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

S. 6407--C A. 9007--C

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

January 14, 2016

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

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

AN ACT intentionally omitted (Part A); to amend the social services law, in relation to facilitating supplemental rebates for fee-for-service pharmaceuticals, and ambulance medical transportation rate adequacy review; to amend the social services law, in relation to authorizing the commissioner of health to apply federally established consumer price index penalties for generic drugs, and authorizing the commissioner of health to impose penalties on managed care plans for reporting late or incorrect encounter data; relating to cost-sharing limits on Medicare part C; to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to reporting requirements for the Medicaid global cap; to amend the public health law and the social services law, in relation to the provision of services to certain persons suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services; to amend the public health law, in relation to rates of payment for certain managed long term care plans; to amend the social services law, in relation to medical assistance for certain inmates and authorizing funding for criminal justice pilot program within health home rates; to amend part H of chapter 59 of the laws of

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

LBD12671-05-6

2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, in relation to extending the expiration of certain provisions relating to rates of payment to residential health care facilities based on the historical costs to the owner, and certain payments to the Citadel Rehab and Nursing Center at Kingsbridge; to amend the public health law, in relation to case payment rates for pediatric ventilator services; directs the commissioner of health to implement a restorative care unit demonstration program; directs the civil service department to create a title for a medicaid redesign team analyst as a competitive class position; to amend the social services law and part C of chapter 60 of the laws of 2014 authorizing the commissioner of health to negotiate an extension of the terms of the contract executed by the department of health for actuarial and consulting services, in relation to the extension of certain contracts; to amend part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures; to amend 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 rate protections for certain behavioral health providers; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to apportioning premium for certain policies; and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool (Part C); 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 extending the authority of the department of health to make disproportionate share payments to public hospitals outside of New York City; to amend chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, in relation to the effectiveness thereof; to amend chapter 58 of the laws of 2009, amending the public health law relating to payment by governmental agencies for general hospital inpatient services, relating to the effectiveness thereof; to amend the public health law, in relation to temporary operator notification; to amend chapter 56 of the laws of 2013, amending the public health law relating to the general public health work program, relating to the effectiveness thereof; to amend the environmental conservation law, in relation to cancer incidence and environmental facility maps project; to amend the public health law, in relation to cancer mapping; to amend chapter 77 of the laws of 2010, amending the environmental conservation law and the public health law relating to an environmental facility and cancer incidence map, relating to the effectiveness thereof; to amend chapter 60 of the laws of 2014 amending the social services law relating to eliminating prescriber prevails for brand name drugs with generic equivalents, in relation to the effectiveness thereof; and to repeal subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public

health law and other laws relating to general hospital reimbursement for annual rates, relating thereto (Part D); intentionally omitted (Part E); relating to grants and loans authorized pursuant to eligible health care capital programs; and to amend the public health law, in relation to the health care facility transformation program (Part F); intentionally omitted (Part G); to amend 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, in relation to the effectiveness thereof (Part H); to amend chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, in relation to the effectiveness of certain provisions thereof (Part I); to amend chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, in relation to extending the expiration of certain provisions thereof; to amend chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, in relation to extending the expiration of certain provisions; and to amend chapter 130 of the laws of 2010 amending the education law and other laws relating to registration of entities providing certain professional services and licensure of certain professions, in relation to extending certain provisions thereof (Part J); intentionally omitted (Part K); to amend the mental hygiene law, in relation to the appointment of temporary operators for the continued operation of programs and the provision of services for persons with serious mental illness and/or developmental disabilities and/or chemical dependence; and providing for the repeal of certain provisions upon expiration thereof (Part L); to amend the mental hygiene law, in relation to sharing clinical records with managed care organizations (Part M); to amend the facilities development corporation act, in relation to the definition of mental hygiene facility (Part N); relating to reports by the office for people with developmental disabilities relating to housing needs; and providing for the repeal of such provisions upon expiration thereof (Part O); to amend the mental hygiene law, in relation to services for people with developmental disabilities (Part P); to amend the mental hygiene law, in relation to the closure or transfer of a state-operated individualized residential alternative; and providing for the repeal of such provisions upon expiration thereof (Part Q); to amend the public health law and the education law, in relation to electronic prescriptions; to amend the public health law, in relation to loan forgiveness and practice support for physicians; to amend the social services law, in relation to the use of EQUAL program funds for adult care facilities; to amend the public health law, in relation to policy changes relating to state aid; to amend the public health law in relation to the relocation of residential health care facility long-term ventilator beds; to amend part H of chapter 60 of the laws of 2014, amending the insurance law, the public health law and the financial services law relating to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, access to out-of-network care and prohibition of excessive emergency charges, in relation to the date the report shall be submitted; and providing for the repeal of certain provisions upon expiration thereof (Part R); and to amend the elder law, in relation to the supportive service program for classic and neighborhood naturally occurring retirement communities; and providing for the repeal of certain provisions upon expiration thereof (Part S)

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 2016-2017 state fiscal year. Each component is wholly contained within a Part identified as Parts A through S. 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

Intentionally Omitted

PART B

Section 1. Intentionally omitted.

S 1-a. Ambulance medical transportation rate adequacy review. The commissioner shall review the rates of reimbursement made through the medicaid program for ambulance medical transportation for rate adequacy. By December 31, 2016 the commissioner shall report the findings, of the rate adequacy review to the temporary president of the senate and the speaker of the assembly.

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. Subdivision 7 of section 367-a of the social services law is amended by adding a new paragraph (f) to read as follows:

(F) (1) THE DEPARTMENT MAY REQUIRE MANUFACTURERS OF DRUGS OTHER THAN SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS, AS SUCH TERMS ARE DEFINED IN 42 U.S.C. S 1396R-8(K), TO PROVIDE REBATES TO THE DEPARTMENT FOR ANY DRUG THAT HAS INCREASED MORE THAN THREE HUNDRED PERCENT OF ITS STATE MAXIMUM ACQUISITION COST (SMAC), ON OR AFTER APRIL 1, 2016, IN COMPARISON TO ITS SMAC AT ANY TIME DURING THE COURSE OF THE PRECEDING TWELVE MONTHS. THE REQUIRED REBATE SHALL BE LIMITED TO THE AMOUNT BY WHICH THE CURRENT SMAC FOR THE DRUG EXCEEDS THREE HUNDRED PERCENT OF THE SMAC FOR THE SAME DRUG AT ANY TIME DURING THE COURSE OF THE PRECEDING TWELVE MONTHS. SUCH REBATES SHALL BE IN ADDITION TO ANY REBATES PAYABLE TO THE DEPARTMENT PURSUANT TO ANY OTHER PROVISION OF FEDERAL OR STATE LAW. NOTHING HEREIN SHALL AFFECT THE DEPARTMENT'S OBLIGATION TO REIMBURSE FOR COVERED OUTPATIENT DRUGS PURSUANT TO PARAGRAPH (D) OF THIS SUBDIVISION.

(2) EXCEPT AS PROVIDED IN SUBPARAGRAPH THREE OF THIS PARAGRAPH, THE COMMISSIONER SHALL NOT DETERMINE ANY FURTHER REBATES TO BE PAYABLE PURSUANT TO THIS PARAGRAPH ONCE THE CENTERS FOR MEDICARE AND MEDICAID

SERVICES HAS ADOPTED A FINAL METHODOLOGY FOR DETERMINING THE AMOUNT OF ADDITIONAL REBATES UNDER THE FEDERAL GENERIC DRUG PRICE INCREASE REBATE PROGRAM PURSUANT TO 42 U.S.C. S 1396R-8 (C)(3), AS AMENDED BY SECTION 602 OF THE BIPARTISAN BUDGET ACT OF 2015.

(3) DURING STATE FISCAL YEAR 2016-2017, IF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES HAS ADOPTED A FINAL METHODOLOGY FOR DETERMINING THE AMOUNT OF ADDITIONAL REBATES UNDER THE FEDERAL GENERIC DRUG PRICE INCREASE REBATE PROGRAM PURSUANT TO 42 U.S.C. S 1396R-8 (C)(3), AS AMENDED BY SECTION 602 OF THE BIPARTISAN BUDGET ACT OF 2015, THE DEPARTMENT MAY COLLECT FOR A GIVEN DRUG THE PORTION OF THE REBATE DETERMINED UNDER THIS PARAGRAPH THAT IS IN EXCESS OF THE REBATE REQUIRED BY SUCH FEDERAL REBATE PROGRAM.

(4) THE ADDITIONAL REBATES AUTHORIZED PURSUANT TO THIS PARAGRAPH SHALL APPLY TO GENERIC PRESCRIPTION DRUGS DISPENSED TO ENROLLEES OF MANAGED CARE PROVIDERS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE AND TO GENERIC PRESCRIPTION DRUGS DISPENSED TO MEDICAID RECIPIENTS WHO ARE NOT ENROLLEES OF SUCH PROVIDERS.

(5) BEGINNING IN TWO THOUSAND SEVENTEEN, THE DEPARTMENT SHALL PROVIDE AN ANNUAL REPORT TO THE LEGISLATURE NO LATER THAN FEBRUARY FIRST SETTING FORTH:

(I) THE NUMBER OF DRUGS THAT EXCEEDED THE CEILING PRICE ESTABLISHED IN THIS PARAGRAPH DURING THE PRECEDING YEAR IN COMPARISON TO THE NUMBER OF DRUGS THAT EXPERIENCED AT LEAST A THREE HUNDRED PERCENT PRICE INCREASE DURING TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN;

(II) THE AVERAGE PERCENT AMOUNT ABOVE THE CEILING PRICE OF DRUGS THAT EXCEEDED THE CEILING PRICE IN THE PRECEDING YEAR IN COMPARISON TO THE NUMBER OF DRUGS THAT EXPERIENCED A PRICE INCREASE MORE THAN THREE HUNDRED PERCENT DURING TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN;

(III) THE NUMBER OF GENERIC DRUGS AVAILABLE TO ENROLLEES IN MEDICAID FEE FOR SERVICE OR MEDICAID MANAGED CARE, BY FISCAL QUARTER, IN THE PRECEDING YEAR IN COMPARISON TO THE DRUGS AVAILABLE, BY FISCAL QUARTER, DURING TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN; AND

(IV) THE TOTAL DRUG SPEND ON GENERIC DRUGS FOR THE PRECEDING YEAR IN COMPARISON TO THE TOTAL DRUG SPEND ON GENERIC DRUGS DURING TWO THOUSAND FOURTEEN AND TWO THOUSAND FIFTEEN.

S 12. The opening paragraph of paragraph (e) of subdivision 7 of section 367-a of the social services law, as added by section 1 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

During the period from April first, two thousand fifteen through March thirty-first, two thousand seventeen, the commissioner may, in lieu of a managed care provider, negotiate directly and enter into an agreement with a pharmaceutical manufacturer for the provision of supplemental rebates relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title AND MAY ALSO NEGOTIATE DIRECTLY AND ENTER INTO SUCH AN AGREEMENT RELATING TO PHARMACEUTICAL UTILIZATION BY MEDICAL ASSISTANCE RECIPIENTS NOT SO ENROLLED. Such rebates shall be limited to drug utilization in the following classes: antiretrovirals approved by the FDA for the treatment of HIV/AIDS and hepatitis C agents for which the pharmaceutical manufacturer has in effect a rebate agreement with the federal secretary of health and human services pursuant to 42 U.S.C. S 1396r-8, and for which the state has established standard clinical criteria. No agreement entered into pursuant to this paragraph shall have an initial term or be extended beyond March thirty-first, two thousand twenty.

S 13. Subparagraph (iv) of paragraph (e) of subdivision 7 of section 367-a of the social services law, as added by section 1 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

(iv) Nothing in this paragraph shall be construed to require a pharmaceutical manufacturer to enter into a supplemental rebate agreement with the commissioner relating to pharmaceutical utilization by enrollees of managed care providers pursuant to section three hundred sixty-four-j of this title OR RELATING TO PHARMACEUTICAL UTILIZATION BY MEDICAL ASSISTANCE RECIPIENTS NOT SO ENROLLED.

S 14. Section 364-j of the social services law is amended by adding a new subdivision 26-a to read as follows:

26-A. MANAGED CARE PROVIDERS SHALL REQUIRE PRIOR AUTHORIZATION OF PRESCRIPTIONS OF OPIOID ANALGESICS IN EXCESS OF FOUR PRESCRIPTIONS IN A THIRTY-DAY PERIOD, PROVIDED, HOWEVER, THAT THIS SUBDIVISION SHALL NOT APPLY IF THE PATIENT IS A RECIPIENT OF HOSPICE CARE, HAS A DIAGNOSIS OF CANCER OR SICKLE CELL DISEASE, OR ANY OTHER CONDITION OR DIAGNOSIS FOR WHICH THE COMMISSIONER OF HEALTH DETERMINES PRIOR AUTHORIZATION IS NOT REQUIRED.

S 15. Section 364-j of the social services law is amended by adding a new subdivision 32 to read as follows:

32. (A) THE COMMISSIONER MAY, IN HIS OR HER DISCRETION, APPLY PENALTIES TO MANAGED CARE ORGANIZATIONS SUBJECT TO THIS SECTION AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, INCLUDING MANAGED LONG TERM CARE PLANS, FOR UNTIMELY OR INACCURATE SUBMISSION OF ENCOUNTER DATA; PROVIDED HOWEVER, NO PENALTY SHALL BE ASSESSED IF THE MANAGED CARE ORGANIZATION SUBMITS, IN GOOD FAITH, TIMELY AND ACCURATE DATA THAT IS NOT SUCCESSFULLY RECEIVED BY THE DEPARTMENT AS A RESULT OF DEPARTMENT SYSTEM FAILURES OR TECHNICAL ISSUES THAT ARE BEYOND THE CONTROL OF THE MANAGED CARE ORGANIZATION.

(B) THE COMMISSIONER SHALL CONSIDER THE FOLLOWING PRIOR TO ASSESSING A PENALTY AGAINST A MANAGED CARE ORGANIZATION AND HAVE THE DISCRETION TO REDUCE OR ELIMINATE A PENALTY:

(I) THE DEGREE TO WHICH THE DATA SUBMITTED IS INACCURATE AND THE FREQUENCY OF INACCURATE DATA SUBMISSIONS BY THE MANAGED CARE ORGANIZATION;

(II) THE DEGREE TO WHICH THE DATA SUBMITTED IS UNTIMELY AND THE FREQUENCY OF UNTIMELY DATA SUBMISSIONS BY THE MANAGED CARE ORGANIZATION;

(III) THE TIMELINESS OF THE MANAGED CARE ORGANIZATION IN CURING OR CORRECTING INACCURATE OR UNTIMELY DATA;

(IV) WHETHER THE UNTIMELY OR INACCURATE DATA WAS SUBMITTED BY THE MANAGED CARE ORGANIZATION OR A THIRD PARTY;

(V) WHETHER THE MANAGED CARE ORGANIZATION HAS TAKEN CORRECTIVE ACTION TO REDUCE THE LIKELIHOOD OF FUTURE INACCURATE OR UNTIMELY DATA SUBMISSIONS; AND

(VI) WHETHER THE MANAGED CARE ORGANIZATION WAS OR SHOULD HAVE BEEN AWARE OF INACCURATE OR UNTIMELY DATA.

FOR PURPOSES OF THIS SECTION, "ENCOUNTER DATA" SHALL MEAN THE TRANSACTIONS REQUIRED TO BE REPORTED UNDER THE MODEL CONTRACT. ANY PENALTY ASSESSED UNDER THIS SUBDIVISION SHALL BE CALCULATED AS A PERCENTAGE OF THE ADMINISTRATIVE COMPONENT OF THE MEDICAID PREMIUM CALCULATED BY THE DEPARTMENT.

(C) SUCH PENALTIES SHALL BE AS FOLLOWS:

(I) FOR ENCOUNTER DATA SUBMITTED OR RESUBMITTED PAST THE DEADLINES SET FORTH IN THE MODEL CONTRACT, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE AND ONE-HALF PERCENT; AND

(II) FOR INCOMPLETE OR INACCURATE ENCOUNTER DATA THAT FAILS TO CONFORM TO DEPARTMENT DEVELOPED BENCHMARKS FOR COMPLETENESS AND ACCURACY, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE-HALF PERCENT; AND

(III) FOR SUBMITTED DATA THAT RESULTS IN A REJECTION RATE IN EXCESS OF TEN PERCENT OF DEPARTMENT DEVELOPED VOLUME BENCHMARKS, MEDICAID PREMIUMS SHALL BE REDUCED BY ONE-HALF PERCENT.

(D) PENALTIES UNDER THIS SUBDIVISION MAY BE APPLIED TO ANY AND ALL CIRCUMSTANCES DESCRIBED IN PARAGRAPH (B) OF THIS SUBDIVISION UNTIL THE MANAGED CARE ORGANIZATION COMPLIES WITH THE REQUIREMENTS FOR SUBMISSION OF ENCOUNTER DATA. NO PENALTIES FOR LATE, INCOMPLETE OR INACCURATE ENCOUNTER DATA SHALL BE ASSESSED AGAINST MANAGED CARE ORGANIZATIONS IN ADDITION TO THOSE PROVIDED FOR IN THIS SUBDIVISION.

S 16. Paragraph (d) of subdivision 1 of section 367-a of the social services law is amended by adding a new subparagraph (iv) to read as follows:

(IV) IF A HEALTH PLAN PARTICIPATING IN PART C OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT PAYS FOR ITEMS AND SERVICES PROVIDED TO ELIGIBLE PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT OR TO QUALIFIED MEDICARE BENEFICIARIES, THE AMOUNT PAYABLE FOR SERVICES UNDER THIS TITLE SHALL BE EIGHTY-FIVE PERCENT OF THE AMOUNT OF ANY CO-INSURANCE LIABILITY OF SUCH ELIGIBLE PERSONS PURSUANT TO FEDERAL LAW IF THEY WERE NOT ELIGIBLE FOR MEDICAL ASSISTANCE OR WERE NOT QUALIFIED MEDICARE BENEFICIARIES WITH RESPECT TO SUCH BENEFITS UNDER SUCH PART B; PROVIDED, HOWEVER, AMOUNTS PAYABLE UNDER THIS TITLE FOR ITEMS AND SERVICES PROVIDED TO ELIGIBLE PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OR TO QUALIFIED MEDICARE BENEFICIARIES BY AN AMBULANCE SERVICE UNDER THE AUTHORITY OF AN OPERATING CERTIFICATE ISSUED PURSUANT TO ARTICLE THIRTY OF THE PUBLIC HEALTH LAW, OR A PSYCHOLOGIST LICENSED UNDER ARTICLE ONE HUNDRED FIFTY-THREE OF THE EDUCATION LAW, SHALL NOT BE LESS THAN THE AMOUNT OF ANY CO-INSURANCE LIABILITY OF SUCH ELIGIBLE PERSONS OR SUCH QUALIFIED MEDICARE BENEFICIARIES, OR FOR WHICH SUCH ELIGIBLE PERSONS OR SUCH QUALIFIED MEDICARE BENEFICIARIES WOULD BE LIABLE UNDER FEDERAL LAW WERE THEY NOT ELIGIBLE FOR MEDICAL ASSISTANCE OR WERE THEY NOT QUALIFIED MEDICARE BENEFICIARIES WITH RESPECT TO SUCH BENEFITS UNDER PART B.

S 17. Subdivision 2-b of section 365-l of the social services law, as added by section 25 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

2-b. The commissioner is authorized to make [grants] LUMP SUM PAYMENTS OR ADJUST RATES OF PAYMENT TO PROVIDERS up to a gross amount of five million dollars, to establish coordination between the health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities, to the extent permitted by law. SUCH RATE ADJUSTMENTS MAY BE MADE TO HEALTH HOMES PARTICIPATING IN A CRIMINAL JUSTICE PILOT PROGRAM WITH THE PURPOSE OF ENROLLING INCARCERATED INDIVIDUALS WITH SERIOUS MENTAL ILLNESS, TWO OR MORE CHRONIC CONDITIONS, INCLUDING SUBSTANCE ABUSE DISORDERS, OR HIV/AIDS, INTO SUCH HEALTH HOME. Health homes receiving funds under this subdivision shall be required to document and demonstrate the effective use of funds distributed herein.

S 18. Subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, as amended by section 8 of part B of chapter 57 of the laws of 2015, is amended to read as follows:

1. For state fiscal years 2011-12 through [2016-17] 2017-18, 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 and state costs or savings from the basic health plan. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

S 19. Subdivision 5 of section 92 of part H of chapter 59 of the laws of 2011 amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, is amended by adding a new paragraph (g) to read as follows:

(G) ANY MATERIAL IMPACT TO THE GLOBAL CAP ANNUAL PROJECTION, ALONG WITH AN EXPLANATION OF THE VARIANCE FROM THE PROJECTION AT THE TIME OF THE ENACTED BUDGET. SUCH MATERIAL IMPACTS SHALL INCLUDE, BUT NOT BE LIMITED TO, POLICY AND PROGRAMMATIC CHANGES, SIGNIFICANT TRANSACTIONS, AND ANY ACTIONS TAKEN, ADMINISTRATIVE OR OTHERWISE, WHICH WOULD MATERIALLY IMPACT EXPENDITURES UNDER THE GLOBAL CAP. REPORTING REQUIREMENTS UNDER THIS PARAGRAPH SHALL INCLUDE MATERIAL IMPACTS FROM THE PRECEDING MONTH AND ANY ANTICIPATED MATERIAL IMPACTS FOR THE MONTH IN WHICH THE REPORT REQUIRED UNDER THIS SUBDIVISION IS ISSUED, AS WELL AS ANTICIPATED MATERIAL IMPACTS FOR THE MONTH SUBSEQUENT TO SUCH REPORT.

S 20. Clauses 2 and 3 of subparagraph (v) of paragraph (b) of subdivision 7 of section 4403-f of the public health law, as amended by section 48 of part A of chapter 56 of the laws of 2013, are amended and four new subparagraphs (v-a), (v-b), (v-c), and (v-d) are added to read as follows:

(2) a participant in the traumatic brain injury waiver program OR A PERSON WHOSE CIRCUMSTANCES WOULD QUALIFY HIM OR HER FOR THE PROGRAM AS IT EXISTED ON JANUARY FIRST, TWO THOUSAND FIFTEEN;

(3) a participant in the nursing home transition and diversion waiver program OR A PERSON WHOSE CIRCUMSTANCES WOULD QUALIFY HIM OR HER FOR THE PROGRAM AS IT EXISTED ON JANUARY FIRST, TWO THOUSAND FIFTEEN;

(V-A) FOR PURPOSES OF CLAUSE TWO OF SUBPARAGRAPH (V) OF THIS PARAGRAPH, PROGRAM FEATURES SHALL BE SUBSTANTIALLY COMPARABLE TO THOSE SERVICES AVAILABLE TO TRAUMATIC BRAIN INJURY WAIVER PARTICIPANTS AS OF JANUARY FIRST, TWO THOUSAND FIFTEEN, SUBJECT TO FEDERAL FINANCIAL PARTICIPATION.

(V-B) FOR PURPOSES OF CLAUSE THREE OF SUBPARAGRAPH (V) OF THIS PARAGRAPH, PROGRAM FEATURES SHALL BE SUBSTANTIALLY COMPARABLE TO THOSE SERVICES OFFERED TO NURSING HOME TRANSITION AND DIVERSION WAIVER PARTICIPANTS AS OF JANUARY FIRST, TWO THOUSAND FIFTEEN, SUBJECT TO FEDERAL FINANCIAL PARTICIPATION.

(V-C) ANY MANAGED CARE PROGRAM PROVIDING SERVICES UNDER CLAUSE TWO OR THREE OF SUBPARAGRAPH (V) OF THIS PARAGRAPH SHALL HAVE AN ADEQUATE NETWORK OF TRAINED PROVIDERS TO MEET THE NEEDS OF ENROLLEES AND PROVIDE SERVICES UNDER THIS SUBDIVISION.

(V-D) ANY INDIVIDUAL PROVIDING SERVICE COORDINATION PURSUANT TO SUBPARAGRAPH (V-A) OR (V-B) OF THIS PARAGRAPH SHALL EXERCISE HIS OR HER PROFESSIONAL DUTIES IN THE INTERESTS OF THE PATIENT. NOTHING IN THIS SUBPARAGRAPH SHALL BE CONSTRUED AS DIMINISHING THE AUTHORITY AND OBLIGATIONS OF A MANAGED LONG TERM CARE PLAN UNDER THIS ARTICLE AND ARTICLE FORTY-NINE OF THIS CHAPTER.

S 20-a. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-2) to read as follows:

(D-2) SERVICES PROVIDED PURSUANT TO WAIVERS, GRANTED PURSUANT TO SUBSECTION (C) OF SECTION 1915 OF THE FEDERAL SOCIAL SECURITY ACT, TO PERSONS SUFFERING FROM TRAUMATIC BRAIN INJURIES OR QUALIFYING FOR NURSING HOME DIVERSION AND TRANSITION SERVICES, SHALL NOT BE PROVIDED TO MEDICAL ASSISTANCE RECIPIENTS THROUGH MANAGED CARE PROGRAMS UNTIL AT LEAST JANUARY FIRST, TWO THOUSAND EIGHTEEN.

S 21. Subdivision 8 of section 4403-f of the public health law, as amended by section 40-a of part B of chapter 57 of the laws of 2015, is amended to read as follows:

8. Payment rates for managed long term care plan 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 and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: 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. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. In setting such payment rates, the commissioner shall consider costs borne by the managed care program to ensure actuarially sound and adequate rates of payment to ensure quality of care SHALL COMPLY WITH ALL APPLICABLE LAWS AND REGULATIONS, STATE AND FEDERAL, INCLUDING REGULATIONS AS TO ACTUARIAL SOUNDNESS FOR MEDICAID MANAGED CARE.

S 21-a. Subdivision 1-a of section 366 of the social services law, as added by chapter 355 of the laws of 2007, is amended to read as follows:

1-a. Notwithstanding any other provision of law, in the event that a person who is an inmate of a state or local correctional facility, as defined in section two of the correction law, was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, such person shall remain eligible for medical assistance while an inmate, except that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided

during such time as the person is an inmate; provided, however, that nothing herein shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an inmate at a hospital outside of the premises of such correctional facility OR PURSUANT TO OTHER FEDERAL AUTHORITY AUTHORIZING THE PROVISION OF MEDICAL ASSISTANCE TO AN INMATE OF A STATE OR LOCAL CORRECTIONAL FACILITY DURING THE THIRTY DAYS PRIOR TO RELEASE, to the extent that federal financial participation is available for the costs of such services. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inmate shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article. THE STATE MAY SEEK FEDERAL AUTHORITY TO PROVIDE MEDICAL ASSISTANCE FOR TRANSITIONAL SERVICES INCLUDING BUT NOT LIMITED TO MEDICAL, PRESCRIPTION, AND CARE COORDINATION SERVICES FOR HIGH NEEDS INMATES IN STATE AND LOCAL CORRECTIONAL FACILITIES DURING THE THIRTY DAYS PRIOR TO RELEASE.

S 22. Notwithstanding any provision of law to the contrary, for rate periods from April 1, 2016 through March 31, 2046, The Citadel Rehab and Nursing Center at Kingsbridge, located at 3400 Cannon Place, Bronx, New York 10463, shall receive one million dollars, annually, for the purpose of reimbursing expenses related to a facility purchased and transferred immediately following the operation of such facility under a court-ordered receivership. Such reimbursement shall be state only Medicaid payments and subject to cash receipts assessment, equity withdrawal limitations and any other provisions of section 2808 of the public health law that does not implicate capital reimbursement, and such reimbursement shall be in addition to real property costs otherwise reimbursable pursuant to section 2808 of the public health law.

S 23. Subparagraph (i) of paragraph (e-2) of subdivision 4 of section 2807-c of the public health law, as added by section 13 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(i) For physical medical rehabilitation services and for chemical dependency rehabilitation services, the operating cost component of such rates shall reflect the use of two thousand five operating costs for each respective category of services as reported by each facility to the department prior to July first, two thousand nine and as adjusted for inflation pursuant to paragraph (c) of subdivision ten of this section, as otherwise modified by any applicable statute, provided, however, that such two thousand five reported operating costs, but not including reported direct medical education cost, shall, for rate-setting purposes, be held to a ceiling of one hundred ten percent of the average of such reported costs in the region in which the facility is located, as determined pursuant to clause (E) of subparagraph [(iii)] (IV) of paragraph (1) of this subdivision; AND PROVIDED, FURTHER, THAT FOR PHYSICAL MEDICAL REHABILITATION SERVICES, THE COMMISSIONER IS AUTHORIZED TO MAKE ADJUSTMENTS TO SUCH RATES FOR THE PURPOSES OF REIMBURSING PEDIATRIC VENTILATOR SERVICES.

S 24. Restorative care unit demonstration program. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health, within amounts appropriated, shall implement a restorative care unit demonstration program within one year of the effective date of this section to reduce hospital admissions and readmissions from residential health care facilities established pursuant to article 28 of the public

health law, through the establishment of restorative care units. Such units shall provide higher-intensity treatment services for residents who are at risk of hospitalization upon an acute change in condition, and seek to improve the capacity of nursing facilities to identify and treat higher acuity patients with multiple co-morbidities as effectively as possible in-situ, rather than through admission to an acute care facility. The unit shall utilize evidence based tools, as well as: (a) a critical indicator monitoring system to evaluate performance indicators; (b) patient-focused education to support advanced care planning and palliative care decisions; and (c) protocols to effect care monitoring practices designed to reduce the likelihood of change in patient status conditions that may require acute care evaluation. A residential health care facility, established pursuant to article 28 of the public health law, wishing to establish restorative care units must contract with an eligible applicant.

2. For the purposes of this section, an eligible applicant must at a minimum meet the following criteria: (a) be a New York state entity in good standing; and (b) have demonstrated experience and capacity in developing and implementing a similar unit as described herein. An eligible applicant for this demonstration program shall contract with a residential health care facility, established pursuant to article 28 of the public health law, with a license in good standing that: (i) employs a nursing home administrator with at least two years operational experience; (ii) has a minimum of 160 certified beds; (iii) accepts reimbursement pursuant to title XVIII and title XIX of the federal social security act; (iv) has achieved at least a three star overall nursing home compare rating from the Center for Medicare and Medicaid Services five-star quality rating system; and (v) operates a discreet dedicated restorative care unit with a minimum of 18 beds. Additionally, the contracting facility must have at the time of application, and maintain during the course of the demonstration, functional wireless internet connectivity throughout the facility, including backup, with sufficient bandwidth to support technological monitoring.

3. Restorative care units; requirements. Restorative care units shall provide on-site healthcare services, including, but not limited to: (a) radiology; (b) peripherally inserted central catheter insertion; (c) blood sugar, hemoglobin/hematocrit, electrolytes and blood gases monitoring; (d) 12-lead transmissible electrocardiograms; (e) specialized cardiac services, including rapid response teams, crash carts, and defibrillators; (f) telemedicine and telemetry which shall have the capability to notify the user, in real time, when an urgent or emergent physiological change has occurred in a patient's condition requiring intervention, and to generate reports that can be accessed by any provider, in real time, in any location to allow for immediate clinical intervention.

4. Electronic health records. For the duration of the demonstration, the restorative care unit shall utilize and maintain an electronic health record system that connects to the local regional health information organization to facilitate the exchange of health information.

5. The department of health shall monitor the quality and effectiveness of the demonstration program in reducing hospital admissions and readmissions over a three year period and shall report to the legislature, within one year of implementation, on the demonstration program's effectiveness in providing a higher level of care at lower cost, and include recommendations regarding the utilization of the restorative care unit model in the state.

S 25. Within one hundred twenty (120) days of the effective date of this section, the department of civil service, in consultation with the department of health, shall create a new title or titles and a new title series, for a Medicaid Redesign Team Analyst, as a permanent competitive class. The Medicaid Redesign Team Analyst series will be responsible for programmatic duties related to health insurance program initiatives such as implementation of new program initiative tasks, compliance monitoring and providing technical assistance to state agencies and health care providers.

S 26. Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, or sections 142 and 143 of the economic development law, or any other contrary provision of law, excepting the responsible vendor requirements of the state finance law, including, but not limited to, sections 163 and 139-k of the state finance law, the commissioner of health is authorized to amend or otherwise extend the terms of a contract awarded prior to the effective date and entered into pursuant to subdivision 24 of section 206 of the public health law, as added by section 39 of part C of chapter 58 of the laws of 2008, and a contract awarded prior to the effective date and entered into to conduct enrollment broker and conflict-free evaluation services for the Medicaid program, both for a period of three years, without a competitive bid or request for proposal process, upon determination that the existing contractor is qualified to continue to provide such services, and provided that efficiency savings are achieved during the period of extension; and provided, further, that the department of health shall submit a request for applications for such contract during the time period specified in this section and may terminate the contract identified herein prior to expiration of the extension authorized by this section.

S 27. Section 48 of part C of chapter 60 of the laws of 2014, authorizing the commissioner of health to negotiate an extension of the terms of the contract executed by the department of health for actuarial and consulting services, is amended to read as follows:

S 48. Notwithstanding sections 112 and 163 of the state finance law, EXCEPTING THE RESPONSIBLE VENDOR REQUIREMENTS OF THE STATE FINANCE LAW, INCLUDING, BUT NOT LIMITED TO, SECTIONS 163 AND 139-K OF THE STATE FINANCE LAW, or any other contrary provision of law, the commissioner of health is authorized to negotiate an extension of the terms of the contract executed by the department of health for actuarial and consulting services, on September 18, 2009, without a competitive bid or request for proposal process; provided, however, such extension shall not extend beyond December 31, [2016] 2017; PROVIDED, HOWEVER, THAT THE DEPARTMENT OF HEALTH SHALL SUBMIT A REQUEST FOR APPLICATIONS FOR SUCH CONTRACT DURING THE TIME PERIOD SPECIFIED IN THIS SECTION AND MAY TERMINATE THE CONTRACT IDENTIFIED HEREIN PRIOR TO EXPIRATION OF THE EXTENSION AUTHORIZED BY THIS SECTION.

S 28. Subdivision 9 of section 365-l of the social services law, as amended by section 35 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

9. The contract 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, EXCEPTING THE RESPONSI-

BLE VENDOR REQUIREMENTS OF THE STATE FINANCE LAW, INCLUDING, BUT NOT LIMITED TO, SECTIONS ONE HUNDRED SIXTY-THREE AND ONE HUNDRED THIRTY-NINE-K OF THE STATE FINANCE LAW, to allow the purchase of additional personnel and services, subject to available funding, for the limited purpose of assisting the department of health with implementing the Balancing Incentive Program, the Fully Integrated Duals Advantage Program, the Vital Access Provider Program, the Medicaid waiver amendment associated with the public hospital transformation, the addition of behavioral health services as a managed care plan benefit, the delivery system reform incentive payment plan, activities to facilitate the transition of vulnerable populations to managed care and/or any workgroups required to be established by the chapter of the laws of two thousand thirteen that added this subdivision. THE DEPARTMENT IS AUTHORIZED TO EXTEND SUCH CONTRACT FOR A PERIOD OF ONE YEAR, WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS, UPON DETERMINATION THAT THE EXISTING CONTRACTOR IS QUALIFIED TO CONTINUE TO PROVIDE SUCH SERVICES; PROVIDED, HOWEVER, THAT THE DEPARTMENT OF HEALTH SHALL SUBMIT A REQUEST FOR APPLICATIONS FOR SUCH CONTRACT DURING THE TIME PERIOD SPECIFIED IN THIS SUBDIVISION AND MAY TERMINATE THE CONTRACT IDENTIFIED HEREIN PRIOR TO EXPIRATION OF THE EXTENSION AUTHORIZED BY THIS SUBDIVISION.

S 29. Section 48-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, as amended by section 1 of part C of chapter 57 of the laws of 2015, is amended to read as follows:

S 48-a. 1. Notwithstanding any contrary provision of law, the commissioners of the office of alcoholism and substance abuse services and the office of mental health are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health, the office of alcoholism and substance abuse services, or the office of mental health for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, be greater than the increased funds made available pursuant to this section. The increase of such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [13] 1 of part C of chapter [60] 57 of the laws of [2014] 2015 through [June 30, 2017] MARCH 31, 2018 for patients in the city of New York, for all rate periods on and after the effective date of section [13] 1 of part C

of chapter [60] 57 of the laws of [2014] 2015 through [December 31, 2017] JUNE 30, 2018 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter through [December 31, 2017] JUNE 30, 2018 for all services provided to persons under the age of twenty-one; provided, however, [that managed] ELIGIBLE PROVIDERS MAY WORK WITH MANAGED CARE PLANS TO ACHIEVE QUALITY AND EFFICIENCY OBJECTIVES AND ENGAGE IN SHARED SAVINGS. NOTHING IN THIS SECTION SHALL PROHIBIT MANAGED care organizations and providers [may negotiate] FROM NEGOTIATING different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, 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. The commissioner of health shall consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [December 31, 2017] JUNE 30, 2018, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

S 30. Section 1 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 2 of part C of chapter 57 of the laws of 2015, is amended to read as follows:

Section 1. a. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be

utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of section [15] 2 of part C of chapter [60] 57 of the laws of [2014] 2015 through [June 30, 2017] MARCH 31, 2018 for patients in the city of New York, for all rate periods on and after the effective date of section [15] 2 of part C of chapter [60] 57 of the laws of [2014] 2015 through [December 31, 2017] JUNE 30, 2018 for patients outside the city of New York, and for all rate periods on and after the effective date of section [15] 2 of part C of chapter [60] 57 of the laws of [2014] 2015 through [December 31, 2017] JUNE 30, 2018 for all services provided to persons under the age of twenty-one; provided, however, [that managed] ELIGIBLE PROVIDERS MAY WORK WITH MANAGED CARE PLANS TO ACHIEVE QUALITY AND EFFICIENCY OBJECTIVES AND ENGAGE IN SHARED SAVINGS. NOTHING IN THIS SECTION SHALL PROHIBIT MANAGED care organizations and providers [may negotiate] FROM NEGOTIATING different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and alcoholism and substance abuse services, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

b. Notwithstanding any contrary provision of law, the fees paid by managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law, to providers licensed pursuant to article 28 of the public health law or article 31 or 32 of the mental hygiene law, for ambulatory behavioral health services provided to patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law, 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. The commissioner of health shall

consult with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health in determining such services and establishing such fees. Such ambulatory behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of this chapter through [December 31, 2017] JUNE 30, 2018, provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The report required under section 16-a of part C of chapter 60 of the laws of 2014 shall also include the population of patients enrolled in the child health insurance program pursuant to title one-A of article 25 of the public health law in its examination on the transition of behavioral health services into managed care.

S 31. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016; provided that:

(a) section eleven of this act shall expire and be deemed repealed March 31, 2018;

(b) the amendments to paragraph (e) of subdivision 7 of section 367-a of the social services law, made by sections twelve and thirteen of this act shall not affect the repeal of such paragraph and shall be deemed repealed therewith;

(c) subdivisions 26-a and 32 of section 364-j of the social services law, as added by sections fourteen and fifteen of this act shall be deemed repealed on the same date and in the same manner as such section is repealed;

(d) the amendments to subdivisions 7 and 8 of section 4403-f of the public health law, made by sections twenty and twenty-one of this act, shall not affect the expiration of such subdivision 7 or the repeal of such section, and shall expire or be deemed repealed therewith;

(e) section sixteen of this act shall take effect July 1, 2016;

(f) the amendments to section 364-j of the social services law, made by section twenty-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith; and

(g) the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section twenty-nine of this act and the amendments to section 1 of part H of chapter 111 of the laws of 2010 made by section thirty of this act shall not affect the expiration of such sections and shall be deemed to expire therewith.

PART C

Section 1. Intentionally omitted.

S 2. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 1 of part Y of chapter 57 of the laws of 2015, is amended to read as follows:

(a) The superintendent of financial services and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance

law; or from an insurer, other than an insurer described in section 5502 of the insurance law, duly authorized to write such coverage and actually writing medical malpractice insurance in this state; or shall purchase equivalent excess coverage in a form previously approved by the superintendent of financial services for purposes of providing equivalent excess coverage in accordance with section 19 of chapter 294 of the laws of 1985, for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 or reimburse the hospital where the hospital purchases equivalent excess coverage as defined in subparagraph (i) of paragraph (a) of subdivision 1-a of this section for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a

hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of financial services during the period of such excess coverage for such occurrences. During such period, such policy for excess coverage or such equivalent excess coverage shall, when combined with the physician's or dentist's primary malpractice insurance coverage or coverage provided through a voluntary attending physician ("channeling") program, total an aggregate level of two million three hundred thousand dollars for each claimant and six million nine hundred thousand dollars for all claimants from all such policies with respect to occurrences in each of such years provided, however, if the cost of primary malpractice insurance coverage in excess of one million dollars, but below the excess medical malpractice insurance coverage provided pursuant to this act, exceeds the rate of nine percent per annum, then the required level of primary malpractice insurance coverage in excess of one million dollars for each claimant shall be in an amount of not less than the dollar amount of such coverage available at nine percent per annum; the required level of such coverage for all claimants under that policy shall be in an amount not less than three times the dollar amount of coverage for each claimant; and excess coverage, when combined with such primary malpractice insurance coverage, shall increase the aggregate level for each claimant by one million dollars and three million dollars for all claimants; and provided further, that, with respect to policies of primary medical malpractice coverage that include occurrences between April 1, 2002 and June 30, 2002, such requirement that coverage be in amounts no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants for such occurrences shall be effective April 1, 2002.

S 3. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 2 of part Y of chapter 57 of the laws of 2015, is amended to read as follows:

(3)(a) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with

subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance or equivalent excess coverage for medical or dental malpractice occurrences between July 1, 1987 and June 30, 1988, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, between July 1, 2013 and June 30, 2014, between July 1, 2014 and June 30, 2015, [and] between July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of financial services shall determine and certify to each general hospital and to the commissioner of health the ratable share of such cost allocable to the period July 1, 1987 to December 31, 1987, to the period January 1, 1988 to June 30, 1988, to the period July 1, 1988 to December 31, 1988, to the period January 1, 1989 to June 30, 1989, to the period July 1, 1989 to December 31, 1989, to the period January 1, 1990 to June 30, 1990, to the period July 1, 1990 to December 31, 1990, to the period January 1, 1991 to June 30, 1991, to the period July 1, 1991 to December 31, 1991, to the period January 1, 1992 to June 30, 1992, to the period July 1, 1992 to December 31, 1992, to the period January 1, 1993 to June 30, 1993, to the period July 1, 1993 to December 31, 1993, to the period January 1, 1994 to June 30, 1994, to the period July 1, 1994 to December 31, 1994, to the period January 1, 1995 to June 30, 1995, to the period July 1, 1995 to December 31, 1995, to the period January 1, 1996 to June 30, 1996, to the period July 1, 1996 to December 31, 1996, to the period January 1, 1997 to June 30, 1997, to the period July 1, 1997 to December 31, 1997, to the period January 1, 1998 to June 30, 1998, to the period July 1, 1998 to December 31, 1998, to the period January 1, 1999 to June 30, 1999, to the period July 1, 1999 to December 31, 1999, to the period January 1, 2000 to June 30, 2000, to the period July 1, 2000 to December 31, 2000, to the period January 1, 2001 to June 30, 2001, to the period July 1, 2001 to June 30, 2002, to the period July 1, 2002 to June 30, 2003, to the period July 1, 2003 to June 30, 2004, to the period July 1, 2004 to June 30, 2005, to the period July 1, 2005 and June 30, 2006, to the period July 1, 2006 and June 30, 2007, to the period July 1, 2007 and June 30, 2008, to the period July 1, 2008 and June 30, 2009, to the period July 1, 2009 and June 30, 2010, to the period July 1, 2010 and June 30, 2011, to the period July 1, 2011 and June 30, 2012, to the period July 1, 2012 and

June 30, 2013, to the period July 1, 2013 and June 30, 2014, to the period July 1, 2014 and June 30, 2015, [and] to the period July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017.

S 4. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 3 of part Y of chapter 57 of the laws of 2015, are amended to read as follows:

(a) To the extent funds available to the hospital excess liability pool pursuant to subdivision 5 of this section as amended, and pursuant to section 6 of part J of chapter 63 of the laws of 2001, as may from time to time be amended, which amended this subdivision, are insufficient to meet the costs of excess insurance coverage or equivalent excess coverage for coverage periods during the period July 1, 1992 to June 30, 1993, during the period July 1, 1993 to June 30, 1994, during the period July 1, 1994 to June 30, 1995, during the period July 1, 1995 to June 30, 1996, during the period July 1, 1996 to June 30, 1997, during the period July 1, 1997 to June 30, 1998, during the period July 1, 1998 to June 30, 1999, during the period July 1, 1999 to June 30, 2000, during the period July 1, 2000 to June 30, 2001, during the period July 1, 2001 to October 29, 2001, during the period April 1, 2002 to June 30, 2002, during the period July 1, 2002 to June 30, 2003, during the period July 1, 2003 to June 30, 2004, during the period July 1, 2004 to June 30, 2005, during the period July 1, 2005 to June 30, 2006, during the period July 1, 2006 to June 30, 2007, during the period July 1, 2007 to June 30, 2008, during the period July 1, 2008 to June 30, 2009, during the period July 1, 2009 to June 30, 2010, during the period July 1, 2010 to June 30, 2011, during the period July 1, 2011 to June 30, 2012, during the period July 1, 2012 to June 30, 2013, during the period July 1, 2013 to June 30, 2014, during the period July 1, 2014 to June 30, 2015, [and] during the period July 1, 2015 and June 30, 2016, AND BETWEEN JULY 1, 2016 AND JUNE 30, 2017 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the peri-

od July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of financial services.

(c) If a physician or dentist liable for payment of a portion of the costs of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of financial services pursuant to paragraph (b) of this subdivision, excess insurance coverage or equivalent excess coverage purchased for such physician or dentist in accordance with this section for such coverage period shall be cancelled and shall be null and void as of the first day on or after the commencement of a policy period where the liability for payment pursuant to this subdivision has not been met.

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of financial services and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30,

2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, or covering the period July 1, 2015 to June 30, 2016, OR COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 that has made payment to such provider of excess insurance coverage or equivalent excess coverage in accordance with paragraph (b) of this subdivision and of each physician and dentist who has failed, refused or neglected to make such payment.

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, and to the period July 1, 2015 to June 30, 2016, AND TO THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the

period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, and covering the period July 1, 2015 to June 30, 2016, AND COVERING THE PERIOD JULY 1, 2016 TO JUNE 30, 2017 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

S 5. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 4 of part Y of chapter 57 of the laws of 2015, is amended to read as follows:

S 40. The superintendent of financial services shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2016] 2017; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2016] 2017, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2016] 2017 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected defi-

ciency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

S 6. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 5 of part Y of chapter 57 of the laws of 2015, are amended to read as follows:

S 5. The superintendent of financial services and the commissioner of health shall determine, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, [and] June 15, 2016, AND JUNE 15, 2017 the amount of funds available in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, and whether such funds are sufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, OR JULY 1, 2016 TO JUNE 30, 2017 as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of financial services and the commissioner of health, and a certification of such determination to the state director of the budget, the chair of the senate committee on finance and the chair of the assembly committee on ways and means, that the amount of funds in the hospital excess liability pool, created pursuant to section 18 of chapter 266 of the laws of 1986, is insufficient for purposes of purchasing excess insurance coverage for eligible participating physicians and dentists during the period July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, or July 1, 2007 to June 30, 2008, or July 1, 2008 to June 30, 2009, or July 1, 2009 to June 30, 2010, or July 1, 2010 to June 30, 2011, or July 1, 2011 to June 30, 2012, or July 1, 2012 to June 30, 2013, or July 1, 2013 to June 30, 2014, or July 1, 2014 to June 30, 2015, or July 1, 2015 to June 30, 2016, OR JULY 1, 2016 TO JUNE 30, 2017 as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of financial services for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, June 15, 2015, [and] June 15, 2016, AND JUNE 15, 2017 as applicable.

S 7. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand sixteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand sixteen; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand sixteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand sixteen, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand sixteen, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand sixteen 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 sixteen.

S 8. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016, provided, however, section two of this act shall take effect July 1, 2016.

PART D

Section 1. 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 B of chapter 56 of the laws of 2013, 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, 2016, AND FOR THE STATE FISCAL YEAR BEGINNING APRIL 1, 2016 THROUGH MARCH 31, 2019, 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 2. Section 10 of chapter 649 of the laws of 1996, amending the public health law, the mental hygiene law and the social services law relating to authorizing the establishment of special needs plans, as amended by section 20 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

S 10. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after July 1, 1996; provided, however, that sections one, two and three of this act shall expire and be deemed repealed on March 31, [2016] 2020 provided, however that the amendments to section 364-j of the social services law made by section four of this act shall not affect the expiration of such section and shall be deemed to expire therewith and provided, further, that the provisions of subdivisions 8, 9 and 10 of section 4401 of the public health law, as added by section one of this act; section 4403-d of the public health law as added by section two of this act and the provisions of section seven of this act, except for the provisions relating to the establishment of no more than twelve comprehensive HIV special needs plans, shall expire and be deemed repealed on July 1, 2000.

S 3. Subdivision 8 of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to general hospital reimbursement for annual rates is REPEALED.

S 4. 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, as amended by section 1 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(f) section twenty-five of this act shall expire and be deemed repealed April 1, [2016] 2019;

S 4-a. Section 2806-a of the public health law is amended by adding a new subdivision 8 to read as follows:

8. THE COMMISSIONER SHALL CAUSE THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE CHAIRS OF THE SENATE AND THE ASSEMBLY HEALTH COMMITTEES TO BE NOTIFIED OF THE APPOINTMENT OF A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH (A) OF SUBDIVISION TWO OF THIS SECTION UPON SUCH APPOINTMENT. SUCH NOTIFICATION SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NAME OF THE ESTABLISHED OPERATOR, THE NAME OF THE APPOINTED TEMPORARY OPERATOR AND A DESCRIPTION OF THE REASONS FOR SUCH APPOINTMENT TO THE EXTENT PRACTICABLE UNDER THE CIRCUMSTANCES AND IN THE SOLE DISCRETION OF THE COMMISSIONER.

S 5. Subdivision (c) of section 122 of part E of chapter 56 of the laws of 2013 amending the public health law relating to the general public health work program, is amended to read as follows:

(c) section fifty of this act shall take effect immediately and shall expire [three] SIX years after it becomes law;

S 5-a. Subdivision 2 of section 3-0317 of the environmental conservation law, as added by chapter 77 of the laws of 2010, is amended to read as follows:

2. The department shall, pursuant to established security protocols, provide to the department of health the GPS coordinates, category of license or permit, facility identification number, and address on current environmental facilities that are necessary for the department of health to develop and maintain cancer incidence and environmental facility maps required pursuant to section twenty-four hundred one-b of the public health law, and shall provide any technical assistance necessary for the development of such maps. The department, in consultation

with the department of health, shall update such data [periodically] NOT LESS THAN ONCE EVERY FIVE YEARS.

S 5-b. Subdivision 9 of section 2401-b of the public health law, as added by chapter 77 of the laws of 2010, is amended to read as follows:

9. The department shall make available to the public cancer incidence and environmental facility maps in the manner described in subdivision four of this section showing cancer clusters by cancer types. Prior to plotting such data, the department shall use an appropriate statistical method to detect statistical anomalies for the purpose of identifying cancer clusters.

[(a)] The department shall make such maps available [as follows:

(i) by June thirtieth, two thousand twelve cancer types listed in paragraphs (a) through (e) of subdivision five of this section;

(ii) by December thirty-first, two thousand twelve cancer types listed in paragraphs (f) through (o) of subdivision five of this section; and

(iii) by June thirtieth, two thousand thirteen cancer types listed in paragraphs (p) through (w) of subdivision five of this section.

(b) The department] ON ITS PUBLIC WEBSITE, AND SHALL, in consultation with the department of environmental conservation, [shall] update the maps [periodically.

(c) The department shall post these maps on its public website as soon as practicable following the dates set forth in paragraph (a) of this subdivision] NOT LESS THAN ONCE EVERY FIVE YEARS.

S 5-c. Section 5 of chapter 77 of the laws of 2010 amending the environmental conservation law and the public health law relating to an environmental facility and cancer incidence map, is amended to read as follows:

S 5. This act shall take effect immediately and shall expire and be deemed repealed March 31, [2016] 2022.

S 6. Subdivision 4-a of section 71 of part C of chapter 60 of the laws of 2014 amending the social services law relating to eliminating prescriber prevails for brand name drugs with generic equivalents, is amended to read as follows:

4-a. section twenty-two of this act shall take effect April 1, 2014, and shall be deemed expired January 1, [2017] 2018;

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, 2016; provided, however, that the amendments to section 2806-a of the public health law made by section four-a of this act, the amendments to section 3-0317 of the environmental conservation law made by section five-a of this act and the amendments to section 2401-b of the public health law made by section five-b of this act shall not affect the repeal of such sections and shall be deemed repealed therewith.

PART E

Intentionally Omitted

PART F

Section 1. Notwithstanding any inconsistent provision of sections 2825-a, 2825-b and 2825-c of the public health law and section 2825-d of the public health law as added by section two of this act, hereinafter referred to as the eligible health care capital programs, and the provisions of any other law to the contrary:

a. The dormitory authority of the state of New York (DASNY) and the department of health (DOH) are authorized to make grants or loans in support of debt restructuring, capital and non-capital projects or purposes from the amounts appropriated for the eligible health care capital programs; provided that such projects or purposes facilitate health care transformation and are intended to create a financially sustainable system of care. Grants or loans shall not be available to support general operating expenses unconnected to such authorized projects or purposes.

b. To the extent that a grant or a loan authorized pursuant to the eligible health care capital programs or this section is determined to not qualify under an eligible health care capital program or cannot be funded with the proceeds of bonds issued pursuant to section 1680-r of the public authorities law, the director of the budget is authorized to make a determination to fund the project or purpose with proceeds of moneys from the New York State Special Infrastructure Account appropriation pursuant to chapter 54 of the laws of 2015, as amended.

c. To the extent that a grant authorized pursuant to the eligible health care capital programs or this section can be funded with the proceeds of bonds issued pursuant to section 1680-r of the public authorities law, the director of the budget is authorized to make a determination to fund the project or purpose with the proceeds of bonds issued pursuant to section 1680-r of the public authorities law and any such projects or purposes shall be approved by the New York state public authorities control board, as required under section 51 of the public authorities law.

d. The total amount of funds awarded may not exceed the total amounts appropriated for the eligible health care capital programs.

e. If DASNY and DOH determine to make funds available in accordance with subdivision a of this section as a loan, the director of the budget is authorized to suballocate such funds to the Health Facility Restructuring Pool and such funds would be used in accordance with section 2815 of the public health law. In no event shall the total of such suballocations exceed ten percent of the total amounts appropriated for the eligible health care capital programs.

f. DASNY and DOH will provide notice to the chair of the senate finance committee and chair of the assembly ways and means committee no later than thirty days prior to making an award pursuant to this act, and such awards shall also be so noted in the quarterly reports required pursuant to each of the eligible health care capital programs.

S 2. The public health law is amended by adding a new section 2825-d to read as follows:

S 2825-D. HEALTH CARE FACILITY TRANSFORMATION PROGRAM: STATEWIDE. 1. A STATEWIDE HEALTH CARE FACILITY TRANSFORMATION PROGRAM IS HEREBY ESTABLISHED UNDER THE JOINT ADMINISTRATION OF THE COMMISSIONER AND THE PRESIDENT OF THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK FOR THE PURPOSE OF STRENGTHENING AND PROTECTING CONTINUED ACCESS TO HEALTH CARE SERVICES IN COMMUNITIES. THE PROGRAM SHALL PROVIDE CAPITAL FUNDING IN SUPPORT OF PROJECTS THAT REPLACE INEFFICIENT AND OUTDATED FACILITIES AS PART OF A MERGER, CONSOLIDATION, ACQUISITION OR OTHER SIGNIFICANT CORPORATE RESTRUCTURING ACTIVITY THAT IS PART OF AN OVERALL TRANSFORMATION PLAN INTENDED TO CREATE A FINANCIALLY SUSTAINABLE SYSTEM OF CARE. THE ISSUANCE OF ANY BONDS OR NOTES HEREUNDER SHALL BE SUBJECT TO SECTION SIXTEEN HUNDRED EIGHTY-R OF THE PUBLIC AUTHORITIES LAW AND THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, AND ANY PROJECTS FUNDED THROUGH THE ISSUANCE OF BONDS OR NOTES HEREUNDER SHALL BE APPROVED BY THE NEW

YORK STATE PUBLIC AUTHORITIES CONTROL BOARD, AS REQUIRED UNDER SECTION FIFTY-ONE OF THE PUBLIC AUTHORITIES LAW.

2. THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY SHALL ENTER INTO AN AGREEMENT, SUBJECT TO APPROVAL BY THE DIRECTOR OF THE BUDGET, AND SUBJECT TO SECTION SIXTEEN HUNDRED EIGHTY-R OF THE PUBLIC AUTHORITIES LAW, FOR THE PURPOSES OF AWARDING, DISTRIBUTING, AND ADMINISTERING THE FUNDS MADE AVAILABLE PURSUANT TO THIS SECTION. SUCH FUNDS MAY BE DISTRIBUTED BY THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY FOR CAPITAL GRANTS TO GENERAL HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS AND CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL HYGIENE LAW, FOR CAPITAL NON-OPERATIONAL WORKS OR PURPOSES THAT SUPPORT THE PURPOSES SET FORTH IN THIS SECTION. A COPY OF SUCH AGREEMENT, AND ANY AMENDMENTS THERETO, SHALL BE PROVIDED TO THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE DIRECTOR OF THE DIVISION OF BUDGET NO LATER THAN THIRTY DAYS PRIOR TO THE RELEASE OF A REQUEST FOR APPLICATIONS FOR FUNDING UNDER THIS PROGRAM. PRIORITY SHALL BE GIVEN TO PROJECTS NOT FUNDED, IN WHOLE OR IN PART, UNDER SECTION TWENTY-EIGHT HUNDRED TWENTY-FIVE OR TWENTY-EIGHT HUNDRED TWENTY-FIVE-C OF THIS ARTICLE. PROJECTS AWARDED, IN WHOLE OR PART, UNDER SECTIONS TWENTY-EIGHT HUNDRED TWENTY-FIVE-A AND TWENTY-EIGHT HUNDRED TWENTY-FIVE-B OF THIS ARTICLE SHALL NOT BE ELIGIBLE FOR GRANTS OR AWARDS MADE AVAILABLE UNDER THIS SECTION.

3. NOTWITHSTANDING SECTION ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW OR ANY INCONSISTENT PROVISION OF LAW TO THE CONTRARY, UP TO TWO HUNDRED MILLION DOLLARS OF THE FUNDS APPROPRIATED FOR THIS PROGRAM SHALL BE AWARDED WITHOUT A COMPETITIVE BID OR REQUEST FOR PROPOSAL PROCESS FOR CAPITAL GRANTS TO HEALTH CARE PROVIDERS (HEREAFTER "APPLICANTS"). PROVIDED HOWEVER THAT A MINIMUM OF THIRTY MILLION DOLLARS OF TOTAL AWARDED FUNDS SHALL BE MADE TO COMMUNITY-BASED HEALTH CARE PROVIDERS, WHICH, FOR PURPOSES OF THIS SECTION SHALL BE DEFINED AS A DIAGNOSTIC AND TREATMENT CENTER LICENSED OR GRANTED AN OPERATING CERTIFICATE UNDER THIS ARTICLE; A MENTAL HEALTH CLINIC LICENSED OR GRANTED AN OPERATING CERTIFICATE UNDER ARTICLE THIRTY-ONE OF THE MENTAL HYGIENE LAW; AN ALCOHOL AND SUBSTANCE ABUSE TREATMENT CLINIC LICENSED OR GRANTED AN OPERATING CERTIFICATE UNDER ARTICLE THIRTY-TWO OF THE MENTAL HYGIENE LAW; PRIMARY CARE PROVIDERS; OR A HOME CARE PROVIDER CERTIFIED OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER. ELIGIBLE APPLICANTS SHALL BE THOSE DEEMED BY THE COMMISSIONER TO BE A PROVIDER THAT FULFILLS OR WILL FULFILL A HEALTH CARE NEED FOR ACUTE INPATIENT, OUTPATIENT, PRIMARY, HOME CARE OR RESIDENTIAL HEALTH CARE SERVICES IN A COMMUNITY.

4. IN DETERMINING AWARDS FOR ELIGIBLE APPLICANTS UNDER THIS SECTION, THE COMMISSIONER AND THE PRESIDENT OF THE AUTHORITY SHALL CONSIDER CRITERIA INCLUDING, BUT NOT LIMITED TO:

(A) THE EXTENT TO WHICH THE PROPOSED CAPITAL PROJECT WILL CONTRIBUTE TO THE INTEGRATION OF HEALTH CARE SERVICES AND LONG TERM SUSTAINABILITY OF THE APPLICANT OR PRESERVATION OF ESSENTIAL HEALTH SERVICES IN THE COMMUNITY OR COMMUNITIES SERVED BY THE APPLICANT;

(B) THE EXTENT TO WHICH THE PROPOSED PROJECT OR PURPOSE IS ALIGNED WITH DELIVERY SYSTEM REFORM INCENTIVE PAYMENT ("DSRIP") PROGRAM GOALS AND OBJECTIVES;

(C) CONSIDERATION OF GEOGRAPHIC DISTRIBUTION OF FUNDS;

(D) THE RELATIONSHIP BETWEEN THE PROPOSED CAPITAL PROJECT AND IDENTIFIED COMMUNITY NEED;

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

(F) THE EXTENT THAT THE PROPOSED CAPITAL PROJECT FURTHERS THE DEVELOPMENT OF PRIMARY CARE AND OTHER OUTPATIENT SERVICES;

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

(H) THE EXTENT TO WHICH THE APPLICANT HAS ENGAGED THE COMMUNITY AFFECTED BY THE PROPOSED CAPITAL PROJECT AND THE MANNER IN WHICH COMMUNITY ENGAGEMENT HAS SHAPED SUCH CAPITAL PROJECT; AND

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

5. DISBURSEMENT OF AWARDS MADE PURSUANT TO THIS SECTION SHALL BE CONDITIONED ON THE AWARDEE ACHIEVING CERTAIN PROCESS AND PERFORMANCE METRICS AND MILESTONES AS DETERMINED IN THE SOLE DISCRETION OF THE COMMISSIONER. SUCH METRICS AND MILESTONES SHALL BE STRUCTURED TO ENSURE THAT THE HEALTH CARE TRANSFORMATION AND PROVIDER SUSTAINABILITY GOALS OF THE PROJECT ARE ACHIEVED, AND SUCH METRICS AND MILESTONES SHALL BE INCLUDED IN GRANT DISBURSEMENT AGREEMENTS OR OTHER CONTRACTUAL DOCUMENTS AS REQUIRED BY THE COMMISSIONER.

6. THE DEPARTMENT SHALL PROVIDE A REPORT ON A QUARTERLY BASIS TO THE CHAIRS OF THE SENATE FINANCE, ASSEMBLY WAYS AND MEANS, SENATE HEALTH AND ASSEMBLY HEALTH COMMITTEES. SUCH REPORTS SHALL BE SUBMITTED NO LATER THAN SIXTY DAYS AFTER THE CLOSE OF THE QUARTER, AND SHALL INCLUDE, FOR EACH AWARD, THE NAME OF THE APPLICANT, A DESCRIPTION OF THE PROJECT OR PURPOSE, THE AMOUNT OF THE AWARD, DISBURSEMENT DATE, AND STATUS OF ACHIEVEMENT OF PROCESS AND PERFORMANCE METRICS AND MILESTONES PURSUANT TO SUBDIVISION FIVE OF THIS SECTION.

S 3. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2016.

PART G

Intentionally Omitted

PART H

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 JJ of chapter 58 of the laws of 2015, 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, [2016] 2019; 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, [2016] 2019.

S 2. The office of mental health shall report on the providers impacted by section one of this act. This information shall be submitted annually to the governor, the temporary president of the senate and the speaker of the assembly no later than December 31st of each year.

S 3. This act shall take effect immediately.

PART I

Section 1. Sections 19 and 21 of chapter 723 of the laws of 1989 amending the mental hygiene law and other laws relating to comprehensive psychiatric emergency programs, as amended by section 1 of part K of chapter 56 of the laws of 2012, are amended to read as follows:

S 19. Notwithstanding any other provision of law, the commissioner of mental health shall, until July 1, [2016] 2020, be solely authorized, in his or her discretion, to designate those general hospitals, local governmental units and voluntary agencies which may apply and be considered for the approval and issuance of an operating certificate pursuant to article 31 of the mental hygiene law for the operation of a comprehensive psychiatric emergency program.

S 21. This act shall take effect immediately, and sections one, two and four through twenty of this act shall remain in full force and effect, until July 1, [2016] 2020, at which time the amendments and additions made by such sections of this act shall be deemed to be repealed, and any provision of law amended by any of such sections of this act shall revert to its text as it existed prior to the effective date of this act.

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, 2016.

PART J

Section 1. Subdivision a of section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work, as amended by section 1 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

a. Nothing in this act shall prohibit or limit the activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the office of temporary and disability assistance, the department of corrections and community supervision, the state office for the aging, the department of health, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, provided, however, this section shall not authorize the use of any title authorized pursuant to article 154 of the education law, except that this section shall be deemed repealed on July 1, [2016] 2018.

S 2. Subdivision a of section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology, as amended by section 2 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

a. In relation to activities and services provided under article 153 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene or the office of children and family

services, or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law. In relation to activities and services provided under article 163 of the education law, nothing in this act shall prohibit or limit such activities or services on the part of any person in the employ of a program or service operated, regulated, funded, or approved by the department of mental hygiene, the office of children and family services, the department of corrections and community supervision, the office of temporary and disability assistance, the state office for the aging and the department of health or a local governmental unit as that term is defined in article 41 of the mental hygiene law or a social services district as defined in section 61 of the social services law, pursuant to authority granted by law. This section shall not authorize the use of any title authorized pursuant to article 153 or 163 of the education law by any such employed person, except as otherwise provided by such articles respectively. This section shall be deemed repealed July 1, [2016] 2018.

S 3. Section 16 of chapter 130 of the laws of 2010 amending the education law and other laws relating to the registration of entities providing certain professional services and the licensure of certain professions, as amended by section 3 of part AA of chapter 57 of the laws of 2013, is amended to read as follows:

S 16. This act shall take effect immediately; provided that sections thirteen, fourteen and fifteen of this act shall take effect immediately and shall be deemed to have been in full force and effect on and after June 1, 2010 and such sections shall be deemed repealed July 1, [2016] 2018; provided further that the amendments to section 9 of chapter 420 of the laws of 2002 amending the education law relating to the profession of social work made by section thirteen of this act shall repeal on the same date as such section repeals; provided further that the amendments to section 17-a of chapter 676 of the laws of 2002 amending the education law relating to the practice of psychology made by section fourteen of this act shall repeal on the same date as such section repeals.

S 4. This act shall take effect immediately.

PART K

Intentionally Omitted

PART L

Section 1. The mental hygiene law is amended by adding a new section 16.25 to read as follows:

S 16.25 TEMPORARY OPERATOR.

(A) FOR THE PURPOSES OF THIS SECTION:

(1) "ESTABLISHED OPERATOR" SHALL MEAN THE PROVIDER OF SERVICES THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE.

(2) "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.

(3) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED MORTGAGE PAYMENTS, MISSED RENT PAYMENTS, A PATTERN OF UNTIMELY PAYMENT

OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM, 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.

(4) "OFFICE" SHALL MEAN THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES.

(5) "TEMPORARY OPERATOR" SHALL MEAN ANY PROVIDER OF SERVICES THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE OR WHICH IS DIRECTLY OPERATED BY THE OFFICE, THAT:

A. AGREES TO PROVIDE SERVICES CERTIFIED PURSUANT TO THIS ARTICLE ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS INDIVIDUALS SERVED BY THE PROGRAM; AND

B. HAS A HISTORY OF COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGULATIONS AND A RECORD OF PROVIDING CARE OF GOOD QUALITY, AS DETERMINED BY THE COMMISSIONER; AND

C. PRIOR TO APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS A PLAN DETERMINED TO BE SATISFACTORY BY THE COMMISSIONER TO ADDRESS THE PROGRAM'S DEFICIENCIES.

(B) (1) IN THE EVENT THAT: (I) THE ESTABLISHED OPERATOR IS SEEKING EXTRAORDINARY FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (III) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR'S BOARD OF DIRECTORS OR ADMINISTRATION IS 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 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 PROVIDER OF SERVICES' OPERATIONS 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.

(2) THE ESTABLISHED OPERATOR 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 INDIVIDUALS UNTIL THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS WITHIN THE DESIGNATED TIME PERIOD OR OTHER ACTION IS TAKEN AS DESCRIBED IN SECTION 16.17 OF THIS ARTICLE.

(C) (1) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE COMMUNITY SERVED BY THE PROVIDER OF SERVICES.

(2) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECESSARY TO APPROPRIATELY PROVIDE SERVICES FOR INDIVIDUALS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, PROVIDE SERVICES IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF SERVICES IN THE COMMUNITY SERVED BY THE ESTABLISHED OPERATOR UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME OPERATIONS OR UNTIL THE OFFICE REVOKES THE OPERATING CERTIFICATE FOR THE SERVICES ISSUED UNDER THIS ARTICLE.

(3) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY OPERATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO

ADDRESS ANY DEFICIENCIES RELATED TO THE PROGRAM EXPERIENCING SERIOUS FINANCIAL INSTABILITY OR AN ESTABLISHED OPERATOR REQUESTING FINANCIAL ASSISTANCE IN ACCORDANCE WITH THIS SECTION. THE TEMPORARY OPERATOR SHALL APPROVE ANY FINANCIAL DECISION RELATED TO AN ESTABLISHED PROVIDER'S DAY TO DAY OPERATIONS OR THE ESTABLISHED PROVIDER'S ABILITY TO PROVIDE SERVICES.

(4) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTABLISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY FIXTURE OF THE PROGRAM, 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.

(D) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR FOR INJURY TO PERSON AND PROPERTY BY REASON OF ITS OPERATION OF SUCH PROGRAM; NO LIABILITY SHALL INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

(E) (1) 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, 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.

(2) 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:

A. THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED PROGRAM DEFICIENCIES, THE RESUMPTION OF PROGRAM OPERATIONS BY THE ESTABLISHED OPERATOR, OR THE REVOCATION OF AN OPERATING CERTIFICATE ISSUED BY THE OFFICE;

B. OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

C. IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING PROVISION OF SERVICES SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

(3) 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.

(F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF SUBDIVISION (B) OF THIS SECTION, CAUSE THE ESTABLISHED OPERATOR 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.

(2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE 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.

(3) IF THE DECISION TO APPOINT A TEMPORARY OPERATOR IS UPHELD SUCH TEMPORARY OPERATOR SHALL BE APPOINTED AS SOON AS IS PRACTICABLE AND SHALL PROVIDE SERVICES PURSUANT TO THE PROVISIONS OF THIS SECTION.

(G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED PROVISION OF SERVICES. 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.

(H) UPON APPOINTMENT OF A TEMPORARY OPERATOR, THE COMMISSIONER SHALL CAUSE THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE CHAIRS OF THE SENATE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES COMMITTEE AND THE ASSEMBLY MENTAL HEALTH COMMITTEE TO BE NOTIFIED OF SUCH DETERMINATION. SUCH NOTIFICATION SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NAME OF THE ESTABLISHED OPERATOR, THE NAME OF THE APPOINTED TEMPORARY OPERATOR AND A DESCRIPTION OF THE REASONS FOR SUCH DETERMINATION TO THE EXTENT PRACTICABLE UNDER THE CIRCUMSTANCES AND IN THE SOLE DISCRETION OF THE COMMISSIONER.

S 2. The mental hygiene law is amended by adding a new section 31.20 to read as follows:

S 31.20 TEMPORARY OPERATOR.

(A) FOR THE PURPOSES OF THIS SECTION:

(1) "ESTABLISHED OPERATOR" SHALL MEAN THE OPERATOR OF A MENTAL HEALTH PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE.

(2) "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.

(3) "MENTAL HEALTH PROGRAM" SHALL MEAN A PROVIDER OF SERVICES FOR PERSONS WITH SERIOUS MENTAL ILLNESS, AS SUCH TERMS ARE DEFINED IN

SECTION 1.03 OF THIS CHAPTER, WHICH IS LICENSED OR OPERATED BY THE OFFICE.

(4) "OFFICE" SHALL MEAN THE OFFICE OF MENTAL HEALTH.

(5) "SERIOUS FINANCIAL INSTABILITY" SHALL INCLUDE BUT NOT BE LIMITED TO DEFAULTING OR VIOLATING MATERIAL COVENANTS OF BOND ISSUES, MISSED MORTGAGE PAYMENTS, A PATTERN OF UNTIMELY PAYMENT OF DEBTS, FAILURE TO PAY ITS EMPLOYEES OR VENDORS, INSUFFICIENT FUNDS TO MEET THE GENERAL OPERATING EXPENSES OF THE PROGRAM, 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.

(6) "TEMPORARY OPERATOR" SHALL MEAN ANY OPERATOR OF A MENTAL HEALTH PROGRAM THAT HAS BEEN ESTABLISHED AND ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE OR WHICH IS DIRECTLY OPERATED BY THE OFFICE OF MENTAL HEALTH, THAT:

A. AGREES TO OPERATE A MENTAL HEALTH PROGRAM ON A TEMPORARY BASIS IN THE BEST INTERESTS OF ITS PATIENTS SERVED BY THE PROGRAM; AND

B. HAS A HISTORY OF COMPLIANCE WITH APPLICABLE LAWS, RULES, AND REGULATIONS AND A RECORD OF PROVIDING CARE OF GOOD QUALITY, AS DETERMINED BY THE COMMISSIONER; AND

C. PRIOR TO APPOINTMENT AS TEMPORARY OPERATOR, DEVELOPS A PLAN DETERMINED TO BE SATISFACTORY BY THE COMMISSIONER TO ADDRESS THE PROGRAM'S DEFICIENCIES.

(B) (1) IN THE EVENT THAT: (I) THE ESTABLISHED OPERATOR IS SEEKING EXTRAORDINARY FINANCIAL ASSISTANCE; (II) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR IS EXPERIENCING SERIOUS FINANCIAL INSTABILITY ISSUES; (III) OFFICE COLLECTED DATA DEMONSTRATES THAT THE ESTABLISHED OPERATOR'S BOARD OF DIRECTORS OR ADMINISTRATION IS 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 MENTAL HEALTH 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 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.

(2) THE ESTABLISHED OPERATOR 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 MENTAL HEALTH PROGRAMS OPERATED OR LICENSED BY THE OFFICE; OR THE OPERATIONS OF THE MENTAL HEALTH PROGRAM SHOULD BE COMPLETELY DISCONTINUED.

(C) (1) A TEMPORARY OPERATOR APPOINTED PURSUANT TO THIS SECTION SHALL USE HIS OR HER BEST EFFORTS TO IMPLEMENT THE PLAN DEEMED SATISFACTORY BY THE COMMISSIONER TO CORRECT OR ELIMINATE ANY DEFICIENCIES IN THE MENTAL HEALTH PROGRAM AND TO PROMOTE THE QUALITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES IN THE COMMUNITY SERVED BY THE MENTAL HEALTH PROGRAM.

(2) IF THE IDENTIFIED DEFICIENCIES CANNOT BE ADDRESSED IN THE TIME PERIOD DESIGNATED IN THE PLAN, THE PATIENTS SHALL BE TRANSFERRED TO OTHER APPROPRIATE MENTAL HEALTH PROGRAMS LICENSED OR OPERATED BY THE OFFICE.

(3) DURING THE TERM OF APPOINTMENT, THE TEMPORARY OPERATOR SHALL HAVE THE AUTHORITY TO DIRECT THE STAFF OF THE ESTABLISHED OPERATOR AS NECESSARY TO APPROPRIATELY TREAT AND/OR TRANSFER THE PATIENTS. THE TEMPORARY OPERATOR SHALL, DURING THIS PERIOD, OPERATE THE MENTAL HEALTH PROGRAM IN SUCH A MANNER AS TO PROMOTE SAFETY AND THE QUALITY AND ACCESSIBILITY OF MENTAL HEALTH SERVICES IN THE COMMUNITY SERVED BY THE ESTABLISHED OPERATOR UNTIL EITHER THE ESTABLISHED OPERATOR CAN RESUME PROGRAM OPERATIONS OR UNTIL THE PATIENTS ARE APPROPRIATELY TRANSFERRED TO OTHER PROGRAMS LICENSED OR OPERATED BY THE OFFICE.

(4) THE ESTABLISHED OPERATOR SHALL GRANT ACCESS TO THE TEMPORARY OPERATOR TO THE ESTABLISHED OPERATOR'S ACCOUNTS AND RECORDS IN ORDER TO ADDRESS ANY DEFICIENCIES RELATED TO A MENTAL HEALTH PROGRAM EXPERIENCING SERIOUS FINANCIAL INSTABILITY OR AN ESTABLISHED OPERATOR 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 MENTAL HEALTH SERVICES.

(5) THE TEMPORARY OPERATOR SHALL NOT BE REQUIRED TO FILE ANY BOND. NO SECURITY INTEREST IN ANY REAL OR PERSONAL PROPERTY COMPRISING THE ESTABLISHED OPERATOR OR CONTAINED WITHIN THE ESTABLISHED OPERATOR OR IN ANY FIXTURE OF THE MENTAL HEALTH PROGRAM, 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.

(D) THE TEMPORARY OPERATOR SHALL BE ENTITLED TO A REASONABLE FEE, AS DETERMINED BY THE COMMISSIONER AND SUBJECT TO THE APPROVAL OF THE DIRECTOR OF THE DIVISION OF THE BUDGET, AND NECESSARY EXPENSES INCURRED WHILE SERVING AS A TEMPORARY OPERATOR. THE TEMPORARY OPERATOR SHALL BE LIABLE ONLY IN ITS CAPACITY AS TEMPORARY OPERATOR OF THE MENTAL HEALTH PROGRAM FOR INJURY TO PERSON AND PROPERTY BY REASON OF ITS OPERATION OF SUCH PROGRAM; NO LIABILITY SHALL INCUR IN THE TEMPORARY OPERATOR'S PERSONAL CAPACITY, EXCEPT FOR GROSS NEGLIGENCE AND INTENTIONAL ACTS.

(E) (1) 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, MENTAL 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.

(2) 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:

A. THE ACTIONS TAKEN DURING THE APPOINTMENT TO ADDRESS THE IDENTIFIED MENTAL HEALTH PROGRAM DEFICIENCIES, THE RESUMPTION OF MENTAL HEALTH PROGRAM OPERATIONS BY THE ESTABLISHED OPERATOR, OR THE TRANSFER OF THE PATIENTS TO OTHER PROVIDERS LICENSED OR OPERATED BY THE OFFICE;

B. OBJECTIVES FOR THE CONTINUATION OF THE TEMPORARY OPERATORSHIP IF NECESSARY AND A SCHEDULE FOR SATISFACTION OF SUCH OBJECTIVES; AND

C. IF APPLICABLE, THE RECOMMENDED ACTIONS FOR THE ONGOING OPERATION OF THE MENTAL HEALTH PROGRAM SUBSEQUENT TO THE TEMPORARY OPERATORSHIP.

(3) 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.

(F) (1) THE COMMISSIONER SHALL, UPON MAKING A DETERMINATION OF AN INTENTION TO APPOINT A TEMPORARY OPERATOR PURSUANT TO PARAGRAPH ONE OF SUBDIVISION (B) OF THIS SECTION CAUSE THE ESTABLISHED OPERATOR 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.

(2) SHOULD THE COMMISSIONER AND THE ESTABLISHED OPERATOR BE UNABLE TO ESTABLISH A PLAN OF CORRECTION PURSUANT TO PARAGRAPH ONE 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.

(3) 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 MENTAL HEALTH PROGRAM PURSUANT TO THE PROVISIONS OF THIS SECTION.

(G) NOTWITHSTANDING THE APPOINTMENT OF A TEMPORARY OPERATOR, THE ESTABLISHED OPERATOR SHALL REMAIN OBLIGATED FOR THE CONTINUED OPERATION OF THE MENTAL HEALTH PROGRAM SO THAT SUCH 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.

(H) UPON APPOINTMENT OF A TEMPORARY OPERATOR, THE COMMISSIONER SHALL CAUSE THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE CHAIRS OF THE SENATE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES COMMITTEE AND THE ASSEMBLY MENTAL HEALTH COMMITTEE TO BE NOTIFIED OF SUCH DETERMINATION. SUCH NOTIFICATION SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NAME OF THE ESTABLISHED OPERATOR, THE NAME OF THE APPOINTED TEMPORARY OPERATOR AND A DESCRIPTION OF THE REASONS FOR SUCH

DETERMINATION TO THE EXTENT PRACTICABLE UNDER THE CIRCUMSTANCES AND IN THE SOLE DISCRETION OF THE COMMISSIONER.

S 3. Subdivision 6 of section 32.20 of the mental hygiene law is amended by adding a new paragraph (d) to read as follows:

(D) UPON APPOINTMENT OF A TEMPORARY OPERATOR, THE COMMISSIONER SHALL CAUSE THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE CHAIRS OF THE SENATE AND ASSEMBLY COMMITTEES ON ALCOHOLISM AND DRUG ABUSE TO BE NOTIFIED OF SUCH DETERMINATION. SUCH NOTIFICATION SHALL INCLUDE, BUT NOT BE LIMITED TO, THE NAME OF THE ESTABLISHED OPERATOR, THE NAME OF THE APPOINTED TEMPORARY OPERATOR AND A DESCRIPTION OF THE REASONS FOR SUCH DETERMINATION TO THE EXTENT PRACTICABLE UNDER THE CIRCUMSTANCES AND IN THE SOLE DISCRETION OF THE COMMISSIONER.

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, 2016; provided, however, that sections one and two of this act shall expire and be deemed repealed on March 31, 2021.

PART M

Section 1. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by section 3 of part E of chapter 111 of the laws of 2010, is amended to read as follows:

(d) Nothing in this section shall prevent the electronic or other exchange of information concerning patients or clients, including identification, between and among (i) facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one of this chapter, or pursuant to agreement with the department, and (ii) the department or any of its licensed or operated facilities. NEITHER SHALL ANYTHING IN THIS SECTION PREVENT THE EXCHANGE OF INFORMATION CONCERNING PATIENTS OR CLIENTS, INCLUDING IDENTIFICATION, BETWEEN FACILITIES AND MANAGED CARE ORGANIZATIONS, BEHAVIORAL HEALTH ORGANIZATIONS, HEALTH HOMES OR OTHER ENTITIES AUTHORIZED BY THE DEPARTMENT OR THE DEPARTMENT OF HEALTH TO PROVIDE, ARRANGE FOR OR COORDINATE HEALTH CARE SERVICES FOR SUCH PATIENTS OR CLIENTS WHO ARE ENROLLED IN OR RECEIVING SERVICES FROM SUCH ORGANIZATIONS OR ENTITIES. PROVIDED HOWEVER, WRITTEN PATIENT OR CLIENT CONSENT SHALL BE OBTAINED PRIOR TO THE EXCHANGE OF INFORMATION WHERE REQUIRED BY 42 USC 290DD-2 AS AMENDED, AND ANY REGULATIONS PROMULGATED THEREUNDER. Furthermore, subject to the prior approval of the commissioner of mental health, hospital emergency services licensed pursuant to article twenty-eight of the public health law shall be authorized to exchange information concerning patients or clients electronically or otherwise with other hospital emergency services licensed pursuant to article twenty-eight of the public health law and/or hospitals licensed or operated by the office of mental health; provided that such exchange of information is consistent with standards, developed by the commissioner of mental health, which are designed to ensure confidentiality of such information. Additionally, information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

S 2. Subdivision (d) of section 33.13 of the mental hygiene law, as amended by section 4 of part E of chapter 111 of the laws of 2010, is amended to read as follows:

(d) Nothing in this section shall prevent the exchange of information concerning patients or clients, including identification, between (i)

facilities or others providing services for such patients or clients pursuant to an approved local services plan, as defined in article forty-one, or pursuant to agreement with the department and (ii) the department or any of its facilities. NEITHER SHALL ANYTHING IN THIS SECTION PREVENT THE EXCHANGE OF INFORMATION CONCERNING PATIENTS OR CLIENTS, INCLUDING IDENTIFICATION, BETWEEN FACILITIES AND MANAGED CARE ORGANIZATIONS, BEHAVIORAL HEALTH ORGANIZATIONS, HEALTH HOMES OR OTHER ENTITIES AUTHORIZED BY THE DEPARTMENT OR THE DEPARTMENT OF HEALTH TO PROVIDE, ARRANGE FOR OR COORDINATE HEALTH CARE SERVICES FOR SUCH PATIENTS OR CLIENTS WHO ARE ENROLLED IN OR RECEIVING SERVICES FROM SUCH ORGANIZATIONS OR ENTITIES. PROVIDED HOWEVER, WRITTEN PATIENT OR CLIENT CONSENT SHALL BE OBTAINED PRIOR TO THE EXCHANGE OF INFORMATION WHERE REQUIRED BY 42 USC 290DD-2 AS AMENDED, AND ANY REGULATIONS PROMULGATED THEREUNDER. Information so exchanged shall be kept confidential and any limitations on the release of such information imposed on the party giving the information shall apply to the party receiving the information.

S 3. Subdivision (f) of section 33.13 of the mental hygiene law, as amended by chapter 330 of the laws of 1993, is amended to read as follows:

(f) ALL RECORDS OF IDENTITY, DIAGNOSIS, PROGNOSIS, TREATMENT, CARE COORDINATION OR ANY OTHER INFORMATION CONTAINED IN A PATIENT OR CLIENT'S RECORD SHALL BE CONFIDENTIAL UNLESS DISCLOSURE IS PERMITTED UNDER SUBDIVISION (C) OF THIS SECTION. Any disclosure made pursuant to this section shall be limited to that information necessary AND REQUIRED in light of the reason for disclosure. Information so disclosed shall be kept confidential by the party receiving such information and the limitations on disclosure in this section shall apply to such party. Except for disclosures made to the mental hygiene legal service, to persons reviewing information or records in the ordinary course of insuring that a facility is in compliance with applicable quality of care standards, or to governmental agents requiring information necessary for payments to be made to or on behalf of patients or clients pursuant to contract or in accordance with law, a notation of all such disclosures shall be placed in the clinical record of that individual who shall be informed of all such disclosures upon request; provided, however, that for disclosures made to insurance companies licensed pursuant to the insurance law, such a notation need only be entered at the time the disclosure is first made.

S 4. This act shall take effect immediately; provided that the amendments to subdivision (d) of section 33.13 of the mental hygiene law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 18 of chapter 408 of the laws of 1999, as amended, when upon such date the provisions of section two of this act shall take effect.

PART N

Section 1. Subdivision 10 of section 3 of section 1 of chapter 359 of the laws of 1968, constituting the facilities development corporation act, as amended by chapter 723 of the laws of 1993, is amended to read as follows:

10. "Mental hygiene facility" shall mean a building, a unit within a building, a laboratory, a classroom, a housing unit, a dining hall, an activities center, a library, real property of any kind or description, or any structure on or improvement to real property, or an interest in

real property, of any kind or description, owned by or under the jurisdiction of the corporation, including fixtures and equipment which are an integral part of any such building, unit, structure or improvement, a walkway, a roadway or a parking lot, and improvements and connections for water, sewer, gas, electrical, telephone, heating, air conditioning and other utility services, or a combination of any of the foregoing, whether for patient care and treatment or staff, staff family or service use, located at or related to any psychiatric center, any developmental center, or any state psychiatric or research institute or other facility now or hereafter established under the department. A mental hygiene facility shall also mean and include a residential care center for adults, a "community mental health and retardation facility" and a treatment facility for use in the conduct of an alcoholism or substance abuse treatment program as defined in the mental hygiene law unless such residential care center for adults, community mental health and retardation facility or alcoholism or substance abuse facility is expressly excepted, or the context clearly requires otherwise, AND SHALL ALSO MEAN AND INCLUDE ANY TREATMENT FACILITY FOR USE IN THE CONDUCT OF AN ALCOHOLISM OR SUBSTANCE ABUSE TREATMENT PROGRAM THAT IS ALSO OPERATED AS AN ASSOCIATED HEALTH CARE FACILITY. The definition contained in this subdivision shall not be construed to exclude therefrom a facility owned or leased by one or more voluntary agencies that is to be financed, refinanced, designed, constructed, acquired, reconstructed, rehabilitated or improved under any lease, sublease, loan or other financing agreement entered into with such voluntary agencies, and shall not be construed to exclude therefrom a facility to be made available from the corporation to a voluntary agency at the request of the commissioners of the offices of the department having jurisdiction thereof. The definition contained in this subdivision shall not be construed to exclude therefrom a facility with respect to which a voluntary agency has an ownership interest in, and proprietary lease from, an organization formed for the purpose of the cooperative ownership of real estate.

S 2. Section 3 of section 1 of chapter 359 of the laws of 1968, constituting the facilities development corporation act, is amended by adding a new subdivision 20 to read as follows:

20. "ASSOCIATED HEALTH CARE FACILITY" SHALL MEAN A FACILITY LICENSED UNDER AND OPERATED PURSUANT TO ARTICLE 28 OF THE PUBLIC HEALTH LAW OR ANY HEALTH CARE FACILITY LICENSED UNDER AND OPERATED IN ACCORDANCE WITH ANY OTHER PROVISIONS OF THE PUBLIC HEALTH LAW OR THE MENTAL HYGIENE LAW THAT PROVIDES HEALTH CARE SERVICES AND/OR TREATMENT TO ALL PERSONS, REGARDLESS OF WHETHER SUCH PERSONS ARE PERSONS RECEIVING TREATMENT OR SERVICES FOR ALCOHOL, SUBSTANCE ABUSE, OR CHEMICAL DEPENDENCY.

S 3. This act shall take effect immediately.

PART O

Section 1. On or before October 1, 2016, the commissioner of developmental disabilities shall issue a report to the temporary president of the senate and the speaker of the assembly to include the following:

(a) Progress the office has made in meeting the housing needs of individuals with developmental disabilities, including through:

(1) its ongoing review of the residential registration list, including information regarding services currently provided to individuals on the list and any available information on priority placement approaches and housing needs for such individuals;

(2) increasing access to rental housing, supportive housing, and other independent living options;
(3) building understanding and awareness of housing options for independent living among people with developmental disabilities, families, public and private organizations, developers and direct support professionals; and
(4) assisting with the creation of a sustainable living environment through funding for home modifications, down payment assistance and home repairs; and
(b) An update on the implementation of the report and recommendations of the transformation panel, including implementation of the panel's recommendations to:
(1) increase and support access to self-directed models of care;
(2) enhance opportunities for individuals to access community integrated housing;
(3) increase integrated employment opportunities; and
(4) examine the program design and fiscal model for managed care to appropriately address the needs of individuals with developmental disabilities.
S 2. This act shall take effect immediately; provided, however, that this act shall be subject to appropriations made specifically available for this purpose and shall expire and be deemed repealed April 1, 2017.

PART P

Section 1. Section 13.41 of the mental hygiene law, as added by section 1 of part E of chapter 60 of the laws of 2014, is amended by adding two new subdivisions (d) and (e) to read as follows:
(D) INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES WHO WERE EMPLOYED IN SHELTERED WORKSHOPS ON OR AFTER JULY FIRST, TWO THOUSAND THIRTEEN WHO ARE NOT INTERESTED IN WORKING OR WHO ARE NOT ABLE TO WORK IN A PROVIDER-OWNED BUSINESS OR PRIVATE BUSINESS IN THE COMMUNITY SHALL, TO THE EXTENT PRACTICABLE AND IN ACCORDANCE WITH THE PRINCIPLES OF PERSON-CENTERED PLANNING, BE AFFORDED THE OPTION OF RECEIVING OTHER SERVICES OF THE OFFICE, INCLUDING, BUT NOT LIMITED TO PATHWAY TO EMPLOYMENT, COMMUNITY PREVOCATIONAL, DAY HABILITATION, COMMUNITY HABILITATION AND SELF-DIRECTED SERVICES. THE PROVISION OF SUCH SERVICES SHALL CONSIDER, BUT NOT BE LIMITED TO, THE FOLLOWING FACTORS:
(1) ASSESSMENT OF THE INDIVIDUAL'S SKILLS, INCLUDING SOCIAL BEHAVIOR, ABILITY TO HANDLE STRESS, ABILITY TO WORK WITH OTHERS, JOB PERFORMANCE, COMMUNICATION SKILLS, WORK ETHIC, AND INTERESTS;
(2) ASSESSMENT OF THE INDIVIDUAL'S SITUATION, INCLUDING TRANSPORTATION NEEDS, FAMILY SUPPORTS, AND PHYSICAL AND MENTAL HEALTH; AND
(3) CREATION OF OPPORTUNITIES TO EXPLORE DIFFERENT COMMUNITY AND VOLUNTEER EXPERIENCES TO OBTAIN INFORMATION THAT WILL BE USED TO CREATE A PERSON-CENTERED PLAN.
(E) FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES WHO WERE EMPLOYED IN SHELTERED WORKSHOPS ON OR AFTER JULY FIRST, TWO THOUSAND THIRTEEN INTERESTED IN RETIREMENT, OFFICE SERVICES SHALL FOCUS ON CONNECTING INDIVIDUALS TO RETIREMENT-RELATED ACTIVITIES, INCLUDING PARTICIPATING IN SENIOR AND COMMUNITY CENTER ACTIVITIES, AND OTHER LOCAL ACTIVITIES FOR RETIREES.
S 2. This act shall take effect immediately.

PART Q

Section 1. Section 13.17 of the mental hygiene law is amended by adding a new subdivision (d) to read as follows:

(D) IN THE EVENT OF A CLOSURE OR TRANSFER OF A STATE-OPERATED INDIVIDUALIZED RESIDENTIAL ALTERNATIVE (IRA), THE COMMISSIONER SHALL:

1. PROVIDE APPROPRIATE AND TIMELY NOTIFICATION TO THE TEMPORARY PRESIDENT OF THE SENATE, AND THE SPEAKER OF THE ASSEMBLY, AND TO APPROPRIATE REPRESENTATIVES OF IMPACTED LABOR ORGANIZATIONS. SUCH NOTIFICATION TO THE REPRESENTATIVES OF IMPACTED LABOR ORGANIZATIONS SHALL BE MADE AS SOON AS PRACTICABLE, BUT NO LESS THAN FORTY-FIVE DAYS PRIOR TO SUCH CLOSURE OR TRANSFER EXCEPT IN THE CASE OF EXIGENT CIRCUMSTANCES IMPACTING THE HEALTH, SAFETY, OR WELFARE OF THE RESIDENTS OF THE IRA AS DETERMINED BY THE OFFICE. PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL LIMIT THE ABILITY OF THE OFFICE TO EFFECTUATE SUCH CLOSURE OR TRANSFER; AND

2. MAKE REASONABLE EFFORTS TO CONFER WITH THE AFFECTED WORKFORCE AND ANY OTHER PARTY HE OR SHE DEEMS APPROPRIATE TO INFORM SUCH AFFECTED WORKFORCE, THE RESIDENTS OF THE IRA, AND THEIR FAMILY MEMBERS, WHERE APPROPRIATE, OF THE PROPOSED CLOSURE OR TRANSFER PLAN.

S 2. This act shall take effect immediately and shall expire and be deemed repealed March 31, 2018.

PART R

Section 1. Section 281 of the public health law is amended by adding a new subdivision 7 to read as follows:

7. NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION OR ANY OTHER LAW TO THE CONTRARY, A PRACTITIONER SHALL NOT BE REQUIRED TO ISSUE PRESCRIPTIONS ELECTRONICALLY IF HE OR SHE CERTIFIES TO THE DEPARTMENT, IN A MANNER SPECIFIED BY THE DEPARTMENT, THAT HE OR SHE WILL NOT ISSUE MORE THAN TWENTY-FIVE PRESCRIPTIONS DURING A TWELVE MONTH PERIOD. PRESCRIPTIONS IN BOTH ORAL AND WRITTEN FORM FOR BOTH CONTROLLED SUBSTANCES AND NON-CONTROLLED SUBSTANCES SHALL BE INCLUDED IN DETERMINING WHETHER THE PRACTITIONER WILL REACH THE LIMIT OF TWENTY-FIVE PRESCRIPTIONS.

(A) A CERTIFICATION SHALL BE SUBMITTED IN ADVANCE OF THE TWELVE-MONTH CERTIFICATION PERIOD, EXCEPT THAT A TWELVE-MONTH CERTIFICATION SUBMITTED ON OR BEFORE JULY FIRST, TWO THOUSAND SIXTEEN, MAY BEGIN MARCH TWENTY-SEVEN, TWO THOUSAND SIXTEEN.

(B) A PRACTITIONER WHO HAS MADE A CERTIFICATION UNDER THIS SUBDIVISION MAY SUBMIT AN ADDITIONAL CERTIFICATION ON OR BEFORE THE EXPIRATION OF THE CURRENT TWELVE-MONTH CERTIFICATION PERIOD, FOR A MAXIMUM OF THREE TWELVE-MONTH CERTIFICATIONS.

(C) A PRACTITIONER MAY MAKE A CERTIFICATION UNDER THIS SUBDIVISION REGARDLESS OF WHETHER HE OR SHE HAS PREVIOUSLY RECEIVED A WAIVER UNDER PARAGRAPH (C) OF SUBDIVISION THREE OF THIS SECTION.

S 2. Section 6810 of the education law is amended by adding a new subdivisions 15 to read as follows:

15. NOTWITHSTANDING ANY OTHER PROVISIONS OF THIS SECTION OR ANY OTHER LAW TO THE CONTRARY, A PRACTITIONER SHALL NOT BE REQUIRED TO ISSUE PRESCRIPTIONS ELECTRONICALLY IF HE OR SHE CERTIFIES TO THE DEPARTMENT OF HEALTH, IN A MANNER SPECIFIED BY THE DEPARTMENT OF HEALTH, THAT HE OR SHE WILL NOT ISSUE MORE THAN TWENTY-FIVE PRESCRIPTIONS DURING A TWELVE MONTH PERIOD. PRESCRIPTIONS IN BOTH ORAL AND WRITTEN FORM FOR BOTH CONTROLLED SUBSTANCES AND NON-CONTROLLED SUBSTANCES SHALL BE INCLUDED IN DETERMINING WHETHER THE PRACTITIONER WILL REACH THE LIMIT OF TWENTY-FIVE PRESCRIPTIONS.

(A) A CERTIFICATION SHALL BE SUBMITTED IN ADVANCE OF THE TWELVE-MONTH CERTIFICATION PERIOD, EXCEPT THAT A TWELVE-MONTH CERTIFICATION SUBMITTED ON OR BEFORE ON JULY FIRST,TWO THOUSAND SIXTEEN, MAY BEGIN MARCH TWENTY-SEVENTH, TWO THOUSAND SIXTEEN.

(B) A PRACTITIONER WHO HAS MADE A CERTIFICATION UNDER THIS SUBDIVISION MAY SUBMIT AN ADDITIONAL CERTIFICATION ON OR BEFORE THE EXPIRATION OF THE CURRENT TWELVE-MONTH CERTIFICATION PERIOD, FOR A MAXIMUM OF THREE TWELVE-MONTH CERTIFICATIONS.

(C) A PRACTITIONER MAY MAKE A CERTIFICATION UNDER THIS SUBDIVISION REGARDLESS OF WHETHER HE OR SHE HAS PREVIOUSLY RECEIVED A WAIVER UNDER PARAGRAPHS (C) OF SUBDIVISION TEN OF THIS SECTION.

S 3. Section 2807-m of the public health law is amended by adding a new subdivision 12 to read as follows:

12. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, APPLICATIONS SUBMITTED ON OR AFTER APRIL FIRST, TWO THOUSAND SIXTEEN, FOR THE PHYSICIAN LOAN REPAYMENT PROGRAM PURSUANT TO PARAGRAPH (D) OF SUBDIVISION FIVE-A OF THIS SECTION AND SUBDIVISION TEN OF THIS SECTION OR THE PHYSICIAN PRACTICE SUPPORT PROGRAM PURSUANT TO PARAGRAPH (E) OF SUBDIVISION FIVE-A OF THIS SECTION, SHALL BE SUBJECT TO THE FOLLOWING CHANGES:

(A) AWARDS SHALL BE MADE FROM THE TOTAL FUNDING AVAILABLE FOR NEW AWARDS UNDER THE PHYSICIAN LOAN REPAYMENT PROGRAM AND THE PHYSICIAN PRACTICE SUPPORT PROGRAM, WITH NEITHER PROGRAM LIMITED TO A SPECIFIC FUNDING AMOUNT WITHIN SUCH TOTAL FUNDING AVAILABLE;

(B) AN APPLICANT MAY APPLY FOR AN AWARD FOR EITHER PHYSICIAN LOAN REPAYMENT OR PHYSICIAN PRACTICE SUPPORT, BUT NOT BOTH;

(C) AN APPLICANT SHALL AGREE TO PRACTICE FOR THREE YEARS IN AN UNDERSERVED AREA AND EACH AWARD SHALL PROVIDE UP TO FORTY THOUSAND DOLLARS FOR EACH OF THE THREE YEARS; AND

(D) TO THE EXTENT PRACTICABLE, AWARDS SHALL BE TIMED TO BE OF USE FOR JOB OFFERS MADE TO APPLICANTS.

S 4. Subdivisions 1 and 4 of section 461-s of the social services law, subdivision 1 as added by section 21 of part D of chapter 56 of the laws of 2012 and subdivision 4 as added by section 6 of part A of chapter 57 of the laws of 2015, are amended to read as follows:

1. The commissioner of health shall establish the enhanced quality of adult living program (referred to in this section as the "EQUAL program" or the "program") for adult care facilities. The program shall be targeted at improving the quality of life for adult care facility residents by means of grants to facilities for specified purposes. The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility as well as resident needs. ON OR BEFORE JUNE FIRST OF EACH YEAR, THE DEPARTMENT SHALL MAKE AVAILABLE THE APPLICATION FOR EQUAL PROGRAM FUNDS.

4. EQUAL program funds shall not be expended for a facility's daily operating expenses, including employee salaries or benefits, or for expenses incurred retrospectively, EXCEPT THAT EXPENDITURES MAY BE INCURRED PRIOR TO THE APPROVAL OF THE FACILITY'S APPLICATION FOR SUCH FISCAL YEAR, PROVIDED THAT: (A) CONSISTENT WITH SUBDIVISION THREE OF THIS SECTION, THE RESIDENTS' COUNCIL APPROVES SUCH EXPENDITURE PRIOR TO THE EXPENDITURE BEING INCURRED, AND THE FACILITY PROVIDES WITH ITS APPLICATION DOCUMENTATION OF SUCH APPROVAL AND THE DATE THEREOF; AND (B) THE EXPENDITURE MEETS ALL APPLICABLE REQUIREMENTS PURSUANT TO THIS SECTION AND IS SUBSEQUENTLY APPROVED BY THE DEPARTMENT. EQUAL program funds may be used for expenditures related to corrective action as

required by an inspection report, provided such expenditure is consistent with subdivision three of this section.

S 5. Section 616 of the public health law is amended by adding a new subdivision 3 to read as follows:

3. ADMINISTRATIVE POLICY CHANGES RELATING TO STATE AID SHALL NOT BE IMPLEMENTED WITHOUT REASONABLE AND STATEWIDE ADVANCE WRITTEN NOTICE TO MUNICIPALITIES.

S 6. Subdivision 2 of section 2802 of the public health law, as amended by section 58 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

2. The commissioner shall not act upon an application for construction of a hospital until the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations, and unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health and health planning council pursuant to the provisions of this article) provided, however, that the commissioner may act upon an application for construction by an applicant possessing a valid operating certificate when the application qualifies for review without the recommendation of the council pursuant to regulations adopted by the council and approved by the commissioner, OR AS OTHERWISE AUTHORIZED BY THIS SECTION; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that, in the case of an application by a hospital established or operated by an organization defined in subdivision one of section four hundred eighty-two-b of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need.

S 7. Section 2802 of the public health law is amended by adding a new subdivision 2-c to read as follows:

2-C. AN APPLICATION FOR THE RELOCATION OF LONG-TERM VENTILATOR BEDS FROM ONE RESIDENTIAL HEALTH CARE FACILITY TO ANOTHER RESIDENTIAL HEALTH CARE FACILITY WITH COMMON OWNERSHIP SHALL BE SUBJECT, AS DETERMINED BY THE COMMISSIONER, TO EITHER AN ADMINISTRATIVE OR LIMITED REVIEW BY THE DEPARTMENT. COMMON OWNERSHIP SHALL BE FOUND WHEN THE OWNERSHIP OR CONTROLLING INTEREST IN THE OPERATOR OF EACH RESIDENTIAL HEALTH CARE FACILITY IS THE SAME, PROVIDED THE PERCENTAGE OF OWNERSHIP INTEREST OF EACH OWNER MAY VARY BETWEEN THE TWO FACILITIES BUT MUST MEET THE WHOLE IN COMMON OWNERSHIP. FOR PURPOSES OF THIS SUBDIVISION, THE COMMISSIONER, WHEN MAKING A DETERMINATION OF PUBLIC NEED, MAY CONSIDER ACCESS TO LONG-TERM VENTILATOR BEDS IN THE AFFECTED PORTIONS OF THE HEALTH SYSTEMS REGION, AND THE QUALITY OF CARE PROVIDED AT THE FACILITIES WITH COMMON OWNERSHIP. AT NO TIME SHALL AN APPLICATION SUBMITTED PURSUANT TO THIS SUBDIVISION RESULT IN A CHANGE IN THE TOTAL COMBINED NUMBER OF LONG-TERM VENTILATOR AND RESIDENTIAL HEALTH CARE FACILITY BEDS, INCLUDING RESIDENTIAL HEALTH CARE FACILITY BEDS CONVERTED FROM TRANSFERRED LONG-TERM VENTILATOR BEDS, OPERATED BY THE TWO FACILITIES WITH COMMON OWNERSHIP.

S 8. Subdivision 4 of section 28 of part H of chapter 60 of the laws of 2014, amending the insurance law, the public health law and the financial services law relating to establishing protections to prevent surprise medical bills including network adequacy requirements, claim submission requirements, access to out-of-network care and prohibition of excessive emergency charges, is amended to read as follows:

4. The workgroup shall report its findings and make recommendations for legislation and regulations to the governor, the speaker of the assembly, the senate majority leader, the chairs of the insurance and health committees in both the assembly and the senate, and the superintendent of the department of financial services no later than [January] OCTOBER 1, 2016.

S 9. This act shall take effect immediately; provided however, that sections one and two of this act shall take effect on the first of June next succeeding the date on which it shall have become a law and shall expire and be deemed repealed four years after such effective date.

PART S

Section 1. Section 209 of the elder law, as amended by section 41 of part A of chapter 58 of the laws of 2010, paragraph (b) of subdivision 1 as separately amended by chapter 348 of the laws of 2010, paragraph (d) of subdivision 1 as amended by chapter 271 of the laws of 2014, paragraph (d) of subdivision 4 as separately amended by chapter 410 of the laws of 2010, and paragraph (k) of subdivision 4, subparagraph (6) of paragraph (c) of subdivision 5-a, and subdivision 6 as amended by chapter 320 of the laws of 2011, is amended to read as follows:

S 209. Naturally occurring retirement community supportive service program. 1. As used in this section:

(a) ["Advisory committee" or "committee" shall mean the advisory committee convened by the director for the purposes specified in this section. Such committee shall be broadly representative of housing and senior citizen groups, and all geographic areas of the state.

(b)] "Older adults" shall mean persons who are sixty years of age or older.

[(c)] (B) "Eligible applicant" shall mean a not-for-profit agency specializing in housing, health or other human services which serves or would serve the community within which a naturally occurring retirement community is located.

(C) "HEALTH INDICATORS/PERFORMANCE IMPROVEMENT" SHALL MEAN A SURVEY TOOL, DATABASE, AND PROCESS THAT PROVIDES GRANTEES WITH PERFORMANCE OUTCOMES DATA.

(d) "Eligible services" shall mean THE FOLLOWING services PROVIDED BY A CLASSIC OR NEIGHBORHOOD NORC PROGRAM, OR IN COORDINATION WITH OTHER ENTITIES, including, but not limited to: [case management, care coordination, counseling, health assessment and monitoring, transportation, socialization activities, home care facilitation and monitoring, education regarding the signs of elder abuse and exploitation and available resources for a senior who is a suspected victim of elder abuse or exploitation, chemical dependence counseling provided by credentialed alcoholism and substance abuse counselors as defined in paragraph three of subdivision (d) of section 19.07 of the mental hygiene law and referrals to appropriate chemical dependence counseling providers, and other services designed to address the needs of residents of naturally occurring retirement communities by helping them extend their independence, improve their quality of life, and avoid unnecessary hospital and nursing home stays.

(e) "Government assistance" shall mean and be broadly interpreted to mean any monetary assistance provided by the federal, the state or a local government, or any agency thereof, or any authority or public benefit corporation, in any form, including loans or loan subsidies, for the construction of an apartment building or housing complex for low and

moderate income persons, as such term is defined by the United States Department of Housing and Urban Development.

(f)] PERSON CENTERED PLANNING, CASE ASSISTANCE, CARE COORDINATION, INFORMATION AND ASSISTANCE, APPLICATION AND BENEFIT ASSISTANCE, HEALTH CARE MANAGEMENT AND ASSISTANCE, VOLUNTEER SERVICES, HEALTH PROMOTION AND LINKAGES TO PREVENTION SERVICES AND SCREENINGS, LINKAGES TO IN-HOME SERVICES, HEALTH INDICATORS/PERFORMANCE IMPROVEMENT, HOUSEKEEPING/CHORE, PERSONAL CARE, COUNSELING, SHOPPING AND/OR MEAL PREPARATION ASSISTANCE, ESCORT, TELEPHONE REASSURANCE, TRANSPORTATION, FRIENDLY VISITING, SUPPORT GROUPS, PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS), MEALS, RECREATION, BILL PAYING ASSISTANCE, EDUCATION REGARDING THE SIGNS OF ELDER ABUSE OR EXPLOITATION AND AVAILABLE RESOURCES FOR A SENIOR WHO IS A SUSPECTED VICTIM OF ELDER ABUSE OR EXPLOITATION, CHEMICAL DEPENDANCE COUNSELING PROVIDED BY CREDENTIALED ALCOHOLISM AND SUBSTANCE ABUSE COUNSELORS AS DEFINED IN PARAGRAPH THREE OF SUBDIVISION (D) OF SECTION 19.07 OF THE MENTAL HYGIENE LAW AND REFERRALS TO APPROPRIATE CHEMICAL DEPENDENCE COUNSELING PROVIDERS, AND OTHER SERVICES DESIGNED TO ADDRESS THE NEEDS OF RESIDENTS OF CLASSIC AND NEIGHBORHOOD NORCS BY HELPING THEM EXTEND THEIR INDEPENDENCE, IMPROVE THEIR QUALITY OF LIFE, AND MAXIMIZE THEIR WELL-BEING.

(E) "Naturally occurring retirement community", "CLASSIC NATURALLY OCCURRING RETIREMENT COMMUNITY" OR "CLASSIC NORC" shall mean an apartment building or housing complex which:

(1) [was constructed with government assistance;

(2)] was not [originally] PREDOMINANTLY built for older adults;

[(3)] (2) does not restrict admissions solely to older adults;

[(4)] (3) (A) at least [fifty] FORTY percent of the units have an occupant who is an older adult [or]; AND

(B) in which at least [twenty-five hundred] TWO HUNDRED FIFTY of the residents OF AN APARTMENT BUILDING are older adults OR FIVE HUNDRED RESIDENTS OF A HOUSING COMPLEX ARE OLDER ADULTS; and

[(5)] (4) a majority of the older adults to be served are low or moderate income, as defined by the United States Department of Housing and Urban Development.

(F) "NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITY" OR "NEIGHBORHOOD NORC" SHALL MEAN A RESIDENTIAL DWELLING OR GROUP OF RESIDENTIAL DWELLINGS IN A GEOGRAPHICALLY DEFINED NEIGHBORHOOD OR GROUP OF CONTIGUOUS NEIGHBORHOODS WHICH:

(1) WAS NOT PREDOMINANTLY DEVELOPED FOR OLDER ADULTS;

(2) DOES NOT PREDOMINANTLY RESTRICT ADMISSION TO OLDER ADULTS;

(3) (A) IN A NON-RURAL AREA, HAS AT LEAST THIRTY PERCENT OF THE RESIDENTS WHO ARE OLDER ADULTS OR THE UNITS HAVE AN OCCUPANT WHO IS AN OLDER ADULT; (B) IN A RURAL AREA, HAS AT LEAST TWENTY PERCENT OF THE RESIDENTS WHO ARE OLDER ADULTS OR THE UNITS HAVE AN OCCUPANT WHO IS AN OLDER ADULT; AND

(4) IS MADE UP OF LOW-RISE BUILDINGS SIX STORIES OR LESS AND/OR SINGLE AND MULTI-FAMILY HOMES, PROVIDED, HOWEVER, THAT APARTMENT BUILDINGS AND HOUSING COMPLEXES MAY BE INCLUDED IN RURAL AREAS.

(G) "RURAL AREAS" SHALL MEAN COUNTIES WITHIN THE STATE HAVING A POPULATION OF LESS THAN TWO HUNDRED THOUSAND PERSONS INCLUDING THE MUNICIPALITIES, INDIVIDUALS, INSTITUTIONS, COMMUNITIES, PROGRAMS, AND SUCH OTHER ENTITIES OR RESOURCES AS ARE FOUND THEREIN; OR, IN COUNTIES WITH A POPULATION OF TWO HUNDRED THOUSAND OR MORE, TOWNS WITH A POPULATION DENSITY OF LESS THAN ONE HUNDRED AND FIFTY PERSONS PER SQUARE MILE INCLUDING THE VILLAGES, INDIVIDUALS, INSTITUTIONS, COMMUNITIES, PROGRAMS, AND SUCH OTHER ENTITIES OR RESOURCES AS ARE FOUND THEREIN.

(H) "NON-RURAL AREAS" SHALL MEAN ANY COUNTY, CITY, OR TOWN THAT HAS A POPULATION OR POPULATION DENSITY GREATER THAN THAT WHICH DEFINES A RURAL AREA PURSUANT TO THIS SUBDIVISION.

2. A naturally occurring retirement community supportive service program is established as a [demonstration] program to be administered by the director.

3. The director shall [be assisted by the advisory committee in the development of] DEVELOP appropriate criteria for the selection of grantees of funds provided pursuant to this section [and programmatic issues as deemed appropriate by the director].

4. The criteria [recommended by the committee and adopted by the director] for the award of grants shall be consistent with the provisions of this section and shall include, at a minimum:

(a) the number, size, type and location of the projects to be served, INCLUDING THE NUMBER, SIZE, TYPE AND LOCATION OF RESIDENTIAL DWELLINGS OR GROUP OF RESIDENTIAL DWELLINGS SELECTED AS CANDIDATES FOR INCLUSION IN A NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITY; provided, that the [committee and] director shall make reasonable efforts to assure that geographic balance in the distribution of such projects is maintained, consistent with the needs to be addressed, funding available, applications for eligible applicants, ABILITY TO COORDINATE SERVICES, other requirements of this section, and other criteria developed by the [committee and] director;

(b) the appropriate number and concentration of older adult residents to be served by an individual project; provided, that such criteria need not specify, in the case of a project which includes several buildings, the number of older adults to be served in any individual building;

(c) the demographic characteristics of the residents to be served;

(d) A REQUIREMENT THAT THE APPLICANT DEMONSTRATE COMMUNITY WIDE SUPPORT FROM RESIDENTS, NEIGHBORHOOD ASSOCIATIONS, COMMUNITY GROUPS, NONPROFIT ORGANIZATIONS AND OTHERS;

(E) IN THE CASE OF NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITIES, A REQUIREMENT THAT THE BOUNDARIES OF THE GEOGRAPHIC AREA TO BE SERVED ARE CLEAR AND COHERENT AND CREATE AN IDENTIFIABLE PROGRAM AND SUPPORTIVE COMMUNITY;

(F) the financial or in-kind support required to be provided to the project by the owners, managers and residents of the housing development OR GEOGRAPHICALLY DEFINED AREA; provided, however, that such criteria need not address whether the funding is public or private, or the source of such support;

[(e)] (G) the scope and intensity of the services to be provided, and their appropriateness for the residents proposed to be served. THE APPLICANT SHALL HAVE CONDUCTED A NEEDS ASSESSMENT ON THE BASIS OF WHICH SUCH APPLICANT SHALL ESTABLISH THE NATURE AND EXTENT OF SERVICES TO BE PROVIDED; AND FURTHER THAT SUCH SERVICES SHALL PROVIDE A MIX OF APPROPRIATE SERVICES THAT PROVIDE ACTIVE AND MEANINGFUL PARTICIPATION FOR RESIDENTS. The criteria shall not require that the applicant agency be the sole provider of such services, but shall require that the applicant at a minimum actively manage the provision of such services. SUCH SERVICES MAY BE THE SAME AS SERVICES PROVIDED BY THE LOCAL MUNICIPALITY OR OTHER COMMUNITY-BASED ORGANIZATION PROVIDED THAT THOSE SERVICES ARE NOT AVAILABLE TO OR DO NOT ENTIRELY MEET THE NEEDS OF THE RESIDENTS OF THE CLASSIC OR NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITY;

[(f)] (H) the experience and financial stability of the applicant agency, [provided that the criteria shall require that priority be given to programs already in operation, including those projects participating

in the resident advisor program administered by the office, and enriched housing programs which meet the requirements of this section and which have demonstrated] WHO SHALL DEMONSTRATE to the satisfaction of the director [and the committee] their fiscal and managerial stability and programmatic success in serving residents;

[(g)] (I) the [nature and extent of requirements proposed to be established] PLAN for active, meaningful participation for residents proposed to be served in project design, implementation, monitoring, evaluation, and governance;

[(h)] (J) an agreement by the applicant to participate in [the] data collection and evaluation [project] necessary to IMPLEMENT PERFORMANCE MEASURES FOR HEALTH INDICATORS/PERFORMANCE IMPROVEMENT AND complete the report required by this section;

[(i)] (K) the policy and program roles of the applicant agency and any other agencies involved in the provision of services or the management of the project, including COMMUNITY-BASED ORGANIZATIONS, the housing development governing body, or other owners or managers of the apartment buildings and housing complexes and the residents of such apartment buildings and housing complexes. The criteria shall require a clear delineation of such policy and program roles;

[(j)] (L) a requirement that each eligible agency document the need for the project and financial commitments to it from such sources as [the committee and] the director shall deem appropriate given the character and nature of the proposed project, and written evidence of support from the appropriate housing development governing body or other owners or managers of the apartment buildings and housing complexes IN THE CASE OF CLASSIC NATURALLY OCCURRING RETIREMENT COMMUNITIES, OR THE GEOGRAPHICALLY DEFINED NEIGHBORHOOD IN THE CASE OF NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITIES. The purpose of such documentation shall be to demonstrate the need for the project, support for it in the areas to be served, and the financial and managerial ability to sustain the project;

[(k)] (M) a requirement that any aid provided pursuant to this section be matched by an equal amount, in-kind support of equal value, or some combination thereof from other sources, provided that such in-kind support [to] be utilized only upon approval from the director and only to the extent matching funds are not available, and that at least twenty-five percent of such amount be contributed by the housing development governing body or other owners or managers and residents of the apartment buildings and housing complexes, OR GEOGRAPHICALLY DEFINED AREA, in which the project is proposed, or, upon approval by the director, sources in neighborhoods contiguous to the boundaries of the geographic areas served where services may also be provided pursuant to subdivision six of this section; [and]

[(l)] (N) the circumstances under which the director may waive all or part of the requirement for provision of an equal amount of funding from other sources required pursuant to paragraph [(k)] (M) of this subdivision, provided that such criteria shall include provision for waiver at the discretion of the director upon a finding by the director that the program will serve a low income or hardship community, and that such waiver is required to assure that such community receive a fair share of the funding available. The committee shall develop appropriate criteria for determining whether a community is a low income or hardship community[.];

(O) THE POLICY AND PROGRAM ROLES OF THE APPLICANT AGENCY AND ANY OTHER AGENCIES INVOLVED IN THE PROVISION OF SERVICES OR THE MANAGEMENT OF THE

NEIGHBORHOOD NATURALLY OCCURRING RETIREMENT COMMUNITY, PROVIDED THAT THE CRITERIA SHALL REQUIRE A CLEAR DELINEATION OF SUCH POLICY AND PROGRAM ROLES; AND

(P) A PLAN FOR COORDINATION WITH THE DESIGNATED AREA AGENCY ON AGING TO LEVERAGE ADDITIONAL SERVICES FOR CLASSIC OR NEIGHBORHOOD NORC PARTICIPANTS.

4-A. THE DIRECTOR SHALL DEVELOP A LIST OF PRIORITY AND OPTIONAL SERVICES FROM THE ELIGIBLE SERVICES LISTED IN PARAGRAPH (D) OF SUBDIVISION ONE OF THIS SECTION WHICH MAY BE USED IN THE SELECTION OF GRANTEES PURSUANT TO THIS SECTION.

4-B. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, PRIORITY SHALL BE GIVEN IN ANY COMPETITIVE BIDDING OR REQUEST FOR PROPOSALS PROCESS CONDUCTED FOR THE NATURALLY OCCURRING RETIREMENT COMMUNITY SUPPORTIVE SERVICES PROGRAM TO APPLICANTS THAT PROPOSE TO SERVE A BUILDING, HOUSING COMPLEX, OR CATCHMENT AREA THAT IS BEING SERVED AT THE TIME OF THE COMPETITIVE BIDDING OR REQUEST FOR PROPOSALS PROCESS.

5. Within amounts specifically appropriated therefor and consistent with the criteria developed and required pursuant to this section the director shall approve grants to eligible applicants [in amounts not to exceed one hundred fifty thousand dollars for a project in any twelve month period. The director shall not approve more than ten grants in the first twelve month period after the effective date of this section.

5-a. The director may, in addition recognize neighborhood naturally occurring retirement communities, or Neighborhood NORCs, and provide program support within amounts specifically available by appropriation therefor, which shall be subject to the requirements, rules and regulations of this section, provided however that:

(a) the term Neighborhood NORC as used in this subdivision shall mean and refer to a residential dwelling or group of residential dwellings in a geographically defined neighborhood of a municipality containing not more than two thousand persons who are older adults reside in at least forty percent of the units and which is made up of low-rise buildings six stories or less in height and/or single and multi-family homes and which area was not originally developed for older adults, and which does not restrict admission strictly to older adults;

(b) grants to an eligible Neighborhood NORC shall be no less than sixty thousand dollars for any twelve-month period;

(c) the director shall be assisted by the advisory committee in the development of criteria for the selection of grants provided pursuant to this section and programmatic issues as deemed appropriate by the director. The criteria recommended by the committee and adopted by the director for the award of grants shall be consistent with the provisions of this subdivision and shall include, at a minimum, the following requirements or items of information using such criteria as the advisory committee and the director shall approve:

(1) the number, size, type and location of residential dwellings or group of residential dwellings selected as candidates for neighborhood NORCs funding. The director shall make reasonable efforts to assure that geographic balance in the distribution of such grants is maintained, consistent with the needs to be addressed, funding available, applications from eligible applicants, ability to coordinate services and other requirements of this section;

(2) the appropriate number and concentration of older adult residents to be served by an individual Neighborhood NORC. The criteria need not specify the number of older adults to be served in any individual building;

(3) the demographic characteristics of the residents to be served;

(4) a requirement that the applicant demonstrate the development or intent to develop community wide support from residents, neighborhood associations, community groups, nonprofit organizations and others;

(5) a requirement that the boundaries of the geographic area to be served are clear and coherent and create an identifiable program and supportive community;

(6) a requirement that the applicant commit to raising matching funds, in-kind support, or some combination thereof from non-state sources, provided that such in-kind support be utilized only upon approval from the director and only to the extent matching funds are not available, equal to fifteen percent of the state grant in the second year after the program is approved, twenty-five percent in the third year, forty percent in the fourth year, and fifty percent in the fifth year, and further commit that in each year, twenty-five percent of such required matching funds, in-kind support, or combination thereof be raised within the community served and, upon approval by the director, in neighborhoods contiguous to the boundaries of the geographic areas served where services may also be provided pursuant to subdivision six of this section. Such local community matching funds, in-kind support, or combination thereof shall include but not be limited to: dues, fees for service, individual and community contributions, and such other funds as the advisory committee and the director shall deem appropriate;

(7) a requirement that the applicant demonstrate experience and financial stability;

(8) a requirement that priority in selection be given to programs in existence prior to the effective date of this subdivision which, except for designation and funding requirements established herein, would have otherwise generally qualified as a Neighborhood NORC;

(9) a requirement that the applicant conduct or have conducted a needs assessment on the basis of which such applicant shall establish the nature and extent of services to be provided; and further that such services shall provide a mix of appropriate services that provide active and meaningful participation for residents;

(10) a requirement that residents to be served shall be involved in design, implementation, monitoring, evaluation and governance of the Neighborhood NORC;

(11) an agreement by the applicant that it will participate in the data collection and evaluation necessary to complete the reporting requirements as established by the director;

(12) the policy and program roles of the applicant agency and any other agencies involved in the provision of services or the management of the Neighborhood NORC, provided that the criteria shall require a clear delineation of such policy and program roles;

(13) a requirement that each applicant document the need for the grant and financial commitments to it from such sources as the advisory committee and the director shall deem appropriate given the character and nature of the proposed Neighborhood NORC and written evidence of support from the community;

(14) the circumstances under which the director may waive all or part of the requirement for provision of an equal amount of funding from other sources required pursuant to this subdivision, provided that such criteria shall include provision for waiver at the discretion of the director upon a finding by the director that the Neighborhood NORC will serve a low income or hardship community, and that such waiver is required to assure that such community receive a fair share of the fund-

ing available. For purposes of this paragraph, a hardship community may be one that has developed a successful model but which needs additional time to raise matching funds required herein. An applicant applying for a hardship exception shall submit a written plan in a form and manner determined by the director detailing its plans to meet the matching funds requirement in the succeeding year;

(15) a requirement that any proposed Neighborhood NORC in a geographically defined neighborhood of a municipality containing more than two thousand older adults shall require the review and recommendation by the advisory committee before being approved by the director;

(d) on or before March first, two thousand eight, the director shall report to the governor and the fiscal and aging committees of the senate and the assembly concerning the effectiveness of Neighborhood NORCs in achieving the objectives set forth by this subdivision. Such report shall address each of the items required for Neighborhood NORCs in achieving the objectives set forth in this section and such other items of information as the director shall deem appropriate, including recommendations concerning continuation or modification of the program, and any recommendations from the advisory committee.

(e) in providing program support for Neighborhood NORCs as authorized by this subdivision, the director shall in no event divert or transfer funding for grants or program support from any naturally occurring retirement community supportive service programs authorized pursuant to other provisions of this section]. INDIVIDUAL GRANTS AWARDED FOR CLASSIC NORC PROGRAMS SHALL BE IN AMOUNTS NOT TO EXCEED TWO HUNDRED THOUSAND ($200,000) DOLLARS AND FOR NEIGHBORHOOD NORCS NOT LESS THAN SIXTY THOUSAND ($60,000) DOLLARS IN ANY TWELVE MONTH PERIOD.

6. The director may allow services provided by a naturally occurring retirement community supportive service program or by a neighborhood naturally occurring retirement community to also include services to residents who live in neighborhoods contiguous to the boundaries of the geographic area served by such programs if: (a) the persons served are older adults; (b) the services affect the health and welfare of such persons; and (c) the services are provided on a one-time basis in the year in which they are provided, and not in a manner which is said or intended to be continuous. The director may also consent to the provision of such services by such program if the program has received a grant which requires services to be provided beyond the geographic boundaries of the program. The director shall establish procedures under which a program may request the ability to provide such services. The provision of such services shall not affect the funding provided to the program by the department pursuant to this section.

7. The director shall promulgate rules and regulations as necessary to carry out the provisions of this section.

8. On or before March first, two thousand [five] NINETEEN, AND EVERY FIVE YEARS THEREAFTER, the director shall report to the governor and the finance committee of the senate and the ways and means committee of the assembly concerning the effectiveness of the naturally occurring retirement community supportive services program[, other than Neighborhood NORCs, as defined in subdivision five-a of this section,] in achieving the objectives set forth by this section, which include helping to address the needs of residents in such CLASSIC AND NEIGHBORHOOD naturally occurring retirement communities, assuring access to a continuum of necessary services, increasing private, philanthropic and other public funding for programs, and preventing unnecessary hospital and nursing home stays. The report shall also include recommendations

concerning continuation or modification of the program from the director [and the committee, and shall note any divergence between the recommendations of the director and the committee]. The director shall provide the required information and any other information deemed appropriate to the report in such form and detail as will be helpful to the legislature and the governor in determining to extend, eliminate or modify the program including, but not limited to, the following:

(a) the number, size, type and location of the projects developed and funded, including the number, kinds and functions of staff in each program;

(b) [the number, size, type and location of the projects proposed but not funded, and the reasons for denial of funding for such projects;

(c)] the age, sex, religion and other appropriate demographic information concerning the residents served;

[(d)] (C) the services provided to residents, reported in such manner as to allow comparison of services by demographic group and region;

[(e)] (D) a listing of the services provided by eligible applicants, including the number, kind and intensity of such services; and

[(f)] (E) a listing of [other] PARTNER organizations providing services, the number, kind and intensity of such services, [the number of referrals to such organizations] and, to the extent practicable, the outcomes of such referrals.

S 2. Paragraph (f) of subdivision 1 of section 209 of the elder law is amended by adding a new subparagraph 6 to read as follows:

(6) NOTWITHSTANDING THE REQUIREMENTS SET FORTH IN SUBPARAGRAPH FOUR OF THIS PARAGRAPH, IN ORDER TO PREVENT THE DISRUPTION OF SERVICES THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND SEVENTEEN, PROGRAMS ESTABLISHED AND PROVIDING SERVICES AS OF MARCH FIRST, TWO THOUSAND SIXTEEN SHALL BE ALLOWED TO HAVE FEWER THAN FIFTY PERCENT OF THE UNITS OCCUPIED BY AN OLDER ADULT AND/OR FEWER THAN TWENTY-FIVE HUNDRED RESIDENTS WHO ARE OLDER ADULTS.

S 3. Subdivision 5-a of section 209 of the elder law is amended by adding a new paragraph (f) to read as follows:

(F) NOTWITHSTANDING THE REQUIREMENTS SET FORTH IN PARAGRAPH (A) OF THIS SUBDIVISION, IN ORDER TO PREVENT THE DISRUPTION OF SERVICES THROUGH DECEMBER THIRTY-FIRST, TWO THOUSAND SEVENTEEN, PROGRAMS ESTABLISHED AND PROVIDING SERVICES AS OF MARCH FIRST, TWO THOUSAND SIXTEEN SHALL BE ALLOWED TO HAVE MORE THAN TWO THOUSAND PERSONS WHO ARE OLDER ADULTS RESIDING IN THE GEOGRAPHICALLY DEFINED AREA AND/OR FEWER THAN FORTY PERCENT OF UNITS WITH OLDER ADULTS RESIDING THEREIN.

S 4. This act shall take effect immediately; provided that section one of this act shall take effect January 1, 2018; and provided further that sections two and three of this act shall expire and be deemed repealed on and after December 31, 2017.

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 S of this act shall be as specifically set forth in the last section of such Parts.