOUS DISEASES. SUCH ACTIVITIES SHALL INCLUDE, BUT NOT BE LIMITED TO, SURVEILLANCE AND EPIDEMIOLOGICAL PROGRAMS, PROGRAMS TO DETECT DISEASES IN THEIR EARLY STAGES, IMMUNIZATIONS AGAINST INFECTIOUS DISEASES, INVESTIGATION OF DISEASES AND PREVENTION OF TRANSMISSION, PREVENTION AND TREATMENT OF SEXUALLY TRANSMISSIBLE DISEASES, AND ARTHROPOD VECTOR-BORNE DISEASE PREVENTION.

(C) CHRONIC DISEASE PREVENTION, WHICH SHALL INCLUDE PROMOTING PUBLIC, HEALTH CARE PROVIDER AND OTHER COMMUNITY SERVICE PROVIDER ACTIVITIES THAT ENCOURAGE CHRONIC DISEASE PREVENTION, EARLY DETECTION AND QUALITY CARE DELIVERY. SUCH ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, THOSE THAT PROMOTE HEALTHY COMMUNITIES AND REDUCE RISK FACTORS SUCH AS TOBACCO USE, POOR NUTRITION AND PHYSICAL INACTIVITY. PROVISION OF CLINICAL SERVICES SHALL NOT BE ELIGIBLE FOR STATE AID, SUBJECT TO SUCH EXCEPTIONS AS THE COMMISSIONER MAY DEEM APPROPRIATE.

(D) COMMUNITY HEALTH ASSESSMENT, AS DESCRIBED IN SECTION SIX HUNDRED TWO-A OF THIS ARTICLE.

(E) ENVIRONMENTAL HEALTH, WHICH SHALL INCLUDE ACTIVITIES THAT PROMOTE HEALTH AND PREVENT ILLNESS AND INJURY BY ASSURING THAT SAFE AND SANITARY CONDITIONS ARE MAINTAINED AT PUBLIC DRINKING WATER SUPPLIES, FOOD SERVICE ESTABLISHMENTS, AND OTHER REGULATED FACILITIES; INVESTIGATING PUBLIC HEALTH NUISANCES TO ASSURE ABATEMENT BY RESPONSIBLE PARTIES; PROTECTING THE PUBLIC FROM UNNECESSARY EXPOSURE TO RADIATION, CHEMICALS, AND OTHER HARMFUL CONTAMINANTS; AND CONDUCTING INVESTIGATIONS OF INCIDENTS THAT RESULT IN ILLNESS, INJURY OR DEATH IN ORDER TO IDENTIFY AND MITIGATE THE ENVIRONMENTAL CAUSES TO PREVENT ADDITIONAL MORBIDITY AND MORTALITY.

(F) PUBLIC HEALTH EMERGENCY PREPAREDNESS AND RESPONSE, INCLUDING PLANNING, TRAINING, AND MAINTAINING READINESS FOR PUBLIC HEALTH EMERGENCIES.

2. THE MUNICIPALITY MUST INCORPORATE INTO EACH CORE PUBLIC HEALTH SERVICE THE FOLLOWING GENERAL ACTIVITIES:

(A) ONGOING ASSESSMENT OF COMMUNITY HEALTH NEEDS;

(B) EDUCATION ON PUBLIC HEALTH ISSUES;

(C) DEVELOPMENT OF POLICIES AND PLANS TO ADDRESS HEALTH NEEDS; AND

(D) ACTIONS TO ASSURE THAT SERVICES NECESSARY TO ACHIEVE AGREED UPON GOALS ARE PROVIDED.

3. THE COMMISSIONER MAY APPROVE A STATE AID APPLICATION IN WHICH THE MUNICIPALITY ACTUALLY PROVIDES FEWER SERVICES THAN THOSE SET FORTH IN SUBDIVISION ONE OF THIS SECTION AS LONG AS THE APPLICATION IDENTIFIES THE AVAILABILITY OF OTHER SERVICES, WHO WILL PROVIDE THOSE SERVICES AND THE MANNER IN WHICH THE SERVICES WILL BE PROVIDED AND FINANCED.

4. THE COMMISSIONER SHALL CONSULT WITH THE COUNTY HEALTH COMMISSIONERS, PUBLIC HEALTH DIRECTORS, AND BOARDS OF PUBLIC HEALTH WHEN PROMUL-

GATING RULES AND REGULATIONS TO EFFECTUATE THE PROVISIONS AND PURPOSES OF THIS ARTICLE. THE COMMISSIONER SHALL NOT HAVE THE POWER TO PRESCRIBE THE NUMBER OF PERSONS TO BE EMPLOYED BY ANY MUNICIPALITY.

S 17. The public health law is amended by adding a new section 602-a to read as follows:

S 602-A. COMMUNITY HEALTH ASSESSMENT. 1. EVERY MUNICIPALITY SHALL SUBMIT TO THE DEPARTMENT NO MORE FREQUENTLY THAN EVERY TWO YEARS, A COMMUNITY HEALTH ASSESSMENT.

2. THE COMMUNITY HEALTH ASSESSMENT SHALL BE IN SUCH FORM AS THE COMMISSIONER SHALL PRESCRIBE, AND SHALL INCLUDE, BUT NOT BE LIMITED TO:

(A) AN ESTIMATE AND DESCRIPTION OF THE HEALTH STATUS OF THE POPULATION AND FACTORS THAT CONTRIBUTE TO HEALTH ISSUES;

(B) IDENTIFICATION OF PRIORITY AREAS FOR HEALTH IMPROVEMENT, IN CONJUNCTION WITH THE STATE HEALTH IMPROVEMENT PLAN;

(C) IDENTIFICATION OF PUBLIC HEALTH SERVICES IN THE MUNICIPALITY AND IN THE COMMUNITY AND OTHER RESOURCES THAT CAN BE MOBILIZED TO IMPROVE POPULATION HEALTH, PARTICULARLY IN THOSE PRIORITY AREAS IDENTIFIED IN PARAGRAPH (B) OF THIS SUBDIVISION; AND

(D) A COMMUNITY HEALTH IMPROVEMENT PLAN CONSISTING OF ACTIONS, POLICIES, STRATEGIES AND MEASURABLE OBJECTIVES THROUGH WHICH THE MUNICIPALITY AND ITS COMMUNITY PARTNERS WILL ADDRESS AREAS FOR HEALTH IMPROVEMENT AND TRACK PROGRESS TOWARD IMPROVEMENT OF PUBLIC HEALTH OUTCOMES.

S 18. Section 603 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 603. [Municipal public health services plan] CORE PUBLIC HEALTH SERVICES; implementation. 1. In order to be eligible for state aid under this title, each municipality shall administer its CORE public health [programs] SERVICES in accordance with [its approved municipal public health services plan and] THE standards of performance established by the commissioner through rules and regulations [and] PURSUANT TO SECTION SIX HUNDRED NINETEEN OF THIS ARTICLE. EACH MUNICIPALITY shall, in particular, ensure that public health services are provided in an efficient and effective manner to all persons in the municipality.

2. The commissioner may withhold state aid reimbursement under this title for the appropriate services if, on ANY audit [and], review OF A STATE AID APPLICATION OR PERIODIC CLAIM FOR STATE AID, OR OTHER INFORMATION AVAILABLE TO THE DEPARTMENT, the commissioner finds that such services are not furnished or rendered in conformance with the rules and regulations established by the commissioner, INCLUDING BUT NOT LIMITED TO THE STANDARDS OF PERFORMANCE ESTABLISHED PURSUANT TO SECTION SIX HUNDRED NINETEEN OF THIS ARTICLE, or that the expenditures were not [made according to the approved public health services plan required by] FOR AN ACTIVITY SET FORTH IN section six hundred two of this title. In such cases, the commissioner, in order to ensure that the public health is promoted as defined in [paragraph (b) of subdivision three of] section six hundred two of this title, may use any proportionate share of a municipality's per capita or base grant that is withheld to contract with agencies, associations, or organizations. The health department may use any such withheld share to provide services upon approval of the director of the division of the budget. Copies of such transactions shall be filed with the fiscal committees of the legislature.

3. CONSISTENT WITH PARAGRAPH (H) OF SUBDIVISION TWO OF SECTION SIX HUNDRED ONE OF THIS TITLE, WHEN DETERMINING WHETHER TO APPROVE A STATE AID APPLICATION OR PERIODIC CLAIM FOR STATE AID, THE COMMISSIONER SHALL HAVE AUTHORITY TO REQUEST ANY AND ALL FINANCIAL AND OTHER DOCUMENTS

NECESSARY OR RELEVANT TO VERIFY THAT THE CLAIMED EXPENDITURES ARE ELIGIBLE FOR STATE AID UNDER THIS ARTICLE.

S 19. Section 604 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 604. Supervision of public health programs. In order to be eligible for state aid, under this title, each municipality shall employ a full-time local commissioner of health or public health director to supervise the provision of public health services [and to implement the approved public health services plan] for that municipality, SUBJECT TO THE FOLLOWING EXCEPTIONS:

1. SUCH PERSON MAY SERVE AS THE HEAD OF A MERGED AGENCY OR MULTIPLE AGENCIES, IF THE APPROVAL OF THE COMMISSIONER IS OBTAINED; AND

2. SUCH PERSON MAY SERVE AS THE LOCAL COMMISSIONER OF HEALTH OR PUBLIC HEALTH DIRECTOR OF ADDITIONAL COUNTIES, WHEN AUTHORIZED PURSUANT TO SECTION THREE HUNDRED FIFTY-ONE OF THIS CHAPTER.

S 20. Section 605 of the public health law, as added by chapter 901 of the laws of 1986, subdivision 1 as amended by section 6 of part B of chapter 57 of the laws of 2006, subdivision 2 as amended by section 13 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 605. State aid; amount of reimbursement. 1. A state aid base grant shall be reimbursed to municipalities for the [base] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title, in an amount of the greater of [fifty-five] SIXTY-FIVE cents per capita, for each person in the municipality, or [five] SIX hundred fifty thousand dollars provided that the municipality expends at least [five] SIX hundred fifty thousand dollars for such [base] CORE public health services. A municipality must provide all the [basic] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title to qualify for such base grant unless the municipality has the approval of the commissioner to expend the base grant on a portion of such [base] CORE public health services. If any services in such [paragraph (b)] SECTION are not [approved in the plan or if no plan is submitted for such services] PROVIDED, the commissioner may limit the municipality's per capita or base grant to [that proportionate share which will fund those services that are submitted in a plan and subsequently approved] REFLECT THE SCOPE OF THE REDUCED SERVICES. The commissioner may use the [proportionate share] AMOUNT that is not granted to contract with agencies, associations, or organizations to provide such services; or the health department may use such proportionate share to provide the services upon approval of the director of the division of the budget.

2. State aid reimbursement for public health services provided by a municipality under this title, shall be made if the municipality is providing some or all of the [basic] CORE public health services identified in [paragraph (b) of subdivision three of] section six hundred two of this title, pursuant to an approved [plan] APPLICATION FOR STATE AID, at a rate of no less than thirty-six per centum of the difference between the amount of moneys expended by the municipality for public health services required by [paragraph (b) of subdivision three of] section six hundred two of this title during the fiscal year and the base grant provided pursuant to subdivision one of this section. No such reimbursement shall be provided for services [if they are not approved in a plan or if no plan is submitted for such services] THAT ARE NOT ELIGIBLE FOR STATE AID PURSUANT TO THIS ARTICLE.

3. Municipalities shall make every reasonable effort to collect payments for public health services provided. All such revenues shall be reported to the commissioner PURSUANT TO SECTION SIX HUNDRED SIX OF THIS TITLE and will be deducted from expenditures identified under subdivision two of this section to produce a net cost eligible for state aid.

S 21. Section 606 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 606. Assessment of fees; THIRD-PARTY COVERAGE OR INDEMNIFICATION. 1. Assessment of fees by municipalities. [Each municipality shall assess fees for services provided by such municipality in accordance with a fee and revenue plan which shall include a schedule of fees that the municipality proposes to charge for each service identified by the commissioner and each additional service identified by the municipality for which a fee is to be charged. In accordance with the provisions of subdivision four of section six hundred two of this chapter, the commissioner shall review each fee and revenue plan submitted to him and, on the basis of such review, issue a notice of intent to disapprove the plan or approve the plan, with or without conditions, within ninety days of his receipt of the plan. In determining whether to approve or disapprove a plan, the commissioner shall consider the extent to which the plan, once implemented, will satisfy standards which the commissioner has promulgated through rules and regulations after consulting with the public health council and county health commissioners, boards and public health directors. Such standards shall include a list of those environmental, personal health and other services for which fees shall be charged, the calculation of cost by each municipality and the relationship of cost to fees, and provisions for prohibiting the assessment of fees which would impede the delivery of services deemed essential to the protection of the health of the public.] EACH MUNICIPALITY SHALL ESTABLISH A SCHEDULE OF FEES FOR PUBLIC HEALTH SERVICES PROVIDED BY THE MUNICIPALITY AND SHALL MAKE EVERY REASONABLE EFFORT TO COLLECT SUCH FEES. Fees for personal health services shall be reflective of an individual's ability to pay and shall not be inconsistent with the reimbursement guidelines of articles twenty-eight and thirty-six of this chapter and applicable federal laws and regulations. To the extent possible revenues generated shall be used to enhance or expand public health services. IN ITS STATE AID APPLICATION, EACH MUNICIPALITY SHALL PROVIDE THE DEPARTMENT WITH A PROJECTION OF FEES AND REVENUE TO BE COLLECTED FOR THAT YEAR. EACH MUNICIPALITY SHALL PERIODICALLY REPORT TO THE DEPARTMENT FEES AND REVENUE ACTUALLY COLLECTED.

2. Assessment of fees by the commissioner. In each municipality, the commissioner shall establish a fee and revenue plan for services provided by the department in a manner consistent with the standards and regulations established pursuant to subdivision one of this section.

3. THIRD PARTY COVERAGE OR INDEMNIFICATION. FOR ANY PUBLIC HEALTH SERVICE FOR WHICH COVERAGE OR INDEMNIFICATION FROM A THIRD PARTY IS AVAILABLE, THE MUNICIPALITY MUST SEEK SUCH COVERAGE OR INDEMNIFICATION AND REPORT ANY ASSOCIATED REVENUE TO THE DEPARTMENT IN ITS STATE AID APPLICATION.

S 22. Subdivisions 1 and 2 of section 609 of the public health law, as amended by chapter 474 of the laws of 1996, are amended to read as follows:

1. Where a laboratory shall have been or is hereafter established pursuant to article five of this chapter, the state, through the legislature and within the limits to be prescribed by the commissioner, shall provide aid at a per centum, determined in accordance with the

provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the actual cost of [installation,] REPAIR, RELOCATION, equipment and maintenance of the laboratory or laboratories FOR SERVICES ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED IN SECTION SIX HUNDRED TWO OF THIS TITLE. Such cost shall be the excess, if any, of such expenditures over available revenues of all types, including adequate and reasonable fees, derived from or attributable to the performance of laboratory services.

2. Where a county or city provides or shall have provided for laboratory service by contracting with an established laboratory FOR SERVICES ASSOCIATED WITH A CORE PUBLIC HEALTH SERVICE, AS DESCRIBED IN SUBDIVISION THREE OF SECTION SIX HUNDRED TWO OF THIS TITLE, with the approval of the commissioner, it shall be entitled to state aid at a per centum, determined in accordance with the provisions of [paragraph (b) of] subdivision two of section six hundred five of this article, of the cost of the contracts. [State aid shall be available for a district laboratory supply station maintained and operated in accordance with article five of this chapter in the same manner and to the same extent as for laboratory services.]

S 23. Sections 610 and 612 of the public health law are REPEALED.

S 24. Paragraphs (a) and (c) of subdivision 1 and subdivision 4 of section 613 of the public health law, paragraphs (a) and (c) of subdivision 1 as amended by chapter 36 of the laws of 2010, subdivision 4 as amended by chapter 207 of the laws of 2004, are amended to read as follows:

(a) The commissioner shall develop and supervise the execution of a program of immunization, surveillance and testing, to raise to the highest reasonable level the immunity of the children of the state against communicable diseases including, but not limited to, influenza, poliomyelitis, measles, mumps, rubella, haemophilus influenzae type b (Hib), diphtheria, pertussis, tetanus, varicella, hepatitis B, pneumococcal disease, and the immunity of adults of the state against diseases identified by the commissioner, including but not limited to influenza, smallpox, [and] hepatitis AND SUCH OTHER DISEASES AS THE COMMISSIONER MAY DESIGNATE THROUGH REGULATION. [The commissioner shall encourage the municipalities] MUNICIPALITIES in the state [to develop and] shall [assist them in the development and the execution of] MAINTAIN local programs of [inoculation] IMMUNIZATION to raise the immunity of the children and adults of each municipality to the highest reasonable level, IN ACCORDANCE WITH AN APPLICATION FOR STATE AID SUBMITTED BY THE MUNICIPALITY AND APPROVED BY THE COMMISSIONER. Such programs shall include ASSURANCE OF provision of vaccine, [surveillance of vaccine effectiveness by means of laboratory tests,] serological testing of individuals and educational efforts to inform health care providers and target populations or their parents, if they are minors, of the facts relative to these diseases and [inoculation] IMMUNIZATIONS to prevent their occurrence.

(c) The commissioner shall invite and encourage the active assistance and cooperation in such education activities of: the medical societies, organizations of other licensed health personnel, hospitals, corporations subject to article forty-three of the insurance law, trade unions, trade associations, parents and teachers and their associations, organizations of child care resource and referral agencies, the media of mass communication, and such other voluntary groups and organizations of citizens as he or she shall deem appropriate. The public health AND HEALTH PLANNING council, the department of education, the department of

family assistance, and the department of mental hygiene shall provide the commissioner with such assistance in carrying out the program as he or she shall request. All other state agencies shall also render such assistance as the commissioner may reasonably require for this program. Nothing in this subdivision shall authorize mandatory immunization of adults or children, except as provided in sections twenty-one hundred sixty-four and twenty-one hundred sixty-five of this chapter.

4. The commissioner shall expend such funds as the legislature shall make available for the purchase of the vaccines described in subdivision one of this section. [All immunization vaccines purchased with such funds shall be purchased by sealed competitive state bids through the office of general services. Immunization vaccine] VACCINES purchased with funds made available under this section shall be made available without charge to licensed private physicians, hospitals, clinics and such others as the commissioner shall determine [in accordance with regulations to be promulgated by the commissioner], and no charge shall be made to any patient for such vaccines.

S 25. Subdivisions 5 and 7 of section 613 of the public health law are REPEALED, and subdivision 6, as added by chapter 901 of the laws of 1986, is amended to read as follows:

[6.] 5. The commissioner shall submit to the governor and the legislature an annual report on the progress of the immunization program. Such reports shall include specific information on the steps taken and planned by the department [and by each participating municipality] to carry out the program[, statistical information on immunization vaccine purchased for each municipality, the number of inoculations administered to children of various ages by municipal agencies, private clinics, private physicians and others, the cost of the several vaccines purchased, information on the results of the immunization program and research on the effects of the vaccine, cooperative education efforts by public and private agencies, special information and administrative measures to reach parents and children in population groups which present special educational problems, the actual and planned use of any federal funds available to meet any part of the cost of the program, and actual and planned expenditure by municipalities to meet costs not provided for by state and federal funds].

S 26. Subdivision 2 of section 614 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

2. "City", each city of the state having a population of [fifty thousand] ONE MILLION or more, according to the last preceding federal census[, but does not include any such city which is included as a part of a county health district pursuant to this chapter].

S 27. Subdivision 1 of section 616 of the public health law, as amended by section 9 of part B of chapter 57 of the laws of 2006, is amended to read as follows:

1. The total amount of state aid provided pursuant to this article shall be limited to the amount of the annual appropriation made by the legislature. In no event, however, shall such state aid be less than an amount to provide the full base grant and, as otherwise provided by paragraph (a) of subdivision two of section six hundred five of this article, at least thirty-six per centum of the difference between the amount of moneys expended by the municipality for ELIGIBLE public health services [required by paragraph (b) of subdivision three of section six hundred two of this article] PURSUANT TO AN APPROVED APPLICATION FOR STATE AID during the fiscal year and the base grant provided pursuant to subdivision one of section six hundred five of this article. [A munici-

pality shall also receive not less than thirty-six per centum of the moneys expended for other public health services pursuant to paragraph (b) of subdivision two of section six hundred five of this article, and, at least the minimum amount so required for the services identified in title two of this article.]

S 28. Section 617 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 617. Maintenance of effort. Such amount of state aid provided will be used to support and to the extent practicable, to increase the level of funds that would otherwise be made available for such purposes and not to supplant the amount to be provided by the municipalities. If a municipality that is provided state aid pursuant to title one of this article reduces its expenditures beneath the amount expended in its base year, which is [the greater of its expenditures in its fiscal year ending in either nineteen hundred eighty-five or] the most recent fiscal year for which the municipality has filed [an annual] ALL expenditure [report] REPORTS to the department, state aid reimbursement provided pursuant to subdivision one of section six hundred five of this article will be reduced by the [difference between the reduction in local expenditures between its base year and its current fiscal year and the reduction in state aid between the base year and the current fiscal year pursuant to paragraphs (a) and (b) of subdivision two of section six hundred five of this article. A municipality may include revenue, excluding third party reimbursement, raised by the municipality in calculating its maintenance of effort] PERCENTAGE REDUCTION IN EXPENDITURES BETWEEN ITS BASE YEAR AND ITS CURRENT FISCAL YEAR. FOR PURPOSES OF THIS SECTION, REDUCTIONS IN EXPENDITURES SHALL BE ADJUSTED FOR: AN ABSENCE OF EXTRAORDINARY EXPENDITURES OF A TEMPORARY NATURE, SUCH AS DISASTER RELIEF; UNAVOIDABLE OR JUSTIFIABLE PROGRAM REDUCTIONS, SUCH AS A PROGRAM BEING SUBSUMED BY ANOTHER AGENCY; OR IN CIRCUMSTANCES WHERE THE MUNICIPALITY CAN DEMONSTRATE, TO THE DEPARTMENT'S SATISFACTION, THAT THE NEED FOR THE EXPENDITURE NO LONGER EXISTS.

S 29. Section 618 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 618. Performance and accountability. The commissioner shall establish, in consultation with the municipalities, uniform statewide performance standards for the services funded pursuant to this article; provided, however, the commissioner may modify a specific standard for a municipality if such municipality demonstrates adequate justification. The commissioner shall recognize the particular needs and capabilities of the various municipalities. The commissioner shall monitor the PERFORMANCE AND expenditures of each municipality to ensure that each one satisfies the performance standards. Any municipality failing to satisfy its standards may be subject to a reduction or loss of aid until such municipality can demonstrate that it has the capacity to satisfy such standards. The commissioner shall establish a uniform accounting system for monitoring the expenditures for services of each municipality to which aid is granted[, and for determining the appropriateness of the costs of such services. The commissioner shall also establish a uniform reporting system to determine the appropriateness of the amount and types of services provided, and the number of people receiving such services.] AND THE AMOUNT OF STATE AID RECEIVED INCLUDING ANY PERFORMANCE PAYMENTS PURSUANT TO SECTION SIX HUNDRED NINETEEN-A OF THIS ARTICLE. Such reporting system shall [also] require information on the amount of public health moneys received from the federal government, the private sector, grants, and fees. Each such municipality shall comply

with the regulations of such accounting and reporting systems. [The commissioner shall determine the extent to which the services maintained and improved the health status of a municipality's residents and maintained and improved the accessibility and quality of care, and controlled costs of the health care system.]

S 30. Section 619 of the public health law, as added by chapter 901 of the laws of 1986, is amended to read as follows:

S 619. Commissioner; regulatory powers. The commissioner shall adopt regulations to effectuate the provisions and purposes of this article, including, but not limited to:

1. setting standards of performance [and reasonable costs] for the provision of [basic] CORE public health services which shall include performance criteria to ensure that reimbursable health services are delivered in an efficient and effective manner by a municipality; and

2. monitoring, COLLECTING DATA and evaluating the provision of [basic] CORE public health services by the municipalities and the amounts expended by the municipalities for such services.

S 31. The public health law is amended by adding a new section 619-a to read as follows:

S 619-A. INCENTIVE STANDARDS OF PERFORMANCE. 1. THE COMMISSIONER MAY ESTABLISH STATEWIDE INCENTIVE PERFORMANCE STANDARDS FOR THE DELIVERY OF CORE PUBLIC HEALTH SERVICES.

2. WITHIN AMOUNTS APPROPRIATED, AND SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE BUDGET, THE COMMISSIONER MAY INCREASE STATE AID TO ANY MUNICIPALITY THAT MEETS OR EXCEEDS STATEWIDE INCENTIVE PERFORMANCE STANDARDS ESTABLISHED UNDER THIS SECTION, PROVIDED THAT THE TOTAL OF SUCH PAYMENTS TO ALL MUNICIPALITIES MAY NOT EXCEED ONE MILLION DOLLARS ANNUALLY.

S 32. The article heading of article 23 of the public health law, as amended by chapter 878 of the laws of 1980, is amended to read as follows:

CONTROL OF SEXUALLY [TRANSMISSIBLE] TRANSMITTED DISEASES

S 33. Sections 2300, 2301, 2302 and 2303 of the public health law are REPEALED.

S 34. The section heading and subdivisions 1 and 2 of section 2304 of the public health law, as amended by chapter 878 of the laws of 1980, are amended and two new subdivisions 4 and 5 are added to read as follows:

Sexually [transmissible] TRANSMITTED diseases; treatment facilities; administration. 1. It shall be the responsibility of each board of health of a health district to provide adequate facilities for the [free] diagnosis and treatment of persons living within its jurisdiction who are suspected of being infected or are infected with a sexually [transmissible] TRANSMITTED disease.

2. The health officer of said health district shall administer these facilities DIRECTLY OR THROUGH CONTRACT and shall promptly examine or arrange for the examination of persons suspected of being infected with a sexually [transmissible] TRANSMITTED disease, and shall promptly institute treatment or arrange for the treatment of those found or otherwise known to be infected with a sexually [transmissible] TRANSMITTED disease, provided that any person may, at his option, be treated at his own expense by a licensed physician of his choice.

4. EACH BOARD OF HEALTH AND LOCAL HEALTH OFFICER SHALL ENSURE THAT DIAGNOSIS AND TREATMENT SERVICES ARE AVAILABLE AND, TO THE GREATEST EXTENT PRACTICABLE, SEEK THIRD PARTY COVERAGE OR INDEMNIFICATION FOR SUCH SERVICES; PROVIDED, HOWEVER, THAT NO BOARD OF HEALTH, LOCAL HEALTH

OFFICER, OR OTHER MUNICIPAL OFFICER OR ENTITY SHALL REQUEST OR REQUIRE THAT SUCH COVERAGE OR INDEMNIFICATION BE UTILIZED AS A CONDITION OF PROVIDING DIAGNOSIS OR TREATMENT SERVICES.

5. THE TERM "HEALTH OFFICER" AS USED IN THIS ARTICLE SHALL MEAN A COUNTY HEALTH OFFICER, A CITY HEALTH OFFICER, A TOWN HEALTH OFFICER, A VILLAGE HEALTH OFFICER, THE HEALTH OFFICER OF A CONSOLIDATED HEALTH DISTRICT OR A STATE DISTRICT HEALTH OFFICER.

S 35. The section heading and subdivisions 1 and 2 of section 2305 of the public health law, as amended by chapter 878 of the laws of 1980, are amended to read as follows:

Sexually [transmissible] TRANSMITTED diseases; treatment by licensed physician or staff physician of a hospital; prescriptions. 1. No person, other than a licensed physician, or, in a hospital, a staff physician, shall diagnose, treat or prescribe for a person who is infected with a sexually [transmissible] TRANSMITTED disease, or who has been exposed to infection with a sexually [transmissible] TRANSMITTED disease, or dispense or sell a drug, medicine or remedy for the treatment of such person except on prescription of a duly licensed physician.

2. A licensed physician, or in a hospital, a staff physician, may diagnose, treat or prescribe for a person under the age of twenty-one years without the consent or knowledge of the parents or guardian of said person, where such person is infected with a sexually [transmissible] TRANSMITTED disease, or has been exposed to infection with a sexually [transmissible] TRANSMITTED disease.

S 36. Section 2306 of the public health law, as amended by chapter 41 of the laws of 2010, is amended to read as follows:

S 2306. Sexually [transmissible] TRANSMITTED diseases; reports and information, confidential. All reports or information secured by a board of health or health officer under the provisions of this article shall be confidential except in so far as is necessary to carry out the purposes of this article. Such report or information may be disclosed by court order in a criminal proceeding in which it is otherwise admissible or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the prosecution and to the defense, or in a proceeding pursuant to article ten of the family court act in which it is otherwise admissible, to the petitioner, respondent and attorney for the child, provided that the subject of the report or information has waived the confidentiality provided for by this section EXCEPT INSOFAR AS IS NECESSARY TO CARRY OUT THE PURPOSES OF THIS ARTICLE. INFORMATION MAY BE DISCLOSED TO THIRD PARTY REIMBURSERS OR THEIR AGENTS TO THE EXTENT NECESSARY TO REIMBURSE HEALTH CARE PROVIDERS FOR HEALTH SERVICES; PROVIDED THAT, WHEN NECESSARY, AN OTHERWISE APPROPRIATE AUTHORIZATION FOR SUCH DISCLOSURE HAS BEEN SECURED BY THE PROVIDER. A person waives the confidentiality provided for by this section if such person voluntarily discloses or consents to disclosure of such report or information or a portion thereof. If such person lacks the capacity to consent to such a waiver, his or her parent, guardian or attorney may so consent. An order directing disclosure pursuant to this section shall specify that no report or information shall be disclosed pursuant to such order which identifies or relates to any person other than the subject of the report or information. REPORTS AND INFORMATION MAY BE USED IN THE AGGREGATE IN PROGRAMS APPROVED BY THE COMMISSIONER FOR THE IMPROVEMENT OF THE QUALITY OF MEDICAL CARE PROVIDED TO PERSONS WITH SEXUALLY TRANSMITTED DISEASES; OR WITH PATIENT IDENTIFIERS 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 IDENTIFIERS SHALL NOT BE DISCLOSED OUTSIDE THE STATE OR LOCAL HEALTH DEPARTMENT EXCEPT AS OTHERWISE PROVIDED FOR IN THIS SECTION.

S 37. The section heading of section 2308 of the public health law is amended to read as follows:

[Venereal] SEXUALLY TRANSMITTED disease; pregnant women; blood test for syphilis.

S 38. Section 2308-a of the public health law, as amended by chapter 878 of the laws of 1980, is amended to read as follows:

S 2308-a. Sexually [transmissible] TRANSMITTED diseases; tests for sexually [transmissible] TRANSMITTED diseases. 1. The administrative officer or other person in charge of a clinic or other facility providing gynecological, obstetrical, genito-urological, contraceptive, sterilization or termination of pregnancy services or treatment shall require the staff of such clinic or facility to offer to administer to every resident of the state of New York coming to such clinic or facility for such services or treatment, appropriate examinations or tests for the detection of sexually [transmissible] TRANSMITTED diseases.

2. Each physician providing gynecological, obstetrical, genito-urological, contraceptive, sterilization, or termination of pregnancy services or treatment shall offer to administer to every resident of the state of New York coming to such physician for such services or treatment, appropriate examinations or tests for the detection of sexually [transmissible] TRANSMITTED diseases.

S 39. Sections 2309 and 2310 of the public health law are REPEALED.

S 40. Section 2311 of the public health law, as added by chapter 878 of the laws of 1980, is amended to read as follows:

S 2311. Sexually [transmissible] TRANSMITTED disease list. The commissioner shall promulgate a list of sexually [transmissible] TRANSMITTED diseases, such as gonorrhea and syphilis, for the purposes of this article. The commissioner, in determining the diseases to be included in such list, shall consider those conditions principally transmitted by sexual contact, OTHER SECTIONS OF THIS CHAPTER ADDRESSING COMMUNICABLE DISEASES and the impact of particular diseases on individual morbidity and the health of newborns.

S 41. Section 2 of chapter 577 of the laws of 2008, amending the public health law relating to expedited partner therapy for persons infected with chlamydia trachomatis, is amended to read as follows:

S 2. This act shall take effect on the one hundred twentieth day after it shall have become a law [and shall expire and be deemed repealed January 1, 2014].

S 42. Intentionally omitted.

S 43. Intentionally omitted.

S 44. Intentionally omitted.

S 45. Intentionally omitted.

S 46. Intentionally omitted.

S 47. Intentionally omitted.

S 48. Intentionally omitted

S 49. Intentionally omitted.

S 50. The public health law is amended by adding a new section 2806-a to read as follows:

S 2806-A. TEMPORARY OPERATOR. 1. FOR THE PURPOSES OF THIS SECTION:

(A) "ADULT CARE FACILITY" SHALL MEAN AN ADULT HOME OR ENRICHED HOUSING PROGRAM LICENSED PURSUANT TO ARTICLE SEVEN OF THE SOCIAL SERVICES LAW OR AN ASSISTED LIVING RESIDENCE LICENSED PURSUANT TO ARTICLE FORTY-SIX-B OF THIS CHAPTER;

(B) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF AN ADULT CARE FACILITY, A GENERAL HOSPITAL OR A DIAGNOSTIC AND TREATMENT CENTER THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE AS SUCH PURSUANT TO THIS ARTICLE;

(C) "FACILITY" SHALL MEAN (I) A GENERAL HOSPITAL OR A DIAGNOSTIC AND TREATMENT CENTER THAT HAS BEEN ISSUED AN OPERATING CERTIFICATE AS SUCH PURSUANT TO THIS ARTICLE; OR (II) AN ADULT CARE FACILITY;

(D) "TEMPORARY OPERATOR" SHALL MEAN ANY PERSON OR ENTITY THAT:

(I) AGREES TO OPERATE A FACILITY ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS RESIDENTS OR PATIENTS AND THE COMMUNITY SERVED BY THE FACILITY; AND

(II) HAS DEMONSTRATED THAT HE OR SHE HAS THE CHARACTER, COMPETENCE AND FINANCIAL ABILITY TO OPERATE THE FACILITY IN COMPLIANCE WITH APPLICABLE STANDARDS;

(E) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING KEY COVENANTS OF LOANS, OR MISSED MORTGAGE PAYMENTS, OR GENERAL UNTIMELY PAYMENT OF OBLIGATIONS, INCLUDING BUT NOT LIMITED TO EMPLOYEE BENEFIT FUND, PAYROLL TAX, AND INSURANCE PREMIUM OBLIGATIONS, OR FAILURE TO MAINTAIN REQUIRED DEBT SERVICE COVERAGE RATIOS OR, AS APPLICABLE, FACTORS THAT HAVE TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE DEPARTMENT BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK; AND

(F) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS PROVIDED TO A FACILITY UPON SUCH FACILITY'S REQUEST FOR THE PURPOSE OF ASSISTING THE FACILITY TO ADDRESS SERIOUS FINANCIAL INSTABILITY. SUCH FUNDS MAY BE DERIVED FROM EXISTING PROGRAMS WITHIN THE DEPARTMENT, SPECIAL APPROPRIATIONS, OR OTHER FUNDS.

2.(A) IN THE EVENT THAT: (I) A FACILITY SEEKS EXTRAORDINARY FINANCIAL ASSISTANCE AND THE COMMISSIONER FINDS THAT THE FACILITY IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY THAT IS JEOPARDIZING EXISTING OR CONTINUED ACCESS TO ESSENTIAL SERVICES WITHIN THE COMMUNITY, OR (II) THE COMMISSIONER FINDS THAT THERE ARE CONDITIONS WITHIN THE FACILITY THAT SERIOUSLY ENDANGER THE LIFE, HEALTH OR SAFETY OF RESIDENTS OR PATIENTS, THE COMMISSIONER MAY APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND SOLE RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY. THE APPOINTMENT OF THE TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO THIS SECTION AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW.

(B) THE ESTABLISHED OPERATOR OF A FACILITY MAY AT ANY TIME REQUEST THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECESSARY TO RESTORE OR MAINTAIN THE PROVISION OF QUALITY CARE TO THE RESIDENTS OR PATIENTS OR ALLEVIATE THE FACILITY'S FINANCIAL INSTABILITY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE APPOINTMENT OF A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND SOLE RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY.

3. (A) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL, PRIOR TO HIS OR HER APPOINTMENT AS TEMPORARY OPERATOR, PROVIDE THE COMMISSIONER WITH A WORK PLAN SATISFACTORY TO THE COMMISSIONER TO ADDRESS THE FACILITY'S DEFICIENCIES AND SERIOUS FINANCIAL INSTABILITY AND A SCHEDULE FOR IMPLEMENTATION OF SUCH PLAN. A WORK PLAN SHALL NOT BE REQUIRED PRIOR TO THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO CLAUSE (II) OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE COMMISSIONER HAS DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPORARY OPERATOR IS NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMINENT DANGER OR THERE EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS OR PRACTICES WHICH POSES IMMINENT DANGER TO THE

HEALTH OR SAFETY OF ANY PATIENT OR RESIDENT OF THE FACILITY. WHERE SUCH IMMEDIATE APPOINTMENT HAS BEEN FOUND TO BE NECESSARY, THE TEMPORARY OPERATOR SHALL PROVIDE THE COMMISSIONER WITH A WORK PLAN SATISFACTORY TO THE COMMISSIONER AS SOON AS PRACTICABLE.

(B) THE TEMPORARY OPERATOR SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE WORK PLAN PROVIDED TO THE COMMISSIONER, IF APPLICABLE, AND TO CORRECT OR ELIMINATE ANY DEFICIENCIES OR FINANCIAL INSTABILITY IN THE FACILITY AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES IN THE COMMUNITY SERVED BY THE FACILITY. SUCH CORRECTION OR ELIMINATION OF DEFICIENCIES OR SERIOUS FINANCIAL INSTABILITY SHALL NOT INCLUDE MAJOR ALTERATIONS OF THE PHYSICAL STRUCTURE OF THE FACILITY. DURING THE TERM OF HIS OR HER APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE SOLE AUTHORITY TO DIRECT THE MANAGEMENT OF THE FACILITY IN ALL ASPECTS OF OPERATION AND SHALL BE AFFORDED FULL ACCESS TO THE ACCOUNTS AND RECORDS OF THE FACILITY. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE FACILITY IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF HEALTH CARE SERVICES OR RESIDENTIAL CARE IN THE COMMUNITY SERVED BY THE FACILITY. THE TEMPORARY OPERATOR SHALL HAVE THE POWER TO LET CONTRACTS THEREFOR OR INCUR EXPENSES ON BEHALF OF THE FACILITY, PROVIDED THAT WHERE INDIVIDUAL ITEMS OF REPAIRS, IMPROVEMENTS OR SUPPLIES EXCEED TEN THOUSAND DOLLARS, THE TEMPORARY OPERATOR SHALL OBTAIN PRICE QUOTATIONS FROM AT LEAST THREE REPUTABLE SOURCES. THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE FACILITY OR CONTAINED WITHIN THE FACILITY, OR IN ANY FIXTURE OF THE FACILITY, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE DEPARTMENT SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPERTY WITHOUT THE PAYMENT OF FAIR COMPENSATION.

4. THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER, AND NECESSARY EXPENSES INCURRED DURING HIS OR HER PERFORMANCE AS TEMPORARY OPERATOR, TO BE PAID FROM THE REVENUE OF THE FACILITY. THE TEMPORARY OPERATOR SHALL COLLECT INCOMING PAYMENTS FROM ALL SOURCES AND APPLY THEM TO THE REASONABLE FEE AND TO COSTS INCURRED IN THE PERFORMANCE OF HIS OR HER FUNCTIONS AS TEMPORARY OPERATOR IN CORRECTING DEFICIENCIES AND CAUSES OF SERIOUS FINANCIAL INSTABILITY. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN HIS OR HER CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND PROPERTY BY REASON OF CONDITIONS OF THE FACILITY IN A CASE WHERE AN ESTABLISHED OPERATOR WOULD HAVE BEEN LIABLE; HE OR SHE SHALL NOT HAVE ANY LIABILITY IN HIS OR HER PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

5. (A) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR SHALL NOT EXCEED ONE HUNDRED EIGHTY DAYS. AFTER ONE HUNDRED EIGHTY DAYS, IF THE COMMISSIONER DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, HEALTH CARE OR RESIDENTIAL CARE IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE CONDITIONS WITHIN THE FACILITY THAT SERIOUSLY ENDANGER THE LIFE, HEALTH OR SAFETY OF RESIDENTS OR PATIENTS, OR THE FINANCIAL INSTABILITY THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSIONER MAY AUTHORIZE UP TO TWO ADDITIONAL NINETY-DAY TERMS.

(B) UPON THE COMPLETION OF THE TWO NINETY-DAY TERMS REFERENCED IN PARAGRAPH (A) OF THIS SUBDIVISION,

(I) IF THE ESTABLISHED OPERATOR IS THE DEBTOR IN A BANKRUPTCY PROCEEDING, AND THE COMMISSIONER DETERMINES THAT THE TEMPORARY OPERATOR

REQUIRES ADDITIONAL TERMS TO OPERATE THE FACILITY DURING THE PENDENCY OF THE BANKRUPTCY PROCEEDING AND TO CARRY OUT ANY PLAN RESULTING FROM THE PROCEEDING, THE COMMISSIONER MAY REAPPOINT THE TEMPORARY OPERATOR FOR ADDITIONAL NINETY-DAY TERMS UNTIL THE TERMINATION OF THE BANKRUPTCY PROCEEDING, PROVIDED THAT THE COMMISSIONER SHALL PROVIDE FOR NOTICE AND A HEARING AS SET FORTH IN SUBDIVISION SIX OF THIS SECTION; OR

(II) IF THE ESTABLISHED OPERATOR REQUESTS THE REAPPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSIONER MAY REAPPOINT THE TEMPORARY OPERATOR FOR ONE ADDITIONAL NINETY-DAY TERM, PURSUANT TO AN AGREEMENT BETWEEN THE ESTABLISHED OPERATOR, THE TEMPORARY OPERATOR AND THE DEPARTMENT.

(C) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT DESCRIBING:

(I) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS SUCH DEFICIENCIES AND FINANCIAL INSTABILITY,

(II) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES,

(III) RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE FACILITY SUBSEQUENT TO THE TERM OF THE TEMPORARY OPERATOR; AND

(IV) WITH RESPECT TO THE FIRST NINETY-DAY TERM REFERENCED IN PARAGRAPH (A) OF THIS SUBDIVISION, A PLAN FOR SUSTAINABLE OPERATION TO AVOID CLOSURE, OR TRANSFORMATION OF THE FACILITY WHICH MAY INCLUDE ANY OPTION PERMISSIBLE UNDER THIS CHAPTER OR THE SOCIAL SERVICES LAW AND IMPLEMENTING REGULATIONS THEREOF. THE REPORT SHALL REFLECT BEST EFFORTS TO PRODUCE A FULL AND COMPLETE ACCOUNTING.

(D) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAPPOINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

6. (A) THE COMMISSIONER, UPON MAKING A DETERMINATION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION SHALL, PRIOR TO THE COMMENCEMENT OF THE APPOINTMENT, CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE DETERMINATION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE DETERMINATION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN TEN BUSINESS DAYS OF THE DATE OF SUCH NOTICE. AT SUCH MEETING, THE ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS ALL RELEVANT FINDINGS. AT SUCH MEETING OR WITHIN TEN ADDITIONAL BUSINESS DAYS, THE COMMISSIONER AND THE ESTABLISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN THE EVENT SUCH PLAN OF CORRECTION IS AGREED UPON, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER NO LONGER INTENDS TO APPOINT A TEMPORARY OPERATOR. A MEETING SHALL NOT BE REQUIRED PRIOR TO THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO CLAUSE (II) OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE COMMISSIONER HAS DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPORARY OPERATOR IS NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMINENT DANGER OR THERE EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS OR PRACTICES WHICH POSES IMMINENT DANGER TO THE HEALTH OR SAFETY OF ANY PATIENT OR RESIDENT OF THE FACILITY. WHERE SUCH IMMEDIATE APPOINTMENT HAS BEEN FOUND TO BE NECESSARY, THE COMMISSIONER SHALL PROVIDE THE

ESTABLISHED OPERATOR WITH A NOTICE AS REQUIRED UNDER THIS PARAGRAPH ON THE DATE OF THE APPOINTMENT OF THE TEMPORARY OPERATOR.

(B) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE COMMISSIONER'S INITIAL NOTIFICATION, A TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND SHALL OPERATE PURSUANT TO THE PROVISIONS OF THIS SECTION.

(C) THE ESTABLISHED OPERATOR SHALL BE AFFORDED AN OPPORTUNITY FOR AN ADMINISTRATIVE HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPERATOR. SUCH ADMINISTRATIVE HEARING SHALL OCCUR PRIOR TO SUCH APPOINTMENT, EXCEPT THAT THE HEARING SHALL NOT BE REQUIRED PRIOR TO THE APPOINTMENT OF THE TEMPORARY OPERATOR PURSUANT TO CLAUSE (II) OF PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION IF THE COMMISSIONER HAS DETERMINED THAT THE IMMEDIATE APPOINTMENT OF A TEMPORARY OPERATOR IS NECESSARY BECAUSE PUBLIC HEALTH OR SAFETY IS IN IMMINENT DANGER OR THERE EXISTS ANY CONDITION OR PRACTICE OR A CONTINUING PATTERN OF CONDITIONS OR PRACTICES WHICH POSES IMMINENT DANGER TO THE HEALTH OR SAFETY OF ANY PATIENT OR RESIDENT OF THE FACILITY. AN ADMINISTRATIVE HEARING AS PROVIDED FOR UNDER THIS PARAGRAPH SHALL BEGIN NO LATER THAN SIXTY DAYS FROM THE DATE OF THE NOTICE TO THE ESTABLISHED OPERATOR AND SHALL NOT BE EXTENDED WITHOUT THE CONSENT OF BOTH PARTIES. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

(D) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION TO REAPPOINT A TEMPORARY OPERATOR FOR THE FIRST OF AN ADDITIONAL NINETY-DAY TERM PURSUANT TO PARAGRAPH (A) OF SUBDIVISION FIVE OF THIS SECTION, CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE DETERMINATION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. IF THE COMMISSIONER DETERMINES THAT ADDITIONAL REAPPOINTMENTS PURSUANT TO SUBPARAGRAPH (I) OF PARAGRAPH (B) OF SUBDIVISION FIVE OF THIS SECTION ARE REQUIRED, THE COMMISSIONER SHALL AGAIN CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF SUCH DETERMINATION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR AT THE COMMENCEMENT OF THE FIRST OF EVERY TWO ADDITIONAL TERMS. UPON RECEIPT OF SUCH NOTIFICATION AT THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR AND BEFORE THE EXPIRATION OF TEN DAYS THEREAFTER, THE ESTABLISHED OPERATOR MAY REQUEST AN ADMINISTRATIVE HEARING ON THE DETERMINATION TO BEGIN NO LATER THAN SIXTY DAYS FROM THE DATE OF THE REAPPOINTMENT OF THE TEMPORARY OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO REAPPOINT THE TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE.

7. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR HEREUNDER; NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES OF THE FACILITY NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF MORTGAGES OR LIENS.

S 51. The mental hygiene law is amended by adding a new section 32.20 to read as follows:

S 32.20 TEMPORARY OPERATOR. 1. FOR THE PURPOSES OF THIS SECTION:

(A) "CHEMICAL DEPENDENCE TREATMENT PROGRAM" SHALL MEAN A PROGRAM CERTIFIED PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

(B) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF A CHEMICAL DEPENDENCE TREATMENT PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO SECTION 32.05 OF THIS ARTICLE;

(C) "TEMPORARY OPERATOR" SHALL MEAN ANY OASAS STAFF MEMBER, PERSON OR ENTITY THAT:

(I) AGREES TO OPERATE A PROGRAM ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS PATIENTS AND THE COMMUNITY SERVED BY THE PROGRAM;

(II) HAS DEMONSTRATED THAT HE OR SHE HAS THE CHARACTER, COMPETENCE AND ABILITY TO OPERATE AN OASAS-CERTIFIED PROGRAM IN COMPLIANCE WITH APPLICABLE STANDARDS; AND

(III) PRIOR TO HIS OR HER APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS WITH GUIDANCE FROM THE COMMISSIONER A SATISFACTORY PLAN TO ADDRESS THE PROGRAM'S DEFICIENCIES;

(D) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING KEY COVENANTS OF BOND ISSUES, MISSED MORTGAGE PAYMENTS, GENERAL UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM AND/OR FACILITY, FAILURE TO MAINTAIN REQUIRED DEBT SERVICE COVERAGE RATIOS AND/OR, AS APPLICABLE, FACTORS THAT HAVE TRIGGERED A WRITTEN EVENT OF DEFAULT NOTICE TO THE OFFICE BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK; AND

(E) "EXTRAORDINARY FINANCIAL ASSISTANCE" SHALL MEAN STATE FUNDS PROVIDED TO, OR REQUESTED BY, A PROGRAM FOR THE EXPRESS PURPOSE OF PREVENTING THE CLOSURE OF THE PROGRAM THAT THE COMMISSIONER FINDS PROVIDES ESSENTIAL AND NECESSARY SERVICES WITHIN THE COMMUNITY.

2. (A) IN THE EVENT THAT: (I) THE PROGRAM IS SEEKING EXTRAORDINARY FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA INDICATES THAT THE PROGRAM IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (III) OFFICE COLLECTED DATA INDICATES THAT THE PROGRAM'S BOARD OF DIRECTORS OR ADMINISTRATION ARE UNABLE OR UNWILLING TO ENSURE THE PROPER OPERATION OF THE PROGRAM; OR (IV) OFFICE COLLECTED DATA INDICATES THERE ARE CONDITIONS THAT SERIOUSLY ENDANGER OR JEOPARDIZE CONTINUED ACCESS TO NECESSARY CHEMICAL DEPENDENCE TREATMENT SERVICES WITHIN THE COMMUNITY, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR OF HIS OR HER INTENTION TO APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE RESPONSIBILITY FOR THE PROGRAM'S TREATMENT OPERATIONS OF THAT FACILITY FOR A LIMITED PERIOD OF TIME. THE APPOINTMENT OF A TEMPORARY OPERATOR SHALL BE EFFECTUATED PURSUANT TO THIS SECTION, AND SHALL BE IN ADDITION TO ANY OTHER REMEDIES PROVIDED BY LAW.

(B) THE ESTABLISHED OPERATOR OF A PROGRAM MAY AT ANY TIME REQUEST THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR. UPON RECEIVING SUCH A REQUEST, THE COMMISSIONER MAY, IF HE OR SHE DETERMINES THAT SUCH AN ACTION IS NECESSARY, ENTER INTO AN AGREEMENT WITH THE ESTABLISHED OPERATOR FOR THE APPOINTMENT OF A TEMPORARY OPERATOR TO RESTORE OR MAINTAIN THE PROVISION OF QUALITY CARE TO THE PATIENTS UNTIL THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD; THE PATIENTS MAY BE TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS; OR THE PROGRAM OPERATIONS OF THAT FACILITY SHOULD BE COMPLETELY DISCONTINUED.

3. (A) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEVELOPED WITH THE GUIDANCE OF THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN

THE PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF CHEMICAL DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY SERVED BY THE PROGRAM.

(B) IF THE IDENTIFIED PROGRAM DEFICIENCIES CANNOT BE ADDRESSED IN THE TIME PERIOD DESIGNATED IN THE PLAN, THE PATIENTS SHALL BE TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS.

(C) DURING THE TERM OF HIS OR HER APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE AUTHORITY TO DIRECT THE PROGRAM STAFF OF THE FACILITY IN ALL ASPECTS NECESSARY TO APPROPRIATELY TREAT AND/OR TRANSFER THE PATIENTS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE PROGRAM IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF CHEMICAL DEPENDENCE TREATMENT SERVICES IN THE COMMUNITY SERVED BY THE FACILITY UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME PROGRAM OPERATIONS OR UNTIL THE PATIENTS ARE APPROPRIATELY TRANSFERRED TO OTHER OASAS-CERTIFIED PROVIDERS.

(D) THE TEMPORARY OPERATOR SHALL ALSO BE AFFORDED ACCESS TO A PROGRAM'S ACCOUNTS AND RECORDS IN ORDER TO ADDRESS ANY DEFICIENCIES RELATED TO A PROGRAM EXPERIENCING SERIOUS FINANCIAL INSTABILITY OR A PROGRAM REQUESTING FINANCIAL ASSISTANCE IN ACCORDANCE WITH THIS SECTION. THE TEMPORARY OPERATOR SHALL APPROVE ANY FINANCIAL DECISION RELATED TO A PROGRAM'S DAY TO DAY OPERATIONS OR PROGRAM'S ABILITY TO PROVIDE CHEMICAL DEPENDENCE SERVICES.

(E) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE FACILITY OR CONTAINED WITHIN THE FACILITY OR IN ANY FIXTURE OF THE FACILITY, SHALL BE IMPAIRED OR DIMINISHED IN PRIORITY BY THE TEMPORARY OPERATOR. NEITHER THE TEMPORARY OPERATOR NOR THE OFFICE SHALL ENGAGE IN ANY ACTIVITY THAT CONSTITUTES A CONFISCATION OF PROPERTY.

4. THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER, AND NECESSARY EXPENSES INCURRED DURING HIS OR HER PERFORMANCE AS TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN HIS OR HER CAPACITY AS TEMPORARY OPERATOR OF THE PROGRAM FOR INJURY TO PERSON AND PROPERTY BY REASON OF HIS OR HER OPERATION OF SUCH PROGRAM; HE OR SHE SHALL NOT HAVE ANY LIABILITY IN HIS OR HER PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

5. (A) THE INITIAL TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR SHALL NOT EXCEED NINETY DAYS. AFTER NINETY DAYS, IF THE COMMISSIONER DETERMINES THAT TERMINATION OF THE TEMPORARY OPERATOR WOULD CAUSE SIGNIFICANT DETERIORATION OF THE QUALITY OF, OR ACCESS TO, HEALTH CARE IN THE COMMUNITY OR THAT REAPPOINTMENT IS NECESSARY TO CORRECT THE DEFICIENCIES THAT REQUIRED THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE COMMISSIONER MAY AUTHORIZE AN ADDITIONAL NINETY-DAY TERM. HOWEVER, SUCH AUTHORIZATION SHALL INCLUDE THE COMMISSIONER'S REQUIREMENTS FOR CONCLUSION OF THE TEMPORARY OPERATORSHIP TO BE SATISFIED WITHIN THE ADDITIONAL TERM.

(B) WITHIN FOURTEEN DAYS PRIOR TO THE TERMINATION OF EACH TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR, THE TEMPORARY OPERATOR SHALL SUBMIT TO THE COMMISSIONER AND TO THE ESTABLISHED OPERATOR A REPORT DESCRIBING:

(I) THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS: THE IDENTIFIED PROGRAM DEFICIENCIES; THE RESUMPTION OF PROGRAM OPERATIONS BY THE ESTABLISHED OPERATOR; OR THE TRANSFER OF THE PATIENTS TO OTHER OASAS-CERTIFIED PROVIDERS;

(II) OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

(III) IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE PROGRAM SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

(C) THE TERM OF THE INITIAL APPOINTMENT AND OF ANY SUBSEQUENT REAPPOINTMENT MAY BE TERMINATED PRIOR TO THE EXPIRATION OF THE DESIGNATED TERM, IF THE ESTABLISHED OPERATOR AND THE COMMISSIONER AGREE ON A PLAN OF CORRECTION AND THE IMPLEMENTATION OF SUCH PLAN.

6. (A) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR OF THE FACILITY TO BE NOTIFIED OF THE INTENTION BY REGISTERED OR CERTIFIED MAIL ADDRESSED TO THE PRINCIPAL OFFICE OF THE ESTABLISHED OPERATOR. SUCH NOTIFICATION SHALL INCLUDE A DETAILED DESCRIPTION OF THE FINDINGS UNDERLYING THE INTENTION TO APPOINT A TEMPORARY OPERATOR, AND THE DATE AND TIME OF A REQUIRED MEETING WITH THE COMMISSIONER AND/OR HIS OR HER DESIGNEE WITHIN TEN BUSINESS DAYS OF THE RECEIPT OF SUCH NOTICE. AT SUCH MEETING, THE ESTABLISHED OPERATOR SHALL HAVE THE OPPORTUNITY TO REVIEW AND DISCUSS ALL RELEVANT FINDINGS. AT SUCH MEETING, THE COMMISSIONER AND THE ESTABLISHED OPERATOR SHALL ATTEMPT TO DEVELOP A MUTUALLY SATISFACTORY PLAN OF CORRECTION AND SCHEDULE FOR IMPLEMENTATION. IN SUCH EVENT, THE COMMISSIONER SHALL NOTIFY THE ESTABLISHED OPERATOR THAT THE COMMISSIONER WILL ABSTAIN FROM APPOINTING A TEMPORARY OPERATOR CONTINGENT UPON THE ESTABLISHED OPERATOR REMEDIATING THE IDENTIFIED DEFICIENCIES WITHIN THE AGREED UPON TIMEFRAME.

(B) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, OR SHOULD THE ESTABLISHED OPERATOR FAIL TO RESPOND TO THE COMMISSIONER'S INITIAL NOTIFICATION, THERE SHALL BE AN ADMINISTRATIVE HEARING ON THE COMMISSIONER'S DETERMINATION TO APPOINT A TEMPORARY OPERATOR TO BEGIN NO LATER THAN THIRTY DAYS FROM THE DATE OF THE NOTICE TO THE ESTABLISHED OPERATOR. ANY SUCH HEARING SHALL BE STRICTLY LIMITED TO THE ISSUE OF WHETHER THE DETERMINATION OF THE COMMISSIONER TO APPOINT A TEMPORARY OPERATOR IS SUPPORTED BY SUBSTANTIAL EVIDENCE. A COPY OF THE DECISION SHALL BE SENT TO THE ESTABLISHED OPERATOR.

(C) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND SHALL OPERATE THE PROGRAM PURSUANT TO THE PROVISIONS OF THIS SECTION.

7. NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTABLISHED OPERATOR REMAINS OBLIGATED FOR THE CONTINUED OPERATION OF THE FACILITY SO THAT THE PROGRAM CAN FUNCTION IN A NORMAL MANNER. NO PROVISION CONTAINED IN THIS SECTION SHALL BE DEEMED TO RELIEVE THE ESTABLISHED OPERATOR OR ANY OTHER PERSON OF ANY CIVIL OR CRIMINAL LIABILITY INCURRED, OR ANY DUTY IMPOSED BY LAW, BY REASON OF ACTS OR OMISSIONS OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON PRIOR TO THE APPOINTMENT OF ANY TEMPORARY OPERATOR OF THE PROGRAM HEREUNDER; NOR SHALL ANYTHING CONTAINED IN THIS SECTION BE CONSTRUED TO SUSPEND DURING THE TERM OF THE APPOINTMENT OF THE TEMPORARY OPERATOR OF THE PROGRAM ANY OBLIGATION OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE MAINTENANCE AND REPAIR OF THE FACILITY, PROVISION OF UTILITY SERVICES, PAYMENT OF TAXES OR OTHER OPERATING AND MAINTENANCE EXPENSES OF THE FACILITY, NOR OF THE ESTABLISHED OPERATOR OR ANY OTHER PERSON FOR THE PAYMENT OF MORTGAGES OR LIENS.

S 52. Intentionally omitted.

S 53. Intentionally omitted.

S 54. Intentionally omitted.

S 55. Intentionally omitted.

S 56. Intentionally omitted.

S 57. Intentionally omitted.

S 58. Intentionally omitted.

S 59. Intentionally omitted.
S 60. Intentionally omitted.
S 61. Intentionally omitted.
S 62. Intentionally omitted.
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S 88. Intentionally omitted.
S 89. Intentionally omitted.
S 90. Intentionally omitted.
S 91. Intentionally omitted.
S 92. Intentionally omitted.
S 93. Intentionally omitted.
S 94. Intentionally omitted.
S 95. Intentionally omitted.
S 96. Intentionally omitted.

S 97. The opening paragraph, and paragraphs (k) and (l) of subdivision 1 of section 3510 of the public health law, as added by chapter 175 of the laws of 2006, are amended and four new paragraphs (m), (n), (o) and (p) are added to read as follows:

The license, registration or intravenous contrast administration certificate of a [radiological] RADIOLOGIC technologist may be suspended for a fixed period, revoked or annulled, or such licensee censured, reprimanded, subject to a civil penalty not to exceed two thousand dollars for every such violation, or otherwise disciplined, in accordance with the provisions and procedures defined in this article, PROVIDED THAT NO CIVIL PENALTY SHALL BE ASSESSED FOR ANY CRIME OR MISCONDUCT THAT OCCURRED OUTSIDE THE JURISDICTION OF NEW YORK STATE upon decision after due hearing that the individual is guilty of the following misconduct:

(k) using the prefix "Dr.", the word "doctor" or any suffix or affix to indicate or imply that the licensee is a duly licensed practitioner as defined in this article when not so licensed; [or]

(l) incompetence or negligence[.];

(M) BEING CONVICTED OF A CRIME WHICH HAS A DIRECT RELATIONSHIP TO THE EMPLOYMENT OR LICENSURE AT ISSUE OR POSES AN UNREASONABLE RISK TO PUBLIC SAFETY PURSUANT TO ARTICLE TWENTY-THREE-A OF THE CORRECTION LAW AND IS A CONVICTION UNDER (I) NEW YORK STATE LAW; (II) FEDERAL LAW; OR (III) THE LAW OF ANOTHER JURISDICTION WHICH, IF COMMITTED WITHIN THIS STATE, WOULD HAVE CONSTITUTED PROFESSIONAL MISCONDUCT UNDER NEW YORK STATE LAW;

(N) HAVING BEEN FOUND GUILTY OF IMPROPER PROFESSIONAL PRACTICE OR PROFESSIONAL MISCONDUCT BY A DULY AUTHORIZED PROFESSIONAL DISCIPLINARY AGENCY OF ANOTHER STATE WHERE THE CONDUCT UPON WHICH THE FINDING WAS BASED, IF COMMITTED IN NEW YORK STATE, WOULD CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE;

(O) HAVING BEEN FOUND GUILTY IN AN ADJUDICATORY PROCEEDING OF VIOLATING A STATE OR FEDERAL STATUTE OR REGULATION, PURSUANT TO A FINAL DECISION OR DETERMINATION, AND WHEN NO APPEAL IS PENDING, OR AFTER RESOLUTION OF THE PROCEEDING BY STIPULATION OR AGREEMENT, AND WHEN THE VIOLATION WOULD CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE; OR

(P) HAVING HIS OR HER LICENSE TO PRACTICE AS A RADIOLOGIC TECHNOLOGIST REVOKED, SUSPENDED OR HAVING OTHER DISCIPLINARY ACTION TAKEN, OR HAVING HIS OR HER APPLICATION FOR A LICENSE REFUSED, REVOKED OR SUSPENDED OR HAVING VOLUNTARILY OR OTHERWISE SURRENDERED HIS OR HER LICENSE AFTER A DISCIPLINARY ACTION WAS INSTITUTED BY A DULY AUTHORIZED PROFESSIONAL DISCIPLINARY AGENCY OF ANOTHER STATE, WHERE THE CONDUCT RESULTING IN THE REVOCATION, SUSPENSION OR OTHER DISCIPLINARY ACTION INVOLVING THE LICENSE OR REFUSAL, REVOCATION OR SUSPENSION OF AN APPLICATION FOR A LICENSE OR THE SURRENDER OF THE LICENSE WOULD, IF COMMITTED IN NEW YORK STATE, CONSTITUTE PROFESSIONAL MISCONDUCT UNDER THE LAWS OF NEW YORK STATE. A RADIOLOGIC TECHNOLOGIST LICENSED IN NEW YORK STATE WHO IS ALSO LICENSED OR SEEKING LICENSURE IN ANOTHER STATE MUST IMMEDIATELY REPORT TO THE DEPARTMENT ANY REVOCATION, SUSPENSION OR OTHER DISCIPLINARY ACTION INVOLVING THE OUT-OF-STATE LICENSE OR REFUSAL, REVOCATION OR SUSPENSION OF AN APPLICATION FOR AN OUT-OF-STATE LICENSE OR THE SURRENDER OF THE OUT-OF-STATE LICENSE.

S 98. Intentionally omitted.

S 99. Intentionally omitted.

S 100. Intentionally omitted.

S 101. Intentionally omitted.

S 102. Intentionally omitted.

S 103. Intentionally omitted.

S 104. Intentionally omitted.

S 105. Intentionally omitted.

S 105-a. Intentionally omitted.

S 106. Intentionally omitted.

S 107. Intentionally omitted.

S 108. 1. 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 periods ending the thirtieth of June, two thousand thirteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand thirteen. For the coverage period beginning the first of July, two thousand thirteen, the superintendent of financial services and the commissioner of health, or their designee, shall purchase up to one thousand policies for excess coverage or equivalent excess coverage in addition to the

number of policies purchased for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand thirteen. A general hospital 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 thirteen, as applied to the greater of one thousand or 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 thirteen 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 thirteen plus one thousand.

2. Notwithstanding any inconsistent provision 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 other contrary provision of law, the superintendent of financial services may enter into a contract or contracts under this subdivision for the purpose of retaining an entity to administer the hospital excess liability pool without a competitive bid or request for proposal process, provided, however, that:

(a) The department of financial services 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 superintendent of financial services; and

(c) The superintendent of financial services shall select such contractor or contractors that, in the superintendent of financial services' discretion, are best suited to serve the purposes of this subdivision.

S 109. Section 5-a of part C of chapter 58 of the laws of 2005, relating to authorizing reimbursements for expenditures made by or on behalf of social services districts for medical assistance for needy persons and the administration thereof, in relation to the use of Medicaid recovery savings, as added by section 52-f of part H of chapter 59 of the laws of 2011, is amended to read as follows:

S 5-a. Notwithstanding any provision of law to the contrary, the commissioner of health is authorized to approve social services district demonstration programs for the purpose of maximizing Medicaid recoveries. The commissioner shall evaluate the results of any such programs, including any savings resulting therefrom. [Ten] TWENTY percent of any such savings, after certification by the director of the division of the budget, shall be shared with the applicable social services district in a manner to be determined jointly by the commissioner of health and the director of the division of the budget.

S 110. Subdivisions 5, 23 and 24 of section 32 of the public health law, as added by chapter 442 of the laws of 2006, are amended and 2 new subdivisions 25 and 26 are added to read as follows:

5. to keep the governor, attorney general, state comptroller, temporary president and minority leader of the senate, the speaker and the minority leader of the assembly, and the heads of agencies with responsibility for the administration of the medical assistance program apprised of efforts to prevent, detect, investigate, and prosecute fraud and abuse within the medical assistance program, AND TO PROVIDE A QUARTERLY BRIEFING TO THE LEGISLATURE ON ACTIVITIES OF THE OFFICE;

23. to annually submit a budget request, for the ensuing state fiscal year, to the division of THE budget, provided that the office's budget request shall not be subject to review, alteration or modification by the commissioner or any other entity or person prior to its submission to the division of THE budget; [and]

24. TO MEET QUARTERLY WITH REPRESENTATIVES OF SOCIAL SERVICES DISTRICTS TO DISCUSS THE STATUS OF ONGOING COOPERATIVE EFFORTS BETWEEN THE OFFICE OF MEDICAID INSPECTOR GENERAL AND DISTRICTS, INCLUDING DEMONSTRATION PROGRAMS AUTHORIZED PURSUANT TO SECTION FIVE-A OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, THE POTENTIAL FOR ADDITIONAL COLLABORATION AND/OR FOR IMPROVED OR INNOVATIVE TECHNIQUES TO BE EMPLOYED, AND ANY ISSUES OF CONCERN TO SUCH DISTRICTS WITH RESPECT TO THE PREVENTION AND DETECTION OF FRAUD AND ABUSE IN THE MEDICAL ASSISTANCE PROGRAM;

25. TO REQUEST SUBMISSION OF SOCIAL SERVICES DISTRICTS ANNUAL BUDGET AND AUDIT WORKPLANS FOR PURPOSES OF PLANNING FOR AND EXECUTING THE COUNTY DEMONSTRATION PROGRAM AND FOR THE CREATION OF THE OFFICE'S ANNUAL WORKPLAN AND TO INCLUDE IN THE OFFICE'S ANNUAL WORKPLAN A DESCRIPTION OF ACTIVITIES THAT WILL BE CONDUCTED IN COLLABORATION WITH SOCIAL SERVICES DISTRICTS;

26. TO DEVELOP TRAINING MATERIALS WITH RESPECT TO THE OFFICE'S AUDIT STANDARDS AND CRITERIA FOR IDENTIFYING FRAUD OR WASTE, FOR USE BY SOCIAL SERVICES DISTRICTS WHO ARE ENGAGED WITH THE OFFICE IN DEMONSTRATION PROGRAMS OR OTHER COLLABORATIVE EFFORTS; AND

27. to perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office in accordance with federal and state law.

S 111. Paragraphs (e) and (f) of subdivision 1 of section 35 of the public health law, as added by chapter 442 of the laws of 2006, are amended and a new paragraph (g) is added to read as follows:

(e) the number, subject and other relevant characteristics of civil actions initiated by the office related to improper payments, the resulting civil settlements entered and overpayments identified and the total dollar value both identified and collected; [and]

(f) a narrative that evaluates the office's performance, describes any specific problems and connection with the procedures and agreements required under this section, discusses any other matters that may have impaired its effectiveness and summarizes the total savings to the state's medical assistance program[.]; AND

(G) A NARRATIVE, PROVIDED BY THE DEPARTMENT IN ITS ANNUAL REPORT PURSUANT TO PARAGRAPH (T) OF SUBDIVISION ONE OF SECTION TWO HUNDRED SIX OF THIS CHAPTER THAT SUMMARIZES THE DEPARTMENT'S ACTIVITIES TO MITIGATE FRAUD, WASTE AND ABUSE DURING THE PRECEDING CALENDAR YEAR.

S 112. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (t) to read as follows:

(T) THE DEPARTMENT SHALL SUBMIT AS PART OF ITS ANNUAL REPORT PREPARED PURSUANT TO SECTION ONE HUNDRED SIXTY-FOUR OF THE EXECUTIVE LAW, WHICH MAY BE SUBMITTED IN ELECTRONIC FORMAT, COMPREHENSIVE INFORMATION INCLUDING, BUT NOT LIMITED TO, A DETAILED DESCRIPTION OF THE DEPARTMENT'S MISSION, PRIORITIES AND GOALS FOR THE UPCOMING YEAR, ACHIEVEMENTS OF THE PAST YEAR, AND ANY RELEVANT DATA AND STATISTICS.

S 113. Section 2500-a of the public health law is amended by adding a new subdivision (c) to read as follows:

(C) BY REGULATION, THE COMMISSIONER SHALL ADD ADRENOLEUKODYSTROPHY ("ALD") TO THE LIST OF DISEASES AND CONDITIONS FOR WHICH TESTING SHALL BE PERFORMED PURSUANT TO SUBDIVISION (A) OF THIS SECTION UPON VALIDATION BY THE WADSWORTH CENTER OF A TEST FOR ALD. THE WADSWORTH CENTER SHALL UNDERTAKE THE PROCESS FOR VALIDATION UPON THE DEVELOPMENT OF A TEST. THIS SUBDIVISION SHALL BE KNOWN AND MAY BE CITED AS "AIDAN'S LAW."

S 114. Intentionally omitted.

S 115. Intentionally omitted.

S 116. Intentionally omitted.

S 117. Intentionally omitted.

S 118. Intentionally omitted.

S 119. 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 120. 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 121. Severability. 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 the 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 122. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013; provided, however, that the provisions of this act shall apply only to actions and proceedings commenced on or after such effective date; provided, further, that:

(a) sections thirty-two, thirty-three, thirty-four, thirty-five, thirty-six, thirty-seven, thirty-nine, forty, forty-one, and one hundred eight of this act shall take effect immediately;

(b) sections fourteen, fifteen, sixteen, seventeen, eighteen, nineteen, twenty, twenty-one, twenty-two, twenty-three, twenty-four, twenty-six, twenty-seven, twenty-eight, twenty-nine, thirty, one hundred twelve, and one hundred thirteen of this act shall take effect January 1, 2014;

(c) section fifty of this act shall take effect immediately and shall expire three years after it becomes law;

(d) 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;

(e) 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;

(f) 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;

(g) 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; and

(h) 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.

PART F

Section 1. Section 19.16 of the mental hygiene law, as added by chapter 223 of the laws of 1992, is amended to read as follows:

S 19.16 Methadone Registry.

The office shall establish and maintain, either directly or through contract, a central registry for purposes of preventing multiple enrollment, ENSURING ACCURATE DOSAGE DELIVERY AND FACILITATING DISASTER MANAGEMENT in methadone programs. The office shall require all methadone programs to utilize such registry and shall have the power to assess methadone programs such fees as are necessary and appropriate.

S 2. The office of alcoholism and substance abuse services shall ensure that accurate dosage delivery and facilitating disaster management shall not result in any new material expenditures by methadone programs.

S 3. This act shall take effect April 1, 2013.

PART G

Section 1. Article 26 of the mental hygiene law is REPEALED.

S 2. The article heading of article 25 of the mental hygiene law, as added by chapter 471 of the laws of 1980, is amended to read as follows:

[FUNDING FOR SUBSTANCE ABUSE SERVICES]
FUNDING FOR SERVICES OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

S 3. Paragraphs 1, 2, 3 and 4 of subdivision (a) of section 25.01 of the mental hygiene law, paragraph 1 as added by chapter 471 of the laws of 1980, and paragraphs 2, 3 and 4 as amended by chapter 223 of the laws of 1992, are amended, and four new paragraphs 5, 6, 7 and 8 are added to read as follows:

1. ["Local agency" shall mean a county governmental unit for a county not wholly within a city, and a city governmental unit for a city having a population of one million or more, designated by such county or city as responsible for substance abuse services in such county or city.]

"LOCAL GOVERNMENTAL UNIT" SHALL HAVE THE SAME MEANING AS THAT CONTAINED IN ARTICLE FORTY-ONE OF THIS CHAPTER.

2. "Operating [costs] EXPENSES" shall mean expenditures[, excluding capital costs and debt service, subject to the approval of the office,] APPROVED BY THE OFFICE AND incurred for the maintenance and operation of substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING programs, including but not limited to expenditures for treatment, administration, personnel, AND contractual services[, rental, depreciation and interest expenses incurred, in connection with the design, construction, acquisition, reconstruction, rehabilitation or improvement of a substance abuse program facility, and payments made to the facilities development corporation for substance abuse program facilities; provided that where the]. OPERATING EXPENSES DO NOT INCLUDE CAPITAL COSTS AND DEBT SERVICE UNLESS SUCH EXPENSES ARE RELATED TO THE rent, financing or refinancing of the design, construction, acquisition, reconstruction, rehabilitation or improvement of a substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING program facility [is through the facilities development corporation, operating costs shall include the debt service to be paid to amortize obligations, including principal and interest, issued by the New York State medical care facilities finance agency to finance or refinance the capital costs of such facilities] PURSUANT TO THE MENTAL HYGIENE FACILITIES FINANCE PROGRAM THROUGH THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK (DASNY; SUCCESSOR TO THE FACILITIES DEVELOPMENT CORPORATION), OR OTHERWISE APPROVED BY THE OFFICE.

3. "Debt service" shall mean amounts, subject to the approval of the office, [as shall be] required to be paid to amortize obligations including principal and interest [issued by the New York state housing finance agency, the New York State medical care facilities finance agency or], ASSUMED by or on behalf of a [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency to finance capital costs for substance abuse program facilities] GOVERNMENTAL UNIT.

4. "Capital costs" shall mean [expenditures, subject to the approval of the office, as shall be obligated to acquire, construct, reconstruct, rehabilitate or improve a substance abuse program facility.] THE COSTS OF A PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR A VOLUNTARY AGENCY WITH RESPECT TO THE ACQUISITION OF REAL PROPERTY ESTATES, INTERESTS, AND COOPERATIVE INTERESTS IN REALTY, THEIR DESIGN, CONSTRUCTION, RECONSTRUCTION, REHABILITATION AND IMPROVEMENT, ORIGINAL FURNISHINGS AND EQUIPMENT, SITE DEVELOPMENT, AND APPURTENANCES OF A FACILITY.

5. "STATE AID" SHALL MEAN FINANCIAL SUPPORT PROVIDED THROUGH APPROPRIATIONS OF THE OFFICE TO SUPPORT THE PROVISION OF SUBSTANCE USE DISORDER TREATMENT, COMPULSIVE GAMBLING, PREVENTION OR OTHER AUTHORIZED SERVICES, WITH THE EXCLUSION OF APPROPRIATIONS FOR THE PURPOSE OF MEDICAL ASSISTANCE.

6. "VOLUNTARY AGENCY CONTRIBUTIONS" SHALL MEAN REVENUE SOURCES OF VOLUNTARY AGENCIES EXCLUSIVE OF STATE AID AND LOCAL TAX LEVY.

7. "APPROVED NET OPERATING COST" SHALL MEAN THE REMAINDER OF TOTAL OPERATING EXPENSES APPROVED BY THE OFFICE, LESS ALL SOURCES OF REVENUE, INCLUDING VOLUNTARY AGENCY CONTRIBUTIONS AND LOCAL TAX LEVY.

8. "VOLUNTARY AGENCY" SHALL MEAN A CORPORATION ORGANIZED OR EXISTING PURSUANT TO THE NOT-FOR-PROFIT CORPORATION LAW FOR THE PURPOSE OF PROVIDING SUBSTANCE USE DISORDER, TREATMENT, COMPULSIVE GAMBLING, PREVENTION OR OTHER AUTHORIZED SERVICES.

S 4. Subdivisions (a) and (b) of section 25.03 of the mental hygiene law, subdivision (a) as amended by chapter 558 of the laws of 1999 and

subdivision (b) as amended by chapter 223 of the laws of 1992, are amended and a new subdivision (d) is added to read as follows:

(a) In accordance with the provisions of this article, AND WITHIN APPROPRIATIONS MADE AVAILABLE, the office may provide [financial support] STATE AID to a [substance abuse program or a] PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT OR VOLUNTARY AGENCY up to one hundred per centum of the APPROVED NET operating costs of such [program] PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT or VOLUNTARY agency, and [either fifty per centum of the capital cost or fifty per centum of the debt service,] STATE AID MAY ALSO BE GRANTED TO A PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR A VOLUNTARY AGENCY FOR CAPITAL COSTS ASSOCIATED WITH THE PROVISION OF SERVICES AT A RATE OF UP TO ONE HUNDRED PERCENT OF APPROVED CAPITAL COSTS. SUCH STATE AID SHALL NOT BE GRANTED UNLESS AND UNTIL SUCH PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY IS IN COMPLIANCE WITH ALL REGULATIONS PROMULGATED BY THE COMMISSIONER REGARDING THE FINANCING OF CAPITAL PROJECTS. SUCH STATE AID for approved [services] NET OPERATING COSTS SHALL BE MADE AVAILABLE by way of advance or reimbursement, through EITHER contracts entered into between the office and such [program or] VOLUNTARY agency[, upon such terms and conditions as the office shall deem appropriate, except as provided in section 25.07 of this article, provided, however, that, upon issuance of an operating certificate in accordance with article thirty-two of this chapter, if required, the office shall provide financial support for approved chemical dependence services in accordance with article twenty-six of this title.] OR BY DISTRIBUTION OF SUCH STATE AID TO LOCAL GOVERNMENTAL UNITS THROUGH A GRANT PROCESS PURSUANT TO SECTION 25.11 OF THIS ARTICLE.

(b) Financial support by the office shall be subject to the approval of the director of the budget AND WITHIN AVAILABLE APPROPRIATIONS.

(D) NOTHING IN THIS SECTION SHALL BE CONSTRUED TO REQUIRE THE STATE TO INCREASE SUCH STATE AID SHOULD A LOCAL GOVERNMENTAL UNIT CHOOSE TO REMOVE ANY PORTION OF ITS LOCAL TAX LEVY SUPPORT OF VOLUNTARY AGENCIES, ALTHOUGH THE STATE MAY CHOOSE TO DO SO TO ADDRESS AN URGENT PUBLIC NEED, OR CONVERSELY, MAY CHOOSE TO REDUCE ITS STATE AID UP TO THE SAME PERCENTAGE AS THE REDUCTION IN LOCAL TAX LEVY.

S 5. Section 25.05 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.05 Reimbursement from other sources.

The office shall not provide a [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT with financial support for obligations incurred by or on behalf of such program or agency for substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services for which reimbursement is or may be claimed under any provision of law other than this article.

S 6. The section heading and subdivisions (a) and (c) of section 25.06 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, are amended to read as follows:

Disclosures by closely allied entities of [substance abuse programs] A VOLUNTARY AGENCY.

(a) A closely allied entity of a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office shall provide the office with the following information:

1. A schedule of the dates, nature and amounts of all fiscal transactions between the closely allied entity and the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office.

2. A copy of the closely allied entity's certified annual financial statements.

3. With respect to any lease agreement between the closely allied entity, as lessor, and the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office, as lessee, of real or personal property:

(i) A certified statement by an independent outside entity providing a fair market appraisal of the real property space to be rented, as well as of any rental of personal property.

(ii) A statement of projected operating costs of the allied entity relative to any such leased property for the budget period. The closely allied entity must furnish the office with a certified statement of its actual operating costs relative to the leased property.

4. A statement of the funds received by the closely allied entity in connection with its fund raising activities conducted on behalf of the substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING program that is funded or has applied for funding from the office which clearly identifies how such funds were and will be distributed or applied to such program.

5. Any other data or information which the office may deem necessary for purposes of making a funding decision.

(c) For purposes of this section, a "closely allied entity" shall mean, but not be limited to, a corporation, partnership or unincorporated association or other body that has been formed or is organized to provide financial assistance and aid for the benefit of a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office AND which FINANCIAL ASSISTANCE AND AID shall include, but not be limited to, engaging in fund raising activities, administering funds, holding title to real property, having an interest in personal property of any nature whatsoever, and engaging in any other activities for the benefit of any such program. Moreover, an entity shall be deemed closely allied to a [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office to the extent that such entity and applicable fiscal transactions are required to be disclosed within the annual financial statements of the [substance abuse program] VOLUNTARY AGENCY that is funded or has applied for funding from the office, under the category of related party transactions, as defined by and in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards (GAAS), as promulgated by the American institute of certified public accountants (AICPA).

S 7. Section 25.07 of the mental hygiene law, as added by chapter 471 of the laws of 1980, is amended to read as follows:

S 25.07 Non-substitution.

A [substance abuse program] VOLUNTARY AGENCY or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT shall not substitute state monies for cash contributions, federal aid otherwise committed to or intended for use in such program or by such agency, revenues derived from the operation of such program or agency, or the other resources available for use in the operation of the program or agency.

S 8. Section 25.09 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.09 Administrative costs.

Subject to the approval of the director of the budget, the office shall establish a limit on the amount of financial support which may be advanced or reimbursed to a [substance abuse program] VOLUNTARY AGENCY

or a PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT for the administration of a [substance abuse] program.

S 9. Section 25.11 of the mental hygiene law, as added by chapter 471 of the laws of 1980, subdivision (a) as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.11 [Comprehensive plan] DISTRIBUTION OF STATE AID TO A LOCAL GOVERNMENTAL UNIT.

[(a) A local agency intending to seek financial support from the office shall no later than July first of each year submit to the office a comprehensive substance abuse services plan, which shall describe the programs and activities planned for its ensuing fiscal year. Such plan shall indicate to the extent possible, the nature of the services to be provided, whether such services are to be provided directly, through subcontract, or through the utilization of existing public resources, the area or areas to be served, and an estimate of the cost of such services, including amounts to be provided other than by office financial support, specifically identifying the amount of local governmental funds committed to substance abuse programs during its current fiscal year, and a commitment that no less than such an amount will be used from such funds for the operation of such programs during the next fiscal year. Such plan shall make provisions for all needed substance abuse services and for the evaluation of the effectiveness of such services.

(b) When a comprehensive plan includes a local school district based substance abuse program such plan shall include the details of an adequate distribution of in-school and community-wide preventive education services, including, but not limited to, services to be provided by local drug abuse prevention councils, and shall emphasize the use of other volunteer agency services as may be available. The description of the program and activities thereunder shall be separately stated, and the data and information required to be provided shall conform to the provisions of subdivision (a) of this section except that the period to be covered may, notwithstanding the fiscal year of the local agency, conform to the school year.] NOTWITHSTANDING SECTION ONE HUNDRED TWELVE OF THE STATE FINANCE LAW, THE OFFICE IS AUTHORIZED TO GRANT STATE AID ANNUALLY TO LOCAL GOVERNMENTAL UNITS IN THE FOLLOWING MANNER:

(A) LOCAL GOVERNMENTAL UNITS SHALL BE GRANTED STATE AID BY A STATE AID FUNDING AUTHORIZATION LETTER ISSUED BY THE OFFICE FOR APPROVED NET OPERATING COSTS FOR VOLUNTARY AGENCIES TO SUPPORT THE BASE AMOUNT OF STATE AID PROVIDED TO SUCH VOLUNTARY AGENCIES FOR THE PRIOR YEAR PROVIDED THAT THE LOCAL GOVERNMENTAL UNIT HAS APPROVED AND SUBMITTED BUDGETS FOR THE VOLUNTARY AGENCIES TO THE OFFICE. THE VOLUNTARY AGENCY BUDGETS SHALL IDENTIFY THE NATURE OF THE SERVICES TO BE PROVIDED WHICH MUST BE CONSISTENT WITH THE LOCAL SERVICES PLAN SUBMITTED BY THE LOCAL GOVERNMENTAL UNIT PURSUANT TO ARTICLE FORTY-ONE OF THIS CHAPTER, THE AREAS TO BE SERVED AND INCLUDE A DESCRIPTION OF THE VOLUNTARY AGENCY CONTRIBUTIONS AND LOCAL GOVERNMENTAL UNIT FUNDING PROVIDED. THE LOCAL GOVERNMENTAL UNIT SHALL ENTER INTO CONTRACTS WITH THE VOLUNTARY AGENCIES RECEIVING SUCH STATE AID. SUCH CONTRACTS SHALL INCLUDE FUNDING REQUIREMENTS SET BY THE OFFICE INCLUDING BUT NOT LIMITED TO RESPONSIBILITIES OF VOLUNTARY AGENCIES RELATING TO WORK SCOPES, PROGRAM PERFORMANCE AND OPERATIONS, APPLICATION OF PROGRAM INCOME, PROHIBITED USE OF FUNDS, RECORDKEEPING AND AUDIT OBLIGATIONS. UPON DESIGNATION BY THE OFFICE, LOCAL GOVERNMENTAL UNITS SHALL NOTIFY VOLUNTARY AGENCIES AS TO THE SOURCE OF FUNDING RECEIVED BY SUCH VOLUNTARY AGENCIES.

(B) STATE AID MADE AVAILABLE TO A LOCAL GOVERNMENTAL UNIT FOR APPROVED NET OPERATING COSTS FOR A PROGRAM OPERATED BY A VOLUNTARY AGENCY OR A LOCAL GOVERNMENTAL UNIT MAY BE REDUCED WHERE A REVIEW OF SUCH VOLUNTARY AGENCY'S PRIOR YEAR'S BUDGET AND/OR PERFORMANCE INDICATES:

(1) THAT THE PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY HAS FAILED TO MEET MINIMUM PERFORMANCE STANDARDS AND REQUIREMENTS OF THE OFFICE INCLUDING, BUT NOT LIMITED TO, MAINTAINING SERVICE UTILIZATION RATES AND PRODUCTIVITY STANDARDS AS SET BY THE OFFICE PROVIDED HOWEVER, THAT UPON DETERMINATION THAT THE PROGRAM IS NOT MEETING THE MINIMUM STANDARDS AND REQUIREMENTS, THE OFFICE SHALL NOTIFY SUCH PROGRAM OPERATED BY A LOCAL GOVERNMENTAL UNIT OR VOLUNTARY AGENCY OF THEIR DEFICIENCIES, AND IF APPROPRIATE, A CORRECTIVE ACTION PLAN THAT INCLUDES SPECIFIC ACTIONS TO ADDRESS ANY DEFICIENCIES AND A TIMETABLE FOR IMPLEMENTATION SHALL BE DEVELOPED. STATE AID MAY BE REDUCED IF A CORRECTIVE ACTION PLAN IS NOT APPROVED BY THE OFFICE OR IS NOT IMPLEMENTED IN A TIMELY AND SATISFACTORY MANNER;

(2) THAT THE VOLUNTARY AGENCY HAS HAD AN INCREASE IN VOLUNTARY AGENCY CONTRIBUTIONS THAT REDUCES THE APPROVED NET OPERATING COSTS NECESSARY, EXCEPT WHERE THE OFFICE HAS APPROVED AN ALTERNATIVE USE OF SUCH VOLUNTARY AGENCY CONTRIBUTIONS OR SUCH VOLUNTARY AGENCY CONTRIBUTIONS ARE NECESSARY TO ENSURE FINANCIAL VIABILITY.

S 10. Section 25.13 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.13 Office is authorized state agency.

(a) The office when designated by the governor is the agency of the state to administer and/or supervise the state plan or plans concerning substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services specified in the federal drug abuse office and treatment act of nineteen hundred seventy-two and to cooperate with the duly designated federal authorities charged with the administration thereof.

(b) The office and all entities to which it provides financial support shall do all that is required and shall render necessary cooperation to ensure optimum use of federal aid for substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services.

(c) The commissioner is authorized and empowered to take such steps, not inconsistent with law, as may be necessary for the purpose of procuring for the people of this state all of the benefits and assistance, financial and otherwise, provided, or to be provided for, by or pursuant to any act of congress relating to substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services.

S 11. Section 25.15 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.15 Optimizing federal aid.

(a) A PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT or [substance abuse program] VOLUNTARY AGENCY shall, unless a specific written waiver of this requirement is made by the office, cause applications to be completed on such forms and in such manner as directed by the office and submit the same to the office for the purpose of causing a determination to be made whether the cost of the services provided individuals and groups qualify for federal aid which may be available for services provided pursuant to titles IV, XVI, XIX and XX of the federal social security act, or any other federal law. A PROGRAM OPERATED BY A local [agency] GOVERNMENTAL UNIT or a [substance abuse program] VOLUNTARY AGENCY shall furnish to the office such other data as may be required and shall render such cooperation as may be necessary to maximize such potential federal aid. All information concerning the

identity of individuals obtained and provided pursuant to this subdivision shall be kept confidential.

(b) To the extent that federal aid may be available for any substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services, the office, notwithstanding any other inconsistent provision of law, and with the approval of the director of the budget, is hereby authorized to seek such federal aid on behalf of [substance abuse programs] VOLUNTARY AGENCIES and A PROGRAM OPERATED BY A local [agencies] GOVERNMENTAL UNIT either directly or through the submission of claims to another state agency authorized to submit the same to an appropriate federal agency. The office is further authorized to certify for payment to [substance abuse programs] VOLUNTARY AGENCIES and A PROGRAM OPERATED BY A local [agencies] GOVERNMENTAL UNIT any federal aid received by the state which is attributable to the activities financed by such programs and agencies.

S 12. Section 25.17 of the mental hygiene law, as amended by chapter 223 of the laws of 1992, is amended to read as follows:

S 25.17 Fees for services.

[Local agencies GOVERNMENTS and substance abuse treatment programs] VOLUNTARY AGENCIES AND PROGRAMS OPERATED BY LOCAL GOVERNMENTAL UNITS funded in whole or in part by the office shall establish, subject to the approval of the office, fee schedules for substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services, not specifically covered by the rates established pursuant to article twenty-eight of the public health law or title two of article five of the social services law. Such fees shall be charged for substance [abuse] USE DISORDER AND/OR COMPULSIVE GAMBLING services furnished to persons who are financially able to pay the same, provided, that such services shall not be refused to any person because of his inability to pay therefor.

S 13. Subdivision (d) of section 41.18 of the mental hygiene law, as amended by chapter 558 of the laws of 1999, is amended to read as follows:

(d) The liability of the state in any state fiscal year for state aid pursuant to this section shall exclude chemical dependence services, which are subject to article [twenty-six] TWENTY-FIVE of this chapter, and shall be limited to the amounts appropriated for such state aid by the legislature for such state fiscal year.

S 14. This act shall take effect April 1, 2013; provided, however, that effective immediately, any rule or regulation necessary for the implementation of this act on its effective date is authorized and directed to be made and completed on or before such effective date.

PART H

Section 1. Subdivision (b) of section 7.17 of the mental hygiene law, as amended by section 1 of part O of chapter 56 of the laws of 2012, is amended to read as follows:

(b) There shall be in the office the hospitals named below for the care, treatment and rehabilitation of persons with mental illness and for research and teaching in the science and skills required for the care, treatment and rehabilitation of such persons with mental illness.

Greater Binghamton Health Center
Bronx Psychiatric Center
Buffalo Psychiatric Center
Capital District Psychiatric Center
Central New York Psychiatric Center

Creedmoor Psychiatric Center
Elmira Psychiatric Center
Kingsboro Psychiatric Center
Kirby Forensic Psychiatric Center
Manhattan Psychiatric Center
Mid-Hudson Forensic Psychiatric Center
Mohawk Valley Psychiatric Center
Nathan S. Kline Institute for Psychiatric Research
New York State Psychiatric Institute
Pilgrim Psychiatric Center
Richard H. Hutchings Psychiatric Center
Rochester Psychiatric Center
Rockland Psychiatric Center
St. Lawrence Psychiatric Center
South Beach Psychiatric Center
New York City Children's Center
Rockland Children's Psychiatric Center
Sagamore Children's Psychiatric Center
Western New York Children's Psychiatric Center

The New York State Psychiatric Institute and The Nathan S. Kline Institute for Psychiatric Research are designated as institutes for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of mental illness. [Whenever the term Bronx Children's Psychiatric Center, Brooklyn Children's Psychiatric Center and Queens Children's Psychiatric Center is referred to or designated in any regulation, contract or document pertaining to the functions, powers, obligations and duties hereby transferred and assigned, such reference or designation shall be deemed to refer to the New York City Children's Center.]

S 2. Section 4 of part O of chapter 56 of the laws of 2012, amending the mental hygiene law relating to the closure and the reduction in size of certain facilities serving persons with mental illness, is amended and a new section 1-a is added to read as follows:

S 1-A. WHENEVER THE TERM BRONX CHILDREN'S PSYCHIATRIC CENTER, BROOKLYN CHILDREN'S PSYCHIATRIC CENTER OR QUEENS CHILDREN'S PSYCHIATRIC CENTER IS REFERRED TO OR DESIGNATED IN ANY REGULATION, CONTRACT OR DOCUMENT PERTAINING TO THE FUNCTIONS, POWERS, OBLIGATIONS AND DUTIES HEREBY TRANSFERRED AND ASSIGNED PURSUANT TO THIS ACT, SUCH REFERENCE OR DESIGNATION SHALL BE DEEMED TO REFER TO THE NEW YORK CITY CHILDREN'S CENTER.

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, 2012; provided that the date for any closure or consolidation pursuant to this act shall be on a date certified by the commissioner of mental health; and provided further, however, that SECTION TWO OF this act shall expire and be deemed repealed March 31, 2013.

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 2 of part C of chapter 111 of the laws of 2010, is amended to read as follows:

S 7. This act shall take effect immediately and shall expire March 31, [2013] 2015 when upon such date the provisions of this act shall be deemed repealed.

S 4. 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 5. This act shall take effect April 1, 2013; provided, however that if this act shall become a law after April 1, 2013, this act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013.

PART I

Section 1. Section 1 of part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs as amended by section 1 of part R of chapter 56 of the laws of 2012, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [2013] 2014; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [2013] 2014.

S 2. This act shall take effect immediately.

PART J

Section 1. Subdivision (a) of section 7.19 of the mental hygiene law, as amended by chapter 307 of the laws of 1979, is amended to read as follows:

(a) The commissioner OR HIS OR HER DESIGNEE may, within the amounts appropriated therefor, appoint and remove in accordance with law and applicable rules of the state civil service commission, such officers and employees of the office of mental health [and facility officers and employees who are designated managerial or confidential pursuant to article fourteen of the civil service law] as are necessary for efficient administration AND SHALL ADMINISTER THE OFFICE'S PERSONNEL SYSTEM IN ACCORDANCE WITH SUCH LAW AND RULES. IN EXERCISING THE APPOINTING AUTHORITY, THE COMMISSIONER SHALL TAKE ALL REASONABLE AND NECESSARY STEPS, CONSISTENT WITH ARTICLE TWENTY-THREE-A OF THE CORRECTION LAW, TO ENSURE THAT ANY SUCH PERSON SO APPOINTED HAS NOT PREVIOUSLY ENGAGED IN

ANY ACT IN VIOLATION OF ANY LAW WHICH COULD COMPROMISE THE HEALTH AND SAFETY OF PATIENTS.

S 2. Subdivision (a) of section 7.21 of the mental hygiene law, as amended by chapter 434 of the laws of 1980, is amended to read as follows:

(a) The director of a facility under the jurisdiction of the office of mental health shall be its chief executive officer. Each such director shall be in the noncompetitive class and designated as confidential as defined by subdivision two-a of section forty-two of the civil service law and shall be appointed by and serve at the pleasure of the commissioner. [Except for facility officers and employees for which subdivision (a) of section 7.19 of this article makes the commissioner the appointing and removing authority, the director of a facility shall have the power, within amounts appropriated therefor, to appoint and remove in accordance with law and applicable rules of the state civil service commission such officers and employees of the facility of which he is director as are necessary for its efficient administration. He shall in exercising this appointing authority take, consistent with article twenty-three-A of the correction law, all reasonable and necessary steps to insure that any such person so appointed has not previously engaged in any act in violation of any law which could compromise the health and safety of patients in the facility of which he is director.] He OR SHE shall manage the facility [and administer its personnel system] subject to applicable law and the regulations of the commissioner of mental health [and the rules of the state civil service commission]. Before the commissioner shall issue any such regulation or any amendment or revision thereof, he OR SHE shall consult with the FACILITY directors [of the office's hospitals] regarding its suitability. The director shall maintain effective supervision of all parts of the facility and over all persons employed therein or coming thereon and shall generally direct the care and treatment of patients. Directors presently serving at office of mental health facilities shall continue to serve under the terms of their original appointment.

S 3. The amendments to sections 7.19 and 7.21 of the mental hygiene law pursuant to Part J of a chapter of the laws of two thousand thirteen shall not authorize the commissioner of mental health to make any decisions with respect to employees in contradiction of the civil service law and regulations, and applicable collective bargaining agreements, nor otherwise alter any geographically discrete layoff unit structures.

S 4. This act shall take effect April 1, 2013.

PART K

Intentionally omitted

PART L

Section 1. The mental hygiene law is amended by adding a new section 31.37 to read as follows:

S 31.37 MENTAL HEALTH INCIDENT REVIEW PANELS.

(A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH, ON HIS OR HER OWN ACCORD OR PURSUANT TO A REQUEST BY A LOCAL GOVERNMENTAL UNIT, A MENTAL HEALTH INCIDENT REVIEW PANEL FOR THE PURPOSES OF REVIEWING IN CONJUNCTION WITH LOCAL REPRESENTATION, THE CIRCUMSTANCES AND EVENTS RELATED TO A SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL ILLNESS. FOR PURPOSES OF THIS SECTION, A "SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL

ILLNESS" MEANS AN INCIDENT OCCURRING IN THE COMMUNITY IN WHICH A PERSON WITH A SERIOUS MENTAL ILLNESS SUFFERS PHYSICAL INJURY AS DEFINED IN SUBDIVISION NINE OF SECTION 10.00 OF THE PENAL LAW OR CAUSES SUCH PHYSICAL INJURY TO ANOTHER PERSON, OR SUFFERS A SERIOUS AND PREVENTABLE MEDICAL COMPLICATION OR BECOMES INVOLVED IN A CRIMINAL INCIDENT INVOLVING VIOLENCE. A PANEL SHALL BE AUTHORIZED TO CONDUCT A REVIEW OF SUCH SERIOUS INCIDENT IN AN ATTEMPT TO IDENTIFY PROBLEMS OR GAPS IN MENTAL HEALTH DELIVERY SYSTEMS AND TO MAKE RECOMMENDATIONS FOR CORRECTIVE ACTIONS TO IMPROVE THE PROVISION OF MENTAL HEALTH OR RELATED SERVICES, TO IMPROVE THE COORDINATION, INTEGRATION AND ACCOUNTABILITY OF CARE IN THE MENTAL HEALTH SERVICE SYSTEM, AND TO ENHANCE INDIVIDUAL AND PUBLIC SAFETY.

(B) A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL INCLUDE REPRESENTATIVES FROM THE OFFICE OF MENTAL HEALTH AND THE CHIEF EXECUTIVE OFFICER OR DESIGNEE OF THE LOCAL GOVERNMENTAL UNIT WHERE THE SERIOUS INCIDENT INVOLVING A PERSON WITH A MENTAL ILLNESS OCCURRED. A MENTAL HEALTH INCIDENT REVIEW PANEL MAY ALSO INCLUDE, IF DEEMED APPROPRIATE BY THE COMMISSIONER BASED ON THE NATURE OF THE SERIOUS INCIDENT BEING REVIEWED, ONE OR MORE REPRESENTATIVES FROM MENTAL HEALTH PROVIDERS, LOCAL DEPARTMENTS OF SOCIAL SERVICES, HUMAN SERVICES PROGRAMS, HOSPITALS, LOCAL SCHOOLS, EMERGENCY MEDICAL OR MENTAL HEALTH SERVICES, THE OFFICE OF THE COUNTY ATTORNEY, STATE OR LOCAL POLICE AGENCIES, THE OFFICE OF THE MEDICAL EXAMINER OR THE OFFICE OF THE CORONER, THE JUDICIARY, OR OTHER APPROPRIATE STATE OR LOCAL OFFICIALS; PROVIDED, HOWEVER, THAT A LOCAL LAW ENFORCEMENT OFFICIAL MAY NOT SERVE AS A MEMBER OF SUCH A REVIEW PANEL IF HIS OR HER OFFICE OR AGENCY IS DIRECTLY INVOLVED IN ANY ONGOING INVESTIGATION OR PROSECUTION OF A CRIME UNDER REVIEW BY THE PANEL, OR ANY APPEAL OF A CRIMINAL CONVICTION FOR SUCH CRIME.

(C) (I) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY AND TO THE EXTENT CONSISTENT WITH FEDERAL LAW, A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL HAVE ACCESS TO THOSE RELEVANT CLIENT-IDENTIFIABLE MENTAL HEALTH RECORDS, AS WELL AS ALL RECORDS, DOCUMENTATION AND REPORTS RELATING TO THE INVESTIGATION OF AN INCIDENT BY THE JUSTICE CENTER, PURSUANT TO ARTICLE TWENTY OF THE EXECUTIVE LAW AND AN INCIDENT BY A FACILITY IN ACCORDANCE WITH REGULATIONS OF THE COMMISSIONER, WHICH ARE NECESSARY FOR THE INVESTIGATION OF THE SERIOUS INCIDENT INVOLVING A PERSON WITH MENTAL ILLNESS AND THE PREPARATION OF A REPORT OF SUCH INCIDENT, AS PROVIDED IN SUBDIVISION (E) OF THIS SECTION. A MENTAL HEALTH INCIDENT REVIEW PANEL INVESTIGATING A SERIOUS INCIDENT INVOLVING A PERSON WITH A MENTAL ILLNESS PURSUANT TO THIS SECTION SHALL BE PROVIDED WITH ACCESS TO ALL RELEVANT, NON-PRIVILEGED RECORDS IN THE POSSESSION OF STATE OR LOCAL OFFICIALS OR AGENCIES, WITHIN TWENTY-ONE DAYS OF RECEIPT OF A REQUEST, EXCEPT: (A) THOSE RECORDS PROTECTED BY SECTION 190.25 OF THE CRIMINAL PROCEDURE LAW; (B) WHERE PROVIDING LAW ENFORCEMENT RECORDS WOULD INTERFERE WITH AN ONGOING LAW ENFORCEMENT INVESTIGATION OR JUDICIAL PROCEEDING, IDENTIFY A CONFIDENTIAL SOURCE OR DISCLOSE CONFIDENTIAL INFORMATION RELATING TO AN ONGOING CRIMINAL INVESTIGATION, HIGHLY SENSITIVE CRIMINAL INVESTIGATIVE TECHNIQUES OR PROCEDURES, OR ENDANGER THE SAFETY OR WELFARE OF AN INDIVIDUAL; (C) WITH RESPECT TO ANY SUCH RECORD THAT IS PRIVILEGED, WHERE THE PRIVILEGE IS HELD BY THE OFFICIAL OR AGENCY AND NO SEPARATE PRIVILEGE HELD BY AN INDIVIDUAL APPLIES, SUCH OFFICIAL OR AGENCY SHALL BE AUTHORIZED TO WAIVE SUCH OFFICIAL'S OR AGENCY'S PRIVILEGE, AS APPLICABLE, AND PROVIDE SUCH RECORD; AND (D) WHENEVER AN AGENCY, DIRECTOR OR UNIT BELIEVES PURSUANT TO SUBPARAGRAPH (B) OF THIS PARAGRAPH THAT RELEASE OF RECORDS WOULD INTERFERE WITH A JUDICIAL PROCEEDING, IT SHALL IDENTIFY THAT PROCEEDING, AND THE MENTAL HEALTH

INCIDENT REVIEW PANEL SHALL BE AUTHORIZED, UPON NOTICE TO SUCH AGENCY, DIRECTOR OR UNIT, TO REQUEST IN WRITING TO THE JUDGE BEFORE WHOM SUCH JUDICIAL PROCEEDING IS PENDING, THAT SUCH JUDGE DETERMINE WHETHER ACCESS TO SUCH RECORDS SHOULD BE DENIED ON THE GROUND THAT RELEASE OF SUCH RECORDS WOULD INTERFERE WITH THE PENDING PROCEEDING. UPON RECEIPT OF SUCH A REQUEST, THE JUDGE SHALL OFFER THE AGENCY, DIRECTOR OR UNIT AND THE PANEL A REASONABLE OPPORTUNITY TO BE HEARD, AND MAY REVIEW THE DISPUTED RECORDS IN CAMERA. THE JUDGE SHALL SUBMIT ITS DETERMINATION TO THE AGENCY, DIRECTOR OR UNIT AND THE MENTAL HEALTH INCIDENT REVIEW PANEL, AND THE AGENCY, DIRECTOR OR UNIT SHALL THEN PROCEED IN ACCORDANCE WITH THE JUDGE'S DETERMINATION.

(II) IN ANY CASE IN WHICH ACCESS TO RECORDS IS DENIED PURSUANT TO THIS SUBDIVISION, THE APPROPRIATE AGENCY SHALL INFORM THE PANEL IN WRITING OF THE REASONING FOR SUCH DENIAL.

(D) MENTAL HEALTH INCIDENT REVIEW PANELS AND MEMBERS OF THE REVIEW PANELS SHALL HAVE IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR ALL REASONABLE AND GOOD FAITH ACTIONS TAKEN PURSUANT TO THIS SECTION, AND SHALL NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING ANY DISCUSSIONS, DELIBERATIONS OR FINDINGS RELATING TO THE OFFICIAL DUTIES OF SUCH REVIEW PANEL. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PREVENT A PERSON FROM TESTIFYING AS TO INFORMATION OBTAINED INDEPENDENTLY OF A MENTAL HEALTH INCIDENT REVIEW PANEL, OR INFORMATION WHICH IS PUBLIC.

(D-1) PERSONS WHO PRESENT INFORMATION TO THE PANEL SHALL HAVE IMMUNITY FROM CIVIL AND CRIMINAL LIABILITY FOR ALL REASONABLE AND GOOD FAITH ACTIONS TAKEN PURSUANT TO THIS SECTION, AND SHALL NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING THEIR AUTHORIZED PARTICIPATION AT A MEETING OF THE PANEL. NEITHER INFORMATION NOR RECORDS RELATING TO THE PERFORMANCE OF A REVIEW PANEL FUNCTION, NOR A PERSON'S PARTICIPATION IN A REVIEW PANEL SHALL BE SUBJECT TO DISCLOSURE PURSUANT TO ARTICLE THIRTY-ONE OF THE CIVIL PRACTICE LAW AND RULES. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PREVENT THE DISCLOSURE OF, OR TESTIMONY REGARDING, INFORMATION THAT EXISTS OR IS OBTAINED INDEPENDENTLY OF THE PANEL OR INFORMATION THAT IS PUBLIC.

(E) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, ALL MEETINGS CONDUCTED, ALL REPORTS AND RECORDS MADE AND MAINTAINED AND ALL BOOKS AND PAPERS OBTAINED BY A MENTAL HEALTH INCIDENT REVIEW PANEL SHALL BE CONFIDENTIAL, AND SHALL NOT BE OPEN OR MADE AVAILABLE, EXCEPT BY COURT ORDER FOR GOOD CAUSE SHOWN OR AS SET FORTH IN SUBDIVISION (G) OF THIS SECTION. EACH MENTAL HEALTH INCIDENT REVIEW PANEL SHALL DEVELOP A REPORT OF THE INCIDENT INVESTIGATED. SUCH REPORT SHALL NOT CONTAIN ANY INDIVIDUALLY IDENTIFIABLE INFORMATION AND SHALL BE PROVIDED TO THE OFFICE OF MENTAL HEALTH UPON COMPLETION. RECORDS, REPORTS, INFORMATION REGARDING TESTIMONY AND OTHER INFORMATION GATHERED BY THE PANEL SHALL NOT BE FURTHER DISSEMINATED BY A PANEL MEMBER.

(F) IF QUALITY PROBLEMS OF PARTICULAR MENTAL HEALTH PROGRAMS ARE IDENTIFIED BASED ON SUCH REVIEWS, THE COMMISSIONER IS AUTHORIZED, PURSUANT TO THE RELEVANT PROVISIONS OF THIS CHAPTER, TO TAKE APPROPRIATE ACTIONS REGARDING THE LICENSURE OF PARTICULAR PROVIDERS, TO REFER THE ISSUE TO OTHER RESPONSIBLE PARTIES FOR INVESTIGATION, OR TO TAKE OTHER APPROPRIATE ACTION WITHIN THE SCOPE OF HIS OR HER AUTHORITY.

(G) IN HIS OR HER DISCRETION, THE COMMISSIONER SHALL BE AUTHORIZED TO PROVIDE THE FINAL REPORT OF A REVIEW PANEL OR PORTIONS THEREOF TO ANY INDIVIDUAL OR ENTITY FOR WHOM THE REPORT MAKES RECOMMENDATIONS FOR CORRECTIVE OR OTHER APPROPRIATE ACTIONS THAT SHOULD BE TAKEN. ANY FINAL REPORT OR PORTION THEREOF SHALL NOT BE FURTHER DISSEMINATED BY THE INDI-

VIDUAL OR ENTITY RECEIVING SUCH REPORT. FURTHER, THE COMMISSIONER SHALL SUBMIT THE FINAL REPORT OF A REVIEW PANEL TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY, CONSISTENT WITH FEDERAL AND STATE CONFIDENTIALITY PROTECTIONS.

(H) THE COMMISSIONER SHALL SUBMIT AN ANNUAL CUMULATIVE REPORT TO THE GOVERNOR AND THE LEGISLATURE INCORPORATING THE DATA IN THE MENTAL HEALTH INCIDENT REVIEW PANEL REPORTS AND INCLUDING A SUMMARY OF THE FINDINGS AND RECOMMENDATIONS MADE BY SUCH REVIEW PANELS AND, TO THE EXTENT PRACTICABLE, ANY RECOMMENDATIONS THAT HAVE BEEN IMPLEMENTED, INCLUDING RECOMMENDATIONS FROM PRIOR YEAR REPORTS, AND THE IMPACT OF SUCH IMPLEMENTATIONS. THE ANNUAL CUMULATIVE REPORTS SHALL THEREAFTER BE MADE AVAILABLE TO THE PUBLIC CONSISTENT WITH FEDERAL AND STATE CONFIDENTIALITY PROTECTIONS.

S 2. Subdivision (c) of section 33.13 of the mental hygiene law is amended by adding a new paragraph 16 to read as follows:

16. TO A MENTAL HEALTH INCIDENT REVIEW PANEL, OR MEMBERS THEREOF, ESTABLISHED BY THE COMMISSIONER PURSUANT TO SECTION 31.37 OF THIS TITLE, IN CONNECTION WITH INCIDENT REVIEWS CONDUCTED BY SUCH PANEL.

S 3. This act shall take effect on the sixtieth day after it shall have become a law.

PART M

Section 1. Section 20 of chapter 723 of the laws of 1989, amending the mental hygiene law and other laws relating to the establishment of comprehensive psychiatric emergency programs, is REPEALED.

S 2. Subdivision (c) of section 7.15 of the mental hygiene law is REPEALED.

S 3. Subdivision (c) of section 13.15 of the mental hygiene law is REPEALED.

S 4. Paragraph 3 of subdivision (d) of section 16.19 of the mental hygiene law is REPEALED.

S 5. Subparagraph e of paragraph 2 of subdivision (b) of section 5.07 of the mental hygiene law, as added by chapter 322 of the laws of 1992, is amended to read as follows:

e. a description of the available community-based acute inpatient, out-patient, [emergency, and community support] COMMUNITY SUPPORT AND EMERGENCY services, WHICH SHALL INCLUDE COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAMS LICENSED PURSUANT TO SECTION 31.27 OF THIS CHAPTER. Such description should include the extent to which these services are currently utilized by persons with mental illness and, as available, compare estimates of utilization with estimates of the prevalence of mental illness among persons residing in the service area to determine unmet need;

S 6. This act shall take effect April 1, 2013.

PART N

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 H of chapter 56 of the laws of 2012, is amended to read as follows:

3-b. Notwithstanding any inconsistent provision of law, beginning April 1, 2009 and ending March 31, [2013] 2014, 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, [2013] 2014 and ending March 31, [2016] 2017, 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, [2016] 2017; provided, further, that sections two and three of this act shall expire and be deemed repealed December 31, 2009.

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, 2013; provided, however, that the amendments to section 1 of part C of chapter 57 of the laws of 2006 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

PART O

Section 1. Legislative findings and purpose. Recent actions by the United States Center for Medicare and Medicaid Services impact the stability of New York state's mental hygiene system. While the state must embark on a deliberate path to replace the existing, long-standing financing system for developmental disability services, replacement of the sudden loss of $1.1 billion in federal revenue is too significant to be solved solely by actions within the mental hygiene system. A partnership with the entire health care community is needed to manage this loss over time. Accordingly, this part authorizes the actions necessary and creates the Mental Hygiene Stabilization Fund that will be supported by department of health medicaid resources under the Global Cap in annual amounts not to exceed $730,000,000 in state fiscal year 2013-14, $445,000,000 in 2014-15, $267,000,000 in 2015-16, and $267,000,000 in 2016-17.

S 2. Notwithstanding any contrary provision of law, the commissioner of health may, in consultation with the director of the budget, annul implementation of the reimbursement reductions authorized by section one of part A of this act with regard to any period between April 1, 2013 and March 31, 2015 if it is determined by the commissioner of health, in consultation with the director of the budget, that such annulment may be accomplished consistent with the implementation of the provisions of section 92 of part H of chapter 59 of the laws of 2011, as amended.

S 3. Notwithstanding any contrary provision of law, implementation of the provisions of sections twenty-two, twenty-three, and/or twenty-four of part A of this act shall be delayed to the state fiscal year beginning April 1, 2014, provided, however, that the commissioner of health may, in consultation with the director of the budget, implement one or more of such provisions during the 2013-14 state fiscal year if it is determined that such implementation may be accomplished consistent with the implementation of the provisions of section 92 of part H of chapter 59 of the laws of 2011, as amended.

S 4. 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 5. 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, as amended, 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 6. 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 7. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2013.

PART P

Section 1. Notwithstanding any other provision of law, for state fiscal year 2013-14, and for each state fiscal year thereafter, up to five million dollars shall be available annually to provide medical assistance for individuals who reside in New York state and are retirees of the New York city off-track betting corporation or were active employees of such corporation with vested pension time or credit as of December 7, 2010, and for the dependents of such individuals, in accordance with the provisions of this section. Such individuals who are Medicare beneficiaries under title XVIII of the federal social security act shall be eligible for assistance under title 11 of article 5 of the social services law with the cost of Medicare premiums and/or cost sharing obligations, as determined in accordance with guidelines established by the commissioner of health. For the period from April 1, 2013 to December 31, 2013, such individuals who are not Medicare beneficiaries under title XVIII of the federal social security act shall be eligible for standard fee-for-service coverage under title 11 of article 5 of the social services law, as determined in accordance with guidelines established by the commissioner of health. Prior to October 1, 2013, the state enrollment center shall provide a written notice of program discontinuance that will become effective as of December 31, 2013, to each individual eligible by a Medicaid fee-for-service plan established pursuant to this section. The notice shall be in such form and contain such information as the commissioner of health may require. In addition to any other information required by such commissioner, the written notice shall include a conspicuous explanation, in plain language, informing such individual of available health insurance options, including coverage through the health benefit exchange established pursuant to section 1311 of the federal affordable care act, (42 USC S 18031) and information on the process by which application therefore may be made through the state enrollment center in order to effectuate health coverage under the health benefit exchange for such individuals beginning on

January 1, 2014. Such commissioner shall direct the state enrollment center to facilitate the enrollment of such individuals into the health benefit exchange established in accordance with the requirements of the federal patient protection and affordable care act (P.L. 111-148), as amended by the federal health care and education act of 2010 (P.L. 111-152). Upon notice to participating individuals, the size and scope of program benefits in a given fiscal year may be reduced by the commissioner of health to remain within program funding levels.

S 2. This act shall take effect immediately.

PART Q

Section 1. Legislative findings. The legislature hereby finds and declares that it is necessary to restructure University Hospital of Brooklyn ("Downstate Hospital") in order to achieve its continued fiscal viability.

S 2. On or before June 1, 2013, the chancellor of the state university of New York shall submit to the governor, the chair of the assembly ways and means committee, the chair of the senate finance committee, the chair of the senate health committee, the chair of the assembly health committee, the chair of the senate higher education committee and the chair of the assembly higher education committee, a sustainability plan achieving the fiscal viability of Downstate Hospital.

S 3. Such sustainability plan shall be subject to the approval of the commissioner of health and the director of the division of the budget and shall set forth recommendations for accomplishing the restructuring of Downstate Hospital for the purpose of achieving fiscal viability while preserving its status as a teaching hospital. Such sustainability plan shall include the elimination and/or reduction of acute, ambulatory and support services that are not necessary or financially sustainable and any additional measures necessary to achieve such restructuring and achieve financial stability.

S 4. In the development of the sustainability plan, the chancellor shall consult with labor representatives, community representatives, and other regional stakeholders. The chancellor shall, to the maximum extent practicable, allow for public comment and input from consumers of health care services in the development of the plan.

S 5. Notwithstanding any contrary provision of law, the approved sustainability plan for Downstate Hospital shall be deemed final and the chancellor shall initiate implementation of such sustainability plan by June 15, 2013.

S 6. Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, section 355 of the education law, or section 142 of the economic development law, or any other law, in academic fiscal year 2013-14 the chancellor, for the purpose of implementing a sustainability plan for Downstate Hospital is hereby authorized to enter into a contract or contracts under this section without a competitive bid or request for proposal process and provided further that such contract or contracts shall not be subject to the requirements set forth in subdivisions 2 and 3 of section 112 of the state finance law, provided, however, that:

(a) (i) such contracts are limited to the purchase of goods and supplies where exigencies require an expedited process, and may also be authorized for restructuring consultant services, revenue collection and billing services, electronic and medical health records, and insurance eligibility and verification services; and (ii) due to the unique

circumstances facing Downstate Hospital, such contracts may also include clinical services pursuant to the sustainability plan, provided, however, that such contracts shall not be of such scope or nature as to alter the character of Downstate Hospital as a public hospital, and shall be limited to fifteen percent of clinical services unless the commissioner of health determines that additional actions are necessary for the full implementation of the sustainability plan, in which case, up to twenty percent of such clinical services may be authorized; and

(b) Downstate Hospital shall post on its website, for a period of no less than fifteen days:

(i) a description of the proposed goods or services to be provided pursuant to the contract or contracts;

(ii) the criteria for contractor selection;

(iii) the period of time during which a prospective contractor may seek selection, which shall be no less than fifteen 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; and

(c) all reasonable and responsive submissions that are received from prospective contractors in a timely fashion shall be reviewed by the chancellor or his or her designee.

S 7. Paragraph a of subdivision 16 of section 355 of the education law, as added by chapter 363 of the laws of 1998, is amended to read as follows:

a. Notwithstanding section one hundred sixty-three of the state finance law, authorize contracts for a state university health care facility for participation in managed care networks and other joint and cooperative arrangements with public, non-profit or business entities including entering into a maximum of twenty network arrangements per year, as partners, JOINT VENTURES, SOLE MEMBER OR members of non-profit OR FOR-PROFIT corporations, SOLE MEMBER OR MEMBERS OF NON-PROFIT OR FOR-PROFIT LIMITED LIABILITY COMPANIES, AS LESSOR OR LESSEE, AS PARTICIPANTS IN JOINT OPERATING AGREEMENTS, and shareholders of business corporations, and the provision of management and administrative services by or for state university; PROVIDED, HOWEVER, THAT ANY SUCH CONTRACTS WITH FOR-PROFIT ENTITIES SHALL BE AUTHORIZED ONLY UPON APPROVAL BY THE COMMISSIONER OF HEALTH AND THE DIRECTOR OF THE DIVISION OF THE BUDGET OF A REQUEST BY THE CHANCELLOR DEMONSTRATING FINANCIAL NEED OF A STATE UNIVERSITY HEALTH CARE FACILITY. Any contract for the provision of management services shall be subject to any provision of the public health law and health regulations applicable to the state university as a health care provider, including any review by the commissioner of health pursuant to 10 NYCRR section 405.3(f). In addition, the commissioner of health shall provide for public comment within thirty days of a submission of any management contract required to be reviewed pursuant to regulation. The trustees may also authorize contracts, including capitation contracts, for a state university health care facility for the provision of general comprehensive and specialty health care services, directly or through contract with other service providers or entities, including state university employees or entities comprised thereof. Contracts authorized hereunder shall be:

(1) consistent with trustee guidelines respecting all terms and conditions necessary and appropriate for managed care and other network, joint or cooperative arrangements, including guidelines for comparative review where appropriate;

(2) subject to laws and regulations applicable to the state university as a health care provider, including with respect to rates and certificates of need; and

(3) subject to article fourteen of the civil service law and the applicable provisions of agreements between the state and employee organizations pursuant to article fourteen of the civil service law.

S 8. Subdivision 8-a of section 355 of the education law, as added by chapter 363 of the laws of 1998, is amended to read as follows:

8-a. All monies received by state university health care facilities from fees, charges, and reimbursement and from all other sources shall be credited to a state university health care account in a fund to be designated by the state comptroller. NOTWITHSTANDING THE PROVISION OF ANY LAW, RULE OR REGULATION TO THE CONTRARY, A PORTION OF SUCH MONIES CREDITED MAY BE TRANSFERRED TO A STATE UNIVERSITY ACCOUNT AS REQUESTED BY THE STATE UNIVERSITY CHANCELLOR OR HIS OR HER DESIGNEE. Monies to establish reserves for long-term expenses of state university health care facilities and to fulfill obligations required for any contract for health care services authorized pursuant to subdivision sixteen of this section may be designated by the state university as a reserve and transferred to a separate contractual reserve account. The amounts in such accounts shall be available for use in accordance with paragraph b of subdivision four and subdivision eight of this section. Monies shall only be expended from the state university health care account and the contractual reserve account pursuant to appropriation. Notwithstanding any provision of this chapter, the state finance law or any other law to the contrary, such appropriations shall remain in full force and effect for two years from the effective date of the appropriation act making the appropriation. Monies so transferred may be returned to the state university health care account; provided, however, that funds in such contractual reserve account must be sufficient to meet the obligations of all such contracts.

S 9. Section 2807 of the public health law is amended by adding a new subdivision 20 to read as follows:

20. 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") 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.

S 10. Section 2807 of the public health law is amended by adding a new subdivision 21 to read as follows:

21. 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.

S 11. This act shall take effect immediately.

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

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