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

S. 2007--B A. 3007--B

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

January 21, 2015

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

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

AN ACT to amend the public health law, in relation to physician profiles; to amend part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to extending the provisions thereof; to amend the social services law, in relation to enhancing the quality of adult living program for adult care facilities; to amend the education law, in relation to delivery of prescriptions off premises of a pharmacy; to amend the public health law, in relation to providing more accountability in expenditures made by the Statewide Health Information Network for New York (SHIN-NY), including information on donating umbilical cord blood as part of the health care and wellness education and outreach program; to amend part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to extending the expiration of certain provisions thereof; to repeal paragraph (e) of subdivision 13 of section 2995-a of the public health law relating to physician profiles; and to repeal section 2801-h of the public health law relating to the community forum on establishment of certain facilities in the county of Bronx; and providing for the repeal of certain provisions upon expiration thereof (Part A); to amend the social services law, in relation to supplemental rebates; to amend part H of chapter 59 of the laws of 2011, amending the public health

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

LBD12571-03-5

law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof; to repeal section 280 of the public health law relating to prescription drug discount program; to amend the public health law, in relation to hospital reimbursement provisions and temporary adjustments to reimbursement rates; to amend the social services law, in relation to exceptions to copayments; to amend part A and part B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, in relation to upper payment limits; to amend the public health law, in relation to reimbursement rate promulgation for residential health care facilities; to amend the public health law, in relation to project advisory committees; to amend the social services law, in relation to grants for coordination between health homes and the criminal justice system and for the integration of information of health homes with state and local correctional facilities; to amend the social services law, in relation to basic health program and rates of payment; to amend part B of chapter 59 of the laws of 2011, amending the public health law relating to rates of payment and medical assistance, in relation to managed care supplemental payments; in relation to part H of chapter 59 of the laws of 2011, amending the public health law relating to general hospital inpatient reimbursement for annual rates, in relation to supplemental Medicaid managed care payments; to amend the social services law, in relation to spousal support; to amend the social services law, in relation to temporary preinvestigation emergency needs assistance or care; to amend the social services law, in relation to supplies and the medical assistance presumptive eligibility program; to amend the social services law, in relation to personal care services and adequacy of assistance; to amend the social services law, in relation to expedited procedures for approving personal care services; to amend the social services law, in relation to expedited procedures for determining medical assistance eligibility; in relation to monies equal to the amount of enhanced federal medical assistance percentage monies available as a result of the state's participation in the community first choice state plan option; to amend the public health law, in relation to an energy audit and/or disaster preparedness review of residential health care facilities; to amend the public health law, in relation to payment rates for managed long term care plan enrollees eligible for medical assistance; to amend the social services law, in relation to reimbursement methodologies for managed care programs; to amend the social services law, in relation to insurance payments; to amend the social services law, in relation to eligibility; to amend the social services law, in relation to transition to managed care; to amend the social services law, in relation to coverage of certain noncitizens; to amend the social services law, in relation to basic health program and eligibility of a non-citizen in a valid nonimmigrant status; to repeal section 365-d of the social services law, relating to early and periodic screening diagnosis and treatment outreach demonstration projects; to amend the social services law, in relation to the Medicaid evidence based benefit review advisory committee; to amend the social services law, in relation to the young adult special populations demonstration program; in relation to amending the public health law, in relation to the hospital-home care - physician collaboration program; to amend the public health law, in relation to universal standards for coding of payment for medical assistance claims for long term care and electron-

ic payment of claims; to amend the social services law, in relation to provision and reimbursement of transportation costs; to amend the public health law, in relation to temporary adjustment to reimbursement rates; to amend the public health law, in relation to residential health care facilities and rates of payment; to amend the social services law, in relation to the long term care demonstration program; to repeal paragraph (e) of subdivision 8 of section 2511 of the public health law relating to subsidy payments; to amend the social services law, in relation to managed care programs and complete actuarial memorandum; to amend part B of chapter 58 of the laws of 2007 amending the elder law and other laws, relating to authorizing the adjustment of the Medical nursing home capital reimbursement cap, in relation to effectuating a residential health care facility construction project by the Jewish Home of Rochester; to repeal certain provisions of the public health law relating thereto; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to rates of payment paid to certain providers by the Child Health Plus Program; and 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 rates of payment paid to certain providers by the Child Health Plus Program (Part C); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to reimbursements; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to the effectiveness thereof; to amend the public health law, in relation to rates of payment for long term home health care programs and making such provisions permanent; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the

public health law and other laws relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend the public authorities law, in relation to the transfer of certain funds; to amend subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, relating to enacting into law major components of legislation necessary to implement the health and mental hygiene budget for the 2011-2012 state fiscal plan, in relation to the effectiveness of program oversight and administration of managed long term care plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to the effectiveness thereof; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs; to amend the social services law, in relation to contracting for transportation services; to amend chapter 459 of the laws of 1996 amending the public health law relating to recertification of persons providing emergency medical care, in relation to making such provisions permanent; to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to extending the provisions thereof; to amend subdivision (o) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law relating to state wide planning and research cooperative system and general powers and duties, in relation to the effectiveness of certain provisions; and to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to extending the provisions of such chapter (Part D); to amend the public health law, in relation to the payment of certain funds for uncompensated care (Part E); Intentionally omitted (Part F); Intentionally omitted (Part G); Intentionally omitted (Part H); to amend the criminal procedure law, in relation to the admissibility of condoms as trial evidence of prosecution; to amend the penal law, in relation to criminal possession of a controlled substance; and to repeal subdivision 2-a of section 2781 of the public health law, relating to certain informed consent for HIV related testing (Part I); Intentionally omitted (Part J); to amend the public health law, in relation to improper delegation of authority by the governing authority or operator of a general hospital (Part K); to amend the public health law, in relation to the enhanced oversight of office-based surgery (Part L); to amend the public health law, in relation to requiring notice and submission of a plan prior to discontinuing fluoridation of a public water supply (Part M); relating to conducting a study to develop a report addressing the feasibility of creating an office of community living for older adults and individuals of all ages with disabilities (Part N); Intentionally omitted (Part O); Intentionally omitted (Part P); Intentionally omitted (Part Q); Intentionally omitted (Part R); Intentionally omitted (Part S); Intentionally omitted (Part T); Intentionally omitted (Part U); to amend the public health law and the education law, in relation to opioid overdose prevention (Part V); to amend the public health law, in relation to requiring the commissioner of health to provide certain records to the temporary president of the senate and the speaker of the assembly; requiring the commissioner of health to convene a task

force to evaluate and make recommendations related to increasing the transparency and accountability of the health care reform act resources fund; and to amend the public health law, in relation to physician loan repayment awards (Part W); to amend the insurance law, in relation to an exemption to certain provisions of law relating to risk-based capital for property/casualty insurance companies (Part X); and 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; 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 and requiring a tax clearance for doctors and dentists to be eligible for such excess coverage (Part Y)

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 2015-2016 state fiscal year. Each component is wholly contained within a Part identified as Parts A through Y. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Paragraph (h) of subdivision 1 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, is amended to read as follows:

(h) current [speciality] SPECIALTY board certification and date of certification;

S 2. The opening paragraph of subdivision 1-a of section 2995-a of the public health law, as added by section 8 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

Each physician licensed and registered to practice in this state shall within [one hundred twenty] THIRTY days of the [effective date of this subdivision] TRANSMITTAL OF AN INITIAL PROFILE SURVEY and upon entering or updating his or her profile information:

S 3. Subdivisions 3, 4 and 9 of section 2995-a of the public health law, subdivisions 3 and 9 as added by chapter 542 of the laws of 2000, and subdivision 4 as amended by chapter 477 of the laws of 2008, are amended to read as follows:

3. Each physician who is self-insured for professional medical malpractice shall periodically report to the department on forms and in the time and manner required by the commissioner the information specified in paragraph [(f)] (E) of subdivision one of this section, except that the physician shall report the dollar amount (to the extent of the

physician's information and belief) for each judgment, award and settlement and not a level of significance or context.

4. Each physician shall periodically report to the department on forms and in the time and manner required by the commissioner any other information as is required by the department for the development of profiles under this section which is not otherwise reasonably obtainable. In addition to such periodic reports and providing the same information, each physician shall update his or her profile information within the six months prior to the expiration date of such physician's registration period, as a condition of registration renewal under article one hundred thirty-one of the education law. EXCEPT FOR OPTIONAL INFORMATION PROVIDED, PHYSICIANS SHALL NOTIFY THE DEPARTMENT OF ANY CHANGE IN THE PROFILE INFORMATION WITHIN THIRTY DAYS OF SUCH CHANGE.

9. The department shall, in addition to hard copy physician profiles, provide for electronic access to and copying of physician profiles developed pursuant to this section through the system commonly known as the Internet. THE DEPARTMENT SHALL UPDATE A PHYSICIAN'S ONLINE PROFILE WITHIN THIRTY DAYS OF RECEIPT OF A COMPLETED PHYSICIAN PROFILE SURVEY OR ANY CHANGE IN PROFILE INFORMATION.

S 4. Paragraphs (a) and (d) of subdivision 13 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, are amended to read as follows:

(a) Data sources. The department shall identify the types of physician data to which the public has access, including all information available from federal, state or local agencies which is useful for making determinations concerning health care quality determinations. The department shall study all physician data reporting requirements and develop recommendations to consolidate data collection and eliminate duplicate and unnecessary reporting requirements, or to supplement existing reporting requirements in order to satisfy the requirements of this section. THE DEPARTMENT SHALL STUDY THE FEASIBILITY OF INCORPORATING HEALTH PLAN REPORTING REQUIREMENTS, WITHOUT IMPOSING ANY EXTRA BURDEN ON THE PHYSICIAN, REGARDING NETWORK PARTICIPATION INTO THIS SECTION TO ENSURE THIS INFORMATION IS AVAILABLE, ACCURATE, UP-TO-DATE AND ACCESSIBLE TO CONSUMERS.

(d) Report. The department shall provide a report of its determinations and recommendations UNDER THIS SUBDIVISION to the governor and legislature, and make such report publicly available, [within six months of the effective date of this section] ON OR BEFORE JANUARY FIRST, TWO THOUSAND SIXTEEN. THE DEPARTMENT SHALL REPORT ANNUALLY THEREAFTER TO THE LEGISLATURE ON THE STATUS OF THE PHYSICIAN PROFILES AND ANY RECOMMENDATIONS FOR ADDITIONS, CONSOLIDATIONS OR OTHER CHANGES DEEMED APPROPRIATE.

S 4-a. Paragraph (e) of subdivision 13 of section 2995-a of the public health law is REPEALED.

S 4-b. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 25 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

S 4. This act shall take effect immediately; provided that the provisions of section one of this act shall be deemed to have been in full force and effect on and after April 1, 2003, and shall expire March 31, [2015] 2017 when upon such date the provisions of such section shall be deemed repealed.

S 5. Intentionally omitted.

S 6. Subdivision 3 of section 461-s of the social services law, as added by section 21 of part D of chapter 56 of the laws of 2012, is amended and a new subdivision 4 is added to read as follows:

3. Prior to applying for EQUAL program funds, a facility shall receive approval of its expenditure plan from the residents' council for the facility. THE RESIDENTS' COUNCIL SHALL ADOPT A PROCESS TO IDENTIFY THE PRIORITIES OF THE RESIDENTS FOR THE USE OF THE PROGRAM FUNDS AND DOCUMENT RESIDENTS' TOP PREFERENCES BY MEANS THAT MAY INCLUDE A VOTE OR SURVEY. THE PLAN SHALL DETAIL HOW PROGRAM FUNDS WILL BE USED TO IMPROVE THE PHYSICAL ENVIRONMENT OF THE FACILITY OR THE QUALITY OF CARE AND SERVICES RENDERED TO RESIDENTS AND MAY INCLUDE, BUT NOT BE LIMITED TO, STAFF TRAINING, AIR CONDITIONING IN RESIDENTS' AREAS, CLOTHING, IMPROVEMENTS IN FOOD QUALITY, FURNISHINGS, EQUIPMENT, SECURITY, AND MAINTENANCE OR REPAIRS TO THE FACILITY. THE FACILITY'S APPLICATION FOR EQUAL PROGRAM FUNDS SHALL INCLUDE A SIGNED ATTESTATION FROM THE PRESIDENT OR CHAIR-PERSON OF THE RESIDENTS' COUNCIL OR, IN THE ABSENCE OF A RESIDENTS' COUNCIL, AT LEAST THREE RESIDENTS OF THE FACILITY, STATING THAT THE APPLICATION REFLECTS THE PRIORITIES OF THE RESIDENTS OF THE FACILITY. THE DEPARTMENT SHALL INVESTIGATE REPORTS OF RESIDENT ABUSE AND RETALIATION RELATED TO PROGRAM APPLICATIONS AND EXPENDITURES.

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. 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 7. The second undesignated paragraph of paragraph (a) of subdivision 2 of section 6810 of the education law, as added by chapter 413 of the laws of 2014, is amended to read as follows:

A pharmacy registered with the department pursuant to section sixty-eight hundred eight OR SIXTY-EIGHT HUNDRED EIGHT-B of this article may not deliver a new or refilled prescription off premises without the consent of the patient or an individual authorized to consent on the patient's behalf. [Consent shall include one of the following:

(1) the patient or authorized individual's signature of acceptance of each prescription delivered;

(2) the pharmacy may contact the patient or other authorized individual for consent to deliver and must document consent in the patient record; or

(3) for pharmacies that administer refill reminder or medication adherence programs and deliver off premises, if a signature is not received on each prescription, then the refill reminder program or medication adherence program shall be an OPT-IN program that is updated with patient consent every one hundred eighty days accompanied by a documented patient record review by a licensed pharmacist from the providing pharmacy and the patient before continuation of medication delivery can occur] FOR THE PURPOSES OF THIS SECTION, CONSENT MAY BE OBTAINED IN THE SAME MANNER AND PROCESS BY WHICH CONSENT IS DEEMED ACCEPTABLE UNDER THE FEDERAL MEDICARE PART D PROGRAM.

S 8. Subdivision 18-a of section 206 of the public health law, as amended by section 11 of part A of chapter 58 of the laws of 2010, paragraphs (b) and (d) as amended by section 16 of part A of chapter 60 of the laws of 2014, paragraph (c) as amended by chapter 132 of the laws of 2014, is amended to read as follows:

18-a. [(a)] Health information technology demonstration program. (A) (i) The commissioner is authorized to issue grant funding to one or more organizations broadly representative of physicians licensed in this state, from funds made available for the purpose of funding research and demonstration projects under subparagraph (ii) of this paragraph designed to promote the development of electronic health information exchange technologies in order to facilitate the adoption of interoperable health records.

(ii) Project funding shall be disbursed to projects pursuant to a request for proposals based on criteria relating to promoting the efficient and effective delivery of quality physician services. Demonstration projects eligible for funding under this paragraph shall include, but not be limited to:

(A) efforts to incentivize electronic health record adoption;

(B) interconnection of physicians through regional collaborations;

(C) efforts to promote personalized health care and consumer choice;

(D) efforts to enhance health care outcomes and health status generally through interoperable public health surveillance systems and streamlined quality monitoring.

(iii) The department shall issue a report to the governor, the temporary president of the senate and the speaker of the assembly within one year following the issuance of the grants. Such report shall contain, at a minimum, the following information: the demonstration projects implemented pursuant to this paragraph, their date of implementation, their costs and the appropriateness of a broader application of the health information technology program to increase the quality and efficiency of health care across the state.

(b) The commissioner shall:

(i) POST ON ITS WEBSITE BY SEPTEMBER FIRST, TWO THOUSAND FIFTEEN AND QUARTERLY THEREAFTER, INFORMATION ON THE USES OF FUNDING IN SUPPORT OF THE STATEWIDE HEALTH INFORMATION NETWORK OF NEW YORK (SHIN-NY), INCLUDING HOW SUCH FUNDS MAY BE USED TO:

(A) SUPPORT HOSPITALS, PHYSICIANS, AND OTHER PROVIDERS IN THE ACHIEVEMENT OF FEDERAL MEANINGFUL USE REQUIREMENTS;

(B) SUPPORT DSRIP HEALTH INFORMATION EXCHANGE AND DATA REQUIREMENTS TO HELP PERFORMING PROVIDER SYSTEMS AND THE STATE MEET DSRIP QUALITY GOALS; AND

(C) INCREASE PARTICIPATION IN REGIONAL HEALTH INFORMATION ORGANIZATIONS BY PROVIDERS AT REASONABLE COSTS TO THE PROVIDERS; AND

(II) convene a workgroup to:

(A) evaluate the state's health information technology infrastructure and systems, as well as other related plans and projects designed to make improvements or modifications to such infrastructure and systems including, but not limited to, the all payor database (APD), the state planning and research cooperative system (SPARCS), regional health information organizations (RHIOs), the statewide health information network of New York (SHIN-NY) and medical assistance eligibility systems; and

(B) develop recommendations for the state to move toward a comprehensive health claims and clinical database aimed at improving quality of care, efficiency, cost of care and patient satisfaction available in a self-sustainable, non-duplicative, interactive and interoperable manner that ensures safeguards for privacy, confidentiality and security;

[(ii)] (III) submit [a] AN INTERIM report to the governor [and], the temporary president of the senate and the speaker of the assembly, which shall [fully consider the evaluation and recommendations of the work-

group] DETAIL THE CONCERNS AND ISSUES ASSOCIATED WITH ESTABLISHING THE STATE'S HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE CONSIDERED BY THE WORKGROUP, on or before December first, two thousand fourteen[.]; AND

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

(c) The members of the workgroup shall include, at a minimum, three members who represent RHIOs, two members employed by the department who are involved in the development of the SHIN-NY and the APD, two members who represent physicians, two members who represent hospitals, two members who represent home care agencies, one member who represents federally qualified health centers, ONE MEMBER WHO REPRESENTS COUNTY HEALTH COMMISSIONERS, the chair of the senate health committee or his or her designee, the chair of the assembly health committee or his or her designee, and other individuals with expertise in matters relevant to the charge of the workgroup.

(d) The commissioner may make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a self-sufficient SHIN-NY to enable widespread, non-duplicative interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, payment and other administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY or any other statewide health information system recommended by the workgroup. [The] IF THE COMMISSIONER SEEKS TO PROMULGATE RULES AND REGULATIONS PRIOR TO ISSUANCE OF THE REPORT IDENTIFIED IN SUBPARAGRAPH (IV) OF PARAGRAPH (B) OF THIS SUBDIVISION, THE COMMISSIONER SHALL SUBMIT THE PROPOSED REGULATIONS TO THE WORKGROUP FOR ITS INPUT. IF THE COMMISSIONER SEEKS TO PROMULGATE RULES AND REGULATIONS AFTER THE ISSUANCE OF THE REPORT IDENTIFIED IN SUCH SUBPARAGRAPH (IV) THEN THE commissioner shall consider the REPORT AND recommendations of the workgroup. If the commissioner acts in a manner inconsistent with the INPUT OR recommendations of the workgroup, he or she shall provide the reasons therefor.

S 9. Intentionally omitted.

S 10. Section 206 of the public health law is amended by adding a new subdivision 29 to read as follows:

29. THE COMMISSIONER SHALL PREPARE A REPORT ON THE IMPLEMENTATION OF THE STATE HEALTH INNOVATION PLAN (SHIP) WHICH SHALL INCLUDE:

(1) THE RECOMMENDATIONS OF THE WORKGROUPS ESTABLISHED TO ASSIST THE STATE IN IMPLEMENTATION OF THE SHIP;

(2) THE DEPARTMENT'S EFFORTS IN ADVANCING THE SHIP'S GOALS; AND

(3) INFORMATION ON THE EXPENDITURES OF THE STATE INNOVATION MODEL GRANT.

THE REPORT SHALL BE SUBMITTED TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIRS OF THE SENATE HEALTH COMMITTEE AND ASSEMBLY HEALTH COMMITTEE ON OR BEFORE JANUARY FIRST, TWO THOUSAND SIXTEEN AND ANNUALLY THEREAFTER.

S 11. Subdivision 1 of section 207 of the public health law is amended by adding a new paragraph (k) to read as follows:

(K) DONATING UMBILICAL CORD BLOOD TO A PUBLIC CORD BLOOD BANK.

S 12. Section 2801-h of the public health law is REPEALED.

S 13. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, as amended by section 37 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

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

S 14. This act shall take effect immediately; provided that the amendments to paragraphs (b) and (d) of subdivision 18-a of section 206 of the public health law, made by section eight of this act shall not affect the expiration of such paragraphs and shall be deemed to expire therewith; provided, however, that section ten of this act shall expire March 31, 2020 when upon such date it shall be deemed repealed.

PART B

Section 1. Subdivision 7 of section 367-a of the social services law is amended by adding a new paragraph (e) to read as follows:

(E) 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. 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.

(I) THE MANUFACTURER SHALL NOT PAY SUPPLEMENTAL REBATES TO A MANAGED CARE PROVIDER, OR ANY OF A MANAGED CARE PROVIDER'S AGENTS, INCLUDING BUT NOT LIMITED TO ANY PHARMACY BENEFIT MANAGER ON THE TWO CLASSES OF DRUGS SUBJECT TO THIS PARAGRAPH WHEN THE STATE IS COLLECTING SUPPLEMENTAL REBATES AND STANDARD CLINICAL CRITERIA ARE IMPOSED ON THE MANAGED CARE PROVIDER.

(II) THE COMMISSIONER SHALL ESTABLISH ADEQUATE RATES OF REIMBURSEMENT WHICH SHALL TAKE INTO ACCOUNT BOTH THE IMPACT OF THE COMMISSIONER NEGOTIATING SUCH REBATES AND ANY LIMITATIONS IMPOSED ON THE MANAGED CARE PROVIDER'S ABILITY TO ESTABLISH CLINICAL CRITERIA RELATING TO THE UTILIZATION OF SUCH DRUGS. IN DEVELOPING THE MANAGED CARE PROVIDER'S REIMBURSEMENT RATE, THE COMMISSIONER SHALL IDENTIFY THE AMOUNT OF REIMBURSEMENT FOR SUCH DRUGS AS A SEPARATE AND DISTINCT COMPONENT FROM THE REIMBURSEMENT OTHERWISE MADE FOR PRESCRIPTION DRUGS AS PRESCRIBED BY THIS SECTION.

(III) THE COMMISSIONER SHALL SUBMIT A REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ANNUALLY BY DECEMBER THIRTY-FIRST. THE REPORT SHALL ANALYZE THE ADEQUACY OF RATES TO MANAGED CARE PROVIDERS FOR DRUG EXPENDITURES RELATED TO THE CLASSES UNDER THIS PARAGRAPH.

(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.

(V) ALL CLINICAL CRITERIA, INCLUDING REQUIREMENTS FOR PRIOR APPROVAL, AND ALL UTILIZATION REVIEW DETERMINATIONS ESTABLISHED BY THE STATE AS DESCRIBED IN THIS PARAGRAPH FOR EITHER OF THE DRUG CLASSES SUBJECT TO THIS PARAGRAPH SHALL BE DEVELOPED USING EVIDENCE-BASED AND PEER-REVIEWED CLINICAL REVIEW CRITERIA IN ACCORDANCE WITH ARTICLE TWO-A OF THE PUBLIC HEALTH LAW, AS APPLICABLE.

(VI) ALL PRIOR AUTHORIZATION AND UTILIZATION REVIEW DETERMINATIONS RELATED TO THE COVERAGE OF ANY DRUG SUBJECT TO THIS PARAGRAPH SHALL BE SUBJECT TO ARTICLE FORTY-NINE OF THE PUBLIC HEALTH LAW, SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE, AND ARTICLE FORTY-NINE OF THE INSURANCE LAW, AS APPLICABLE. NOTHING IN THIS PARAGRAPH SHALL DIMINISH ANY RIGHTS RELATING TO ACCESS, PRIOR AUTHORIZATION, OR APPEAL RELATING TO ANY DRUG CLASS OR DRUG AFFORDED TO A RECIPIENT UNDER ANY OTHER PROVISION OF LAW.

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. 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 33 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

1. For state fiscal years 2011-12 through [2015-16] 2016-17, 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 9. Section 280 of the public health law is REPEALED.

S 10. Intentionally omitted.

S 11. Section 2807 of the public health law is amended by adding a new subdivision 14-a to read as follows:

14-A. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH, PURSUANT TO REGULATIONS, A STATEWIDE GENERAL HOSPITAL QUALITY POOL FOR THE PURPOSE OF INCENTIVIZING AND FACILITATING QUALITY IMPROVEMENTS IN GENERAL HOSPITALS. AWARDS FROM SUCH POOL SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF BUDGET. IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE, THEN THE NON-FEDERAL SHARE OF AWARDS MADE PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

(A) THIRTY DAYS PRIOR TO ADOPTING OR APPLYING A METHODOLOGY OR PROCEDURE FOR MAKING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO ADOPT OR APPLY THE METHODOLOGY OR PROCEDURE, INCLUDING A DETAILED EXPLANATION OF THE METHODOLOGY OR PROCEDURE.

(B) THIRTY DAYS PRIOR TO EXECUTING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO DISTRIBUTE SUCH FUNDS. SUCH NOTICE SHALL INCLUDE, BUT NOT BE LIMITED TO, INFORMATION ON THE METHODOLOGY USED TO DISTRIBUTE THE FUNDS, THE FACILITY SPECIFIC ALLOCATIONS OF THE FUNDS, ANY FACILITY SPECIFIC PROJECT DESCRIPTIONS OR REQUIREMENTS FOR RECEIVING SUCH FUNDS, THE MULTI-YEAR IMPACTS OF THESE ALLOCATIONS, AND THE AVAILABILITY OF FEDERAL MATCHING FUNDS. THE COMMISSIONER SHALL PROVIDE QUARTERLY REPORTS TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON THE DISTRIBUTION AND DISBURSEMENT OF SUCH FUNDS.

S 12. Section 2807 of the public health law is amended by adding a new subdivision 22 to read as follows:

22. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, GENERAL HOSPITALS DESIGNATED AS SOLE COMMUNITY HOSPITALS IN ACCORDANCE WITH TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT FOR INPATIENT AND/OR OUTPATIENT SERVICES OF UP TO TWELVE MILLION DOLLARS UNDER A SUPPLEMENTAL OR REVISED RATE METHODOLOGY, ESTABLISHED BY THE COMMISSIONER IN REGULATION, FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING THE QUALITY OF CARE. IF FEDERAL FINANCIAL PARTICIPATION IS

UNAVAILABLE, THEN THE NON-FEDERAL SHARE OF SUCH PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

(A) THIRTY DAYS PRIOR TO ADOPTING OR APPLYING A METHODOLOGY OR PROCEDURE FOR MAKING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO ADOPT OR APPLY THE METHODOLOGY OR PROCEDURE, INCLUDING A DETAILED EXPLANATION OF THE METHODOLOGY OR PROCEDURE.

(B) THIRTY DAYS PRIOR TO EXECUTING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO DISTRIBUTE SUCH FUNDS. SUCH NOTICE SHALL INCLUDE, BUT NOT BE LIMITED TO, INFORMATION ON THE METHODOLOGY USED TO DISTRIBUTE THE FUNDS, THE FACILITY SPECIFIC ALLOCATIONS OF THE FUNDS, ANY FACILITY SPECIFIC PROJECT DESCRIPTIONS OR REQUIREMENTS FOR RECEIVING SUCH FUNDS, THE MULTI-YEAR IMPACTS OF THESE ALLOCATIONS, AND THE AVAILABILITY OF FEDERAL MATCHING FUNDS. THE COMMISSIONER SHALL PROVIDE QUARTERLY REPORTS TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON THE DISTRIBUTION AND DISBURSEMENT OF SUCH FUNDS.

S 13. Subdivision (e) of section 2826 of the public health law, as added by section 27 of part C of chapter 60 of the laws of 2014, is amended and a new subdivision (e-1) is added to read as follows:

(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than [five] SEVEN million FIVE HUNDRED THOUSAND dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than [December] JUNE first, two thousand [fourteen] FIFTEEN providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, INCLUDING AN EXAMINATION OF PERMANENT MEDICAID RATE METHODOLOGY CHANGES.

(E-1) THIRTY DAYS PRIOR TO EXECUTING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SECTION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE WITH REGARDS TO THE INTENT TO DISTRIBUTE SUCH FUNDS. SUCH NOTICE SHALL INCLUDE, BUT NOT BE LIMITED TO, INFORMATION ON THE METHODOLOGY USED TO DISTRIBUTE THE FUNDS, THE FACILITY SPECIFIC ALLOCATIONS OF THE FUNDS, ANY FACILITY SPECIFIC PROJECT DESCRIPTIONS OR REQUIREMENTS FOR RECEIVING SUCH FUNDS, THE MULTI-YEAR IMPACTS OF THESE ALLOCATIONS, AND THE AVAILABILITY OF FEDERAL MATCHING FUNDS. THE COMMISSIONER SHALL PROVIDE QUARTERLY REPORTS TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON THE DISTRIBUTION AND DISBURSEMENT OF SUCH FUNDS. WITHIN SIXTY DAYS OF THE EFFECTIVENESS OF THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE A WRITTEN REPORT TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON ALL AWARDS MADE PURSUANT TO THIS SECTION PRIOR TO THE EFFECTIVENESS OF THIS SUBDIVISION, INCLUDING ALL INFORMATION THAT IS REQUIRED TO BE INCLUDED IN THE NOTICE REQUIREMENTS OF THIS SUBDIVISION.

S 14. Section 2826 of the public health law is amended by adding a new subdivision (f) to read as follows:

(F) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, NO LESS THAN TEN MILLION DOLLARS

SHALL BE ALLOCATED TO PROVIDERS DESCRIBED IN THIS SUBDIVISION; PROVIDED, HOWEVER THAT IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE FOR ANY ELIGIBLE PROVIDER, OR FOR ANY POTENTIAL INVESTMENT UNDER THIS SUBDIVISION THEN THE NON-FEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

(I) PROVIDERS SERVING RURAL AREAS AS SUCH TERM IS DEFINED IN SECTION TWO THOUSAND NINE HUNDRED FIFTY-ONE OF THIS CHAPTER, INCLUDING BUT NOT LIMITED TO HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AMBULATORY SURGERY CENTERS AND CLINICS SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT UNDER A SUPPLEMENTAL RATE METHODOLOGY FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING THE QUALITY OF CARE.

(II) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, ESSENTIAL COMMUNITY PROVIDERS, WHICH, FOR THE PURPOSES OF THIS SECTION, SHALL MEAN A PROVIDER THAT OFFERS HEALTH SERVICES WITHIN A DEFINED AND ISOLATED GEOGRAPHIC REGION WHERE SUCH SERVICES WOULD OTHERWISE BE UNAVAILABLE TO THE POPULATION OF SUCH REGION, SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT UNDER A SUPPLEMENTAL RATE METHODOLOGY FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING QUALITY OF CARE. ELIGIBLE PROVIDERS UNDER THIS PARAGRAPH MAY INCLUDE, BUT ARE NOT LIMITED TO, HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AMBULATORY SURGERY CENTERS AND CLINICS.

(III) IN MAKING SUCH PAYMENTS THE COMMISSIONER MAY CONTEMPLATE THE EXTENT TO WHICH ANY SUCH PROVIDER RECEIVES ASSISTANCE UNDER SUBDIVISION (A) OF THIS SECTION AND MAY REQUIRE SUCH PROVIDER TO SUBMIT A WRITTEN PROPOSAL DEMONSTRATING THAT THE NEED FOR MONIES UNDER THIS SUBDIVISION EXCEEDS MONIES OTHERWISE DISTRIBUTED PURSUANT TO THIS SECTION.

(IV) PAYMENTS UNDER THIS SUBDIVISION MAY INCLUDE, BUT NOT BE LIMITED TO, TEMPORARY RATE ADJUSTMENTS, LUMP SUM MEDICAID PAYMENTS, SUPPLEMENTAL RATE METHODOLOGIES AND ANY OTHER PAYMENTS AS DETERMINED BY THE COMMISSIONER.

(V) PAYMENTS UNDER THIS SUBDIVISION SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF THE BUDGET.

(VI) THE COMMISSIONER MAY PROMULGATE REGULATIONS TO EFFECTUATE THE PROVISIONS OF THIS SUBDIVISION.

(VII) THIRTY DAYS PRIOR TO ADOPTING OR APPLYING A METHODOLOGY OR PROCEDURE FOR MAKING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO ADOPT OR APPLY THE METHODOLOGY OR PROCEDURE, INCLUDING A DETAILED EXPLANATION OF THE METHODOLOGY OR PROCEDURE.

(VIII) THIRTY DAYS PRIOR TO EXECUTING AN ALLOCATION OR MODIFICATION TO AN ALLOCATION MADE PURSUANT TO THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE WRITTEN NOTICE TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE, THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE SENATE AND ASSEMBLY HEALTH COMMITTEES WITH REGARD TO THE INTENT TO DISTRIBUTE SUCH FUNDS. SUCH NOTICE SHALL INCLUDE, BUT NOT BE LIMITED TO, INFORMATION ON THE METHODOLOGY USED TO DISTRIBUTE THE FUNDS, THE FACILITY SPECIFIC ALLOCATIONS OF THE FUNDS, ANY FACILITY SPECIFIC PROJECT DESCRIPTIONS OR REQUIREMENTS FOR RECEIVING SUCH FUNDS, THE MULTI-YEAR IMPACTS OF THESE ALLOCATIONS, AND THE AVAILABILITY OF FEDERAL MATCHING FUNDS. THE COMMISSIONER SHALL PROVIDE QUARTERLY REPORTS TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON THE DISTRIBUTION AND DISBURSEMENT OF SUCH FUNDS.

S 15. Paragraph (b) of subdivision 6 of section 367-a of the social services law, as added by chapter 41 of the laws of 1992, subparagraph (iii) as amended by chapter 843 of the laws of 1992, subparagraph (iv) as amended by section 40 of part C of chapter 58 of the laws of 2005, is amended and a new paragraph (b-1) is added to read as follows:

(b) Co-payments shall apply to all eligible persons for the services defined in paragraph (d) of this subdivision with the exception of:

(i) individuals under twenty-one years of age;

(ii) pregnant women;

(iii) individuals who are inpatients in a medical facility who have been required to spend all of their income for medical care, except their personal needs allowance or residents of community based residential facilities licensed by the office of mental health or the office of mental retardation and developmental disabilities who have been required to spend all of their income, except their personal needs allowance;

(iv) individuals enrolled in health maintenance organizations or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs, except that such persons, other than persons otherwise exempted from co-payments pursuant to subparagraphs (i), (ii), (iii) and (v) of this paragraph, and other than those persons enrolled in a managed long term care program, shall be subject to co-payments as described in subparagraph (v) of paragraph (d) of this subdivision; [and]

(v) INDIVIDUALS WHOSE FAMILY INCOME IS LESS THAN ONE HUNDRED PERCENT OF THE FEDERAL POVERTY LINE, AS DEFINED IN SUBPARAGRAPH FOUR OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE, FOR A FAMILY OF THE SAME SIZE; AND

(VI) any other individuals required to be excluded by federal law or regulations.

(B-1) THE COMMISSIONER IS AUTHORIZED TO SUBMIT ANY REQUEST OR APPLICATION TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AS MAY BE NECESSARY TO BE GRANTED A WAIVER OF THE REQUIREMENT FOR THE DEPARTMENT OF HEALTH TO CALCULATE ITS MEDICAID PAYMENTS TO MANAGED CARE ORGANIZATIONS TO INCLUDE COST SHARING ESTABLISHED UNDER THE STATE PLAN FOR MEDICAL ASSISTANCE FOR ENROLLEES WHO ARE NOT EXEMPT FROM COST SHARING. IN THE ABSENCE OF SUCH A WAIVER, THE COMMISSIONER SHALL ADJUST MEDICAID PAYMENTS TO MANAGED CARE ORGANIZATIONS BEGINNING OCTOBER FIRST, TWO THOUSAND FIFTEEN OR ON THE DATE THE CENTERS FOR MEDICARE AND MEDICAID SERVICES COMMENCES ENFORCEMENT OF SUCH REQUIREMENT, WHICHEVER IS LATER.

S 15-a. Paragraph (b) of subdivision 6 of section 367-a of the social services law, as amended by section fifteen of this act, is amended to read as follows:

(b) Co-payments shall apply to all eligible persons for the services defined in paragraph (d) of this subdivision with the exception of:

(i) individuals under twenty-one years of age;

(ii) pregnant women;

(iii) individuals who are inpatients in a medical facility who have been required to spend all of their income for medical care, except their personal needs allowance or residents of community based residential facilities licensed by the office of mental health or the office of mental retardation and developmental disabilities who have been required to spend all of their income, except their personal needs allowance;

(iv) [individuals enrolled in health maintenance organizations or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs, except that such persons, other than persons otherwise exempted from co-payments

pursuant to subparagraphs (i), (ii), (iii) and (v) of this paragraph, and other than those persons enrolled in a managed long term care program, shall be subject to co-payments as described in subparagraph (v) of paragraph (d) of this subdivision;

(v)] individuals whose family income is less than one hundred percent of the federal poverty line, as defined in subparagraph four of paragraph (a) of subdivision one of section three hundred sixty-six of this title, for a family of the same size; and

[(vi)] (V) any other individuals required to be excluded by federal law or regulations.

S 16. Section 12 of part A of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 12. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period September 1, 2001 through March 31, 2002, and state fiscal years thereafter, UNTIL MARCH 31, 2012, the department of health is authorized to pay a specialty hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, receiving reimbursement for all inpatient services under title XIX of the federal social security act pursuant to paragraph (e) of subdivision 4 of section 2807-c of the public health law, and located in a city with a population of over 1 million, of up to four hundred sixty-three million dollars for the period September 1, 2001 through March 31, 2002 and up to seven hundred ninety-four million dollars annually for state fiscal years thereafter as medical assistance payments for inpatient services 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 based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

S 17. Section 13 of part B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 13. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2002 through March 31, 2003, and state fiscal years thereafter UNTIL MARCH 31, 2012, the department of health is authorized to pay a specialty hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, receiving reimbursement for all inpatient services under title XIX of the federal social security act pursuant to paragraph (e) of subdivision 4 of section 2807-c of the public health law, and located in a city with a population of over one million, of up to two hundred eighty-six million dollars as medical assistance payments for inpatient services 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 based on each such hospital's proportionate share of the sum of all inpatient discharges for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate

share payment may be added to rates of payment or made as aggregate payments to eligible hospitals.

S 18. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2012, through March 31, 2013, and state fiscal years thereafter, the department of health is authorized to pay a public hospital adjustment to public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over 1 million, of up to one billion eighty million dollars annually as medical assistance payments for inpatient services 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 based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

S 19. Section 14 of part A of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 14. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period January 1, 2002 through March 31, 2002, and state fiscal years thereafter UNTIL MARCH 31, 2011, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over one million, which experienced free patient visits in excess of twenty percent of their total self-pay and free patient visits based on data reported on exhibit 33 of their 1999 institutional cost report and which experienced uninsured outpatient losses in excess of seventy-five percent of their total inpatient and outpatient uninsured losses based on data reported on exhibit 47 of their 1999 institutional cost report, of up to thirty-four million dollars for the period January 1, 2002 through March 31, 2002 and up to one hundred thirty-six million dollars annually for state fiscal years thereafter as medical assistance payments for outpatient services 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 based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

S 20. Section 14 of part B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 14. Notwithstanding any inconsistent provision of law or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period January 1, 2002 through March 31, 2002, and state fiscal years thereafter UNTIL MARCH 31, 2011, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population of over one million, which experienced free patient visits in excess of twenty percent of their total self-pay and free patient visits based on data reported on exhibit 33 of their 1999 institutional cost report and which experienced uninsured outpatient losses in excess of seventy-five percent of their total inpatient and outpatient uninsured losses based on data reported on exhibit 47 of their 1999 institutional cost report, of up to thirty-seven million dollars for the period January 1, 2002 through March 31, 2002 and one hundred fifty-one million dollars annually for state fiscal years thereafter as medical assistance payments for outpatient services 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 based on each such hospital's proportionate share of the sum of all outpatient visits for all facilities eligible for an adjustment pursuant to this section for the base year two years prior to the rate year. Such proportionate share payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

S 21. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for the period April 1, 2011 through March 31, 2012, and state fiscal years thereafter, the department of health is authorized to increase the operating cost component of rates of payment for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law for public general hospitals, as defined in subdivision 10 of section 2801 of the public health law, other than those operated by the state of New York or the state university of New York, and located in a city with a population over one million, up to two hundred eighty-seven million dollars annually as medical assistance payments for outpatient services 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 based on such criteria and methodologies as the commissioner may from time to time set through a memorandum of understanding with the New York city health and hospitals corporation, and such adjustments shall be paid by means of one or more estimated payments, with such estimated payments to be reconciled to the commissioner of health's final adjustment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment

payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

S 22. Section 16 of part A of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 16. Any amounts provided pursuant to sections eleven, twelve, thirteen and fourteen of this act shall be effective for purposes of determining payments for public general hospitals contingent on receipt of all approvals required by federal law or regulations for federal financial participation in payments made pursuant to title XIX of the federal social security act. If federal approvals are not granted for payments based on such amounts or components thereof, payments to public general hospitals shall be determined without consideration of such amounts or such components. Public general hospitals shall refund to the state, or the state may recoup from prospective payments, any overpayment received, including those based on a retroactive reduction in the payments. Any reduction in federal financial participation pursuant to title XIX of the federal social security act related to federal upper payment limits APPLICABLE TO PUBLIC GENERAL HOSPITALS OTHER THAN THOSE OPERATED BY THE STATE OF NEW YORK OR THE STATE UNIVERSITY OF NEW YORK shall be deemed to apply first to amounts provided pursuant to sections eleven, twelve, thirteen and fourteen of this act AND SECTIONS EIGHTEEN AND TWENTY-ONE OF THE CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN THAT AMENDED THIS SECTION.

S 23. Section 20 of part B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, is amended to read as follows:

S 20. Any amounts provided pursuant to sections thirteen and fourteen of this act shall be effective for purposes of determining payments for public general hospitals contingent on receipt of all approvals required by federal law or regulations for federal financial participation in payments made pursuant to title XIX of the federal social security act. If federal approvals are not granted for payments based on such amounts or components thereof, payments to public general hospitals shall be determined without consideration of such amounts or such components. Public general hospitals shall refund to the state, or the state may recoup from prospective payments, any overpayment received, including those based on a retroactive reduction in the payments. Any reduction in federal financial participation pursuant to title XIX of the federal social security act related to federal upper payment limits APPLICABLE TO PUBLIC GENERAL HOSPITALS OTHER THAN THOSE OPERATED BY THE STATE OF NEW YORK OR THE STATE UNIVERSITY OF NEW YORK shall be deemed to apply first to amounts provided pursuant to sections thirteen and fourteen of this act AND SECTIONS EIGHTEEN AND TWENTY-ONE OF THE CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN THAT AMENDED THIS SECTION.

S 24. Subdivision 7 of section 2807 of the public health law, as amended by section 195 of part A of chapter 389 of the laws of 1997, is amended to read as follows:

7. Reimbursement rate promulgation. The commissioner shall notify each [hospital] RESIDENTIAL HEALTH CARE FACILITY and health-related service of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least sixty days prior to the beginning of an established rate period for which the rate is to become effective AND FOR GENERAL HOSPITALS AT LEAST THIRTY DAYS PRIOR TO THE BEGINNING OF AN ESTABLISHED RATE PERIOD FOR WHICH THE RATE IS TO BECOME EFFECTIVE. Notification shall be made only after approval of rate schedules by the state director of the budget. The sixty and thirty day notice

provisions, herein, shall not apply to rates issued following judicial annulment or invalidation of any previously issued rates, or rates issued pursuant to changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of previously issued rates. Notwithstanding any provision of law to the contrary, nothing in this subdivision shall prohibit the recalculation and payment of rates, including both positive and negative adjustments, based on a reconciliation of amounts paid by residential health care facilities beginning April first, nineteen hundred ninety-seven for additional assessments or further additional assessments pursuant to section twenty-eight hundred seven-d of this article with the amounts originally recognized for reimbursement purposes.

S 24-a. Intentionally omitted.

S 24-b. Paragraphs (c), (d) and (e) of subdivision 20 of section 2807 of the public health law, as added by section 8-a of part A of chapter 60 of the laws of 2014, are relettered paragraphs (d), (e) and (f) and amended and a new paragraph (c) is added to read as follows:

(C)(I) PROJECT ADVISORY COMMITTEES. 1. LEAD ENTITIES OF SYSTEMS ESTABLISHED UNDER THE MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT ("DSRIP") PROGRAM SHALL ESTABLISH A PROJECT ADVISORY COMMITTEE. THE COMMITTEE SHALL CONSIDER AND ADVISE THE ENTITY ON MATTERS CONCERNING SYSTEM OPERATIONS, SERVICE DELIVERY ISSUES, ELIMINATION OF HEALTH CARE DISPARITIES, MEASUREMENT OF PROJECT OUTCOMES, THE DEGREE TO WHICH PROJECT GOALS ARE BEING REACHED AND THE DEVELOPMENT OF ANY PLANS OR PROGRAMS. THE ENTITY MAY ESTABLISH RULES WITH RESPECT TO ITS PROJECT ADVISORY COMMITTEE.

(II) THE MEMBERS OF THE COMMITTEE SHALL BE REPRESENTATIVES OF THE COMMUNITY, OR GEOGRAPHIC SERVICE AREAS, SERVED BY THE SYSTEM, INCLUDING MEDICAID CONSUMERS ATTRIBUTED TO THAT SYSTEM, AND ANY OTHER MEMBERS REQUIRED BY THE TERMS AND CONDITIONS OF THE DSRIP PROGRAM. THE LEAD ENTITY SHALL FILE WITH THE COMMISSIONER, AND FROM TIME TO TIME UPDATE, AN UP-TO-DATE LIST OF THE MEMBERS OF THE COMMITTEE, WHICH SHALL BE MADE AVAILABLE TO THE PUBLIC BY THE DEPARTMENT ON ITS WEBSITE.

(III) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, NO OFFICER OR EMPLOYEE OF THE STATE OR OF ANY CIVIL DIVISION THEREOF, SHALL BE DEEMED TO HAVE FORFEITED OR SHALL FORFEIT HIS OR HER OFFICE OR EMPLOYMENT BY REASON OF HIS OR HER ACCEPTANCE OF MEMBERSHIP ON A PROJECT ADVISORY COMMITTEE. NO MEMBER OF A PROJECT ADVISORY COMMITTEE SHALL RECEIVE COMPENSATION OR ALLOWANCE FOR SERVICES RENDERED ON THE COMMITTEE, EXCEPT, HOWEVER, THAT MEMBERS OF A COMMITTEE MAY BE REIMBURSED BY THE ENTITY OR SYSTEM FOR NECESSARY EXPENSES INCURRED IN RELATION TO SERVICE ON A PROJECT ADVISORY COMMITTEE.

(d) For periods on and after April first, two thousand fourteen, the commissioner shall provide a report on a quarterly basis to the chairs of the senate finance, assembly ways and means, senate health and assembly health committees with regard to the status of the DSRIP program. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include the most current information submitted by providers to the state and the federal CMS. The reports shall include:

(i) analysis of progress made toward DSRIP goals;

(ii) the impact on the state's health care delivery system;

(iii) information on the number and types of providers who participate;

(iv) plans and progress for monitoring provider compliance with requirements;

(v) a status update on project milestone progress;
(vi) information on project spending and budget;
(vii) analysis of impact on Medicaid beneficiaries served;
(viii) a summary of public engagement and public comments received;
(ix) a description of DSRIP funding applications that were denied;
(x) a description of all regulation waivers issued pursuant to paragraph [(e)] (F) of this subdivision; and
(xi) a summary of the statewide geographic distribution of funds.
(e) For periods on and after April first, two thousand fourteen the commissioner shall promptly make all DSRIP governing documents, including 1115 waiver standard terms and conditions, supporting attachments and detailed project descriptions, and all materials made available to the legislature pursuant to paragraph [(c)] (D) of this subdivision, available on the department's website. The commissioner shall also provide a detailed overview on the department's website of the opportunities for public comment on the DSRIP program.
(f) Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow applicants under this subdivision and paragraph (a) of subdivision two of section twenty-eight hundred twenty-five of this article to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the authorizing commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be described, including each [regulations] REGULATION waived and the project it relates to, in the report provided pursuant to paragraph [(c)] (D) of this subdivision.
S 25. Section 365-l of the social services law is amended by adding two new subdivisions 2-b and 2-c to read as follows:
2-B. THE COMMISSIONER IS AUTHORIZED TO MAKE GRANTS 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. HEALTH HOMES RECEIVING FUNDS UNDER THIS SUBDIVISION SHALL BE REQUIRED TO DOCUMENT AND DEMONSTRATE THE EFFECTIVE USE OF FUNDS DISTRIBUTED HEREIN.
2-C. THE COMMISSIONER IS AUTHORIZED TO MAKE GRANTS UP TO A GROSS AMOUNT OF ONE MILLION DOLLARS FOR CERTIFIED APPLICATION COUNSELORS AND ASSISTORS TO FACILITATE THE ENROLLMENT OF PERSONS IN HIGH RISK POPULATIONS, INCLUDING BUT NOT LIMITED TO PERSONS WITH MENTAL HEALTH AND/OR SUBSTANCE ABUSE CONDITIONS THAT HAVE BEEN RECENTLY DISCHARGED OR ARE PENDING RELEASE FROM STATE AND LOCAL CORRECTIONAL FACILITIES. FUNDS ALLOCATED FOR CERTIFIED APPLICATION COUNSELORS AND ASSISTORS SHALL BE EXPENDED THROUGH A REQUEST FOR PROPOSAL PROCESS.
S 26. Intentionally omitted.
S 27. Intentionally omitted.
S 28. Subdivisions 6 and 7 of section 369-gg of the social services law are renumbered 7 and 8 and a new subdivision 6 is added to read as follows:

6. RATES OF PAYMENT. (A) THE COMMISSIONER SHALL SELECT THE CONTRACT WITH AN INDEPENDENT ACTUARY TO STUDY AND RECOMMEND APPROPRIATE REIMBURSEMENT METHODOLOGIES FOR THE COST OF HEALTH CARE SERVICE COVERAGE PURSUANT TO THIS TITLE. SUCH INDEPENDENT ACTUARY SHALL REVIEW AND MAKE RECOMMENDATIONS CONCERNING APPROPRIATE ACTUARIAL ASSUMPTIONS RELEVANT TO THE ESTABLISHMENT OF REIMBURSEMENT METHODOLOGIES, INCLUDING BUT NOT LIMITED TO; THE ADEQUACY OF RATES OF PAYMENT IN RELATION TO THE POPULATION TO BE SERVED ADJUSTED FOR CASE MIX, THE SCOPE OF HEALTH CARE SERVICES APPROVED ORGANIZATIONS MUST PROVIDE, THE UTILIZATION OF SUCH SERVICES AND THE NETWORK OF PROVIDERS REQUIRED TO MEET STATE STANDARDS.

(B) UPON CONSULTATION WITH THE INDEPENDENT ACTUARY AND ENTITIES REPRESENTING APPROVED ORGANIZATIONS, THE COMMISSIONER SHALL DEVELOP REIMBURSEMENT METHODOLOGIES AND FEE SCHEDULES FOR DETERMINING RATES OF PAYMENT, WHICH RATE SHALL BE APPROVED BY THE DIRECTOR OF THE DIVISION OF THE BUDGET, TO BE MADE BY THE DEPARTMENT TO APPROVED ORGANIZATIONS FOR THE COST OF HEALTH CARE SERVICES COVERAGE PURSUANT TO THIS TITLE. SUCH REIMBURSEMENT METHODOLOGIES AND FEE SCHEDULES MAY INCLUDE PROVISIONS FOR CAPITATION ARRANGEMENTS.

(C) THE COMMISSIONER SHALL HAVE THE AUTHORITY TO PROMULGATE REGULATIONS, INCLUDING EMERGENCY REGULATIONS, NECESSARY TO EFFECTUATE THE PROVISIONS OF THIS SUBDIVISION.

(D) THE DEPARTMENT SHALL REQUIRE THE INDEPENDENT ACTUARY SELECTED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION TO PROVIDE A COMPLETE ACTUARIAL REPORT, ALONG WITH ALL ACTUARIAL ASSUMPTIONS MADE AND ALL OTHER DATA, MATERIALS AND METHODOLOGIES USED IN THE DEVELOPMENT OF RATES FOR THE BASIC HEALTH PLAN AUTHORIZED UNDER THIS SECTION. SUCH REPORT SHALL BE PROVIDED ANNUALLY TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY.

S 28-a. Subdivision 2 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014, is amended and a new subdivision 9 is added to read as follows:

2. Authorization. If it is in the financial interest of the state to do so, the commissioner of health is authorized, with the approval of the director of the budget, to establish a basic health program. The commissioner's authority pursuant to this section is contingent upon obtaining and maintaining all necessary approvals from the secretary of health and human services to offer a basic health program in accordance with 42 U.S.C. 18051. The commissioner may take any and all actions necessary to obtain such approvals. NOTWITHSTANDING THE FOREGOING, WITHIN NINETY DAYS OF THE EFFECTIVE DATE OF THE CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN WHICH AMENDED THIS SUBDIVISION THE COMMISSIONER SHALL SUBMIT A REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY DETAILING A CONTINGENCY PLAN IN THE EVENT ELIGIBILITY RULES OR REGULATIONS ARE MODIFIED OR REPEALED; OR IN THE EVENT FEDERAL PAYMENT IS REDUCED FROM NINETY FIVE PERCENT OF THE PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148). THE CONTINGENCY PLAN SHALL BE IMPLEMENTED WITHIN NINETY DAYS OF THE ABOVE STATED EVENTS OR THE TIME PERIOD SPECIFIED IN FEDERAL LAW.

9. REPORTING. THE COMMISSIONER SHALL SUBMIT A REPORT TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ANNUALLY BY DECEMBER THIRTY-FIRST. THE REPORT SHALL INCLUDE, AT A MINIMUM, AN ANALYSIS OF THE BASIC HEALTH PROGRAM AND ITS IMPACT ON THE FINANCIAL INTEREST OF THE STATE; ITS IMPACT ON THE HEALTH BENEFIT EXCHANGE INCLUDING ENROLLMENT AND PREMIUMS; ITS IMPACT ON THE NUMBER OF UNINSURED INDIVIDUALS IN THE STATE; ITS IMPACT ON THE MEDICAID GLOBAL CAP; AND THE DEMO-

GRAPHICS OF BASIC HEALTH PROGRAM ENROLLEES INCLUDING AGE AND IMMIGRATION STATUS.

S 29. Section 1 of part B of chapter 59 of the laws of 2011, amending the public health law relating to rates of payment and medical assistance, is amended to read as follows:

Section 1. (a) Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for professional services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice at the State University of New York, in accordance with 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 amounts that will increase fees for such professional services to an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule [or], made as aggregate lump sum payments to eligible clinical practice plans authorized to receive professional fees OR MADE AS SUPPLEMENTAL PAYMENTS MADE FOR SUCH PURPOSE AS DESCRIBED HEREIN TO MEDICAID MANAGED CARE ORGANIZATIONS. SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS UNDER THIS SECTION SHALL BE DISTRIBUTED TO PROVIDERS AS DETERMINED BY THE MANAGED CARE MODEL CONTRACT AND MAY UTILIZE MANAGED CARE ORGANIZATION REPORTED ENCOUNTER DATA AND OTHER SUCH METRICS AS DETERMINED BY THE DEPARTMENT OF HEALTH IN ORDER TO ENSURE RATES OF PAYMENT EQUIVALENT TO THE AVERAGE COMMERCIAL OR MEDICARE RATE THAT WOULD OTHERWISE BE RECEIVED FOR SUCH SERVICES RENDERED BY SUCH PHYSICIANS, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.

(b) The affiliated State University of New York health science centers shall be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for all services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice, in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services.

S 30. Section 93 of part H of chapter 59 of the laws of 2011, amending the public health law relating to general hospital inpatient reimbursement for annual rates, is amended to read as follows:

S 93. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for professional services provided by physicians, nurse practitioners and physician assistants who are employed by a public benefit corporation or a non-state operated public

general hospital operated by a public benefit corporation or who are providing professional services at a facility of such public benefit corporation as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation, in accordance with 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 amounts that will increase fees for such professional services to an amount equal to either the Medicare rate or the average commercial rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule [or], made as aggregate lump sum payments to entities authorized to receive professional fees OR MADE AS SUPPLEMENTAL PAYMENTS MADE FOR SUCH PURPOSE AS DESCRIBED HEREIN TO MEDICAID MANAGED CARE ORGANIZATIONS. SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS UNDER THIS SECTION SHALL BE DISTRIBUTED TO PROVIDERS AS DETERMINED BY THE MANAGED CARE MODEL CONTRACT AND MAY UTILIZE MANAGED CARE ORGANIZATION REPORTED ENCOUNTER DATA AND OTHER SUCH METRICS AS DETERMINED BY THE DEPARTMENT OF HEALTH IN ORDER TO ENSURE RATES OF PAYMENT EQUIVALENT TO THE AVERAGE COMMERCIAL OR MEDICARE RATE THAT WOULD OTHERWISE BE RECEIVED FOR SUCH SERVICES RENDERED BY SUCH PHYSICIANS, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.

2. The supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for professional services authorized by subdivision one of this section may be made only at the election of the public benefit corporation or the local social services district in which the non-state operated public general hospital is located. The electing public benefit corporation or local social services district shall, notwithstanding the social services district Medicaid cap provisions of Part C of chapter 58 of the laws of 2005, be responsible for payment of one hundred percent of the non-federal share of such supplemental Medicaid payments, in accordance with section 365-a of the social services law, regardless of whether another social services district or the department of health may otherwise be responsible for furnishing medical assistance to the eligible persons receiving such services. Social services district or public benefit corporation funding of the non-federal share of any such payments shall be deemed to be voluntary for purposes of the increased federal medical assistance percentage provisions of the American Recovery and Reinvestment Act of 2009, provided, however, that in the event the federal Centers for Medicare and Medicaid Services determines that such non-federal share payments are not voluntary payments for purposes of such act, the provisions of this section shall be null and void.

S 31. Subparagraph (iii) of paragraph (d) of subdivision 1 of section 367-a of the social services law, as amended by section 65 of part H of chapter 59 of the laws 2011, is amended to read as follows:

(iii) [When payment under part B of title XVIII of the federal social security act for] WITH RESPECT TO items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and [for] items and services provided to

qualified medicare beneficiaries under part B of title XVIII of the federal social security act [would exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary, the amount payable for services covered under this title shall be twenty percent of], THE AMOUNT PAYABLE FOR SERVICES COVERED UNDER THIS TITLE SHALL BE the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B, BUT SHALL NOT EXCEED THE AMOUNT THAT OTHERWISE WOULD BE MADE UNDER THIS TITLE IF PROVIDED TO AN ELIGIBLE PERSON OTHER THAN A PERSON WHO IS ALSO A BENEFICIARY UNDER PART B OR IS A QUALIFIED MEDICARE BENEFICIARY MINUS THE AMOUNT PAYABLE UNDER 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, a psychologist licensed under article one hundred fifty-three of the education law, or a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health 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 32.Intentionally omitted.

S 33.Intentionally omitted.

S 34.Intentionally omitted.

S 35. Section 133 of the social services law, as amended by chapter 455 of the laws of 2010, is amended to read as follows:

S 133. Temporary preinvestigation emergency needs assistance or care. Upon application for public assistance or care under this chapter, the local social services district shall notify the applicant in writing of the availability of a monetary grant adequate to meet emergency needs assistance or care and shall, at such time, determine whether such person is in immediate need. If it shall appear that a person is in immediate need, emergency needs assistance or care shall be granted pending completion of an investigation. The written notification required by this section shall inform such person of a right to an expedited hearing when emergency needs assistance or care is denied. A public assistance applicant who has been denied emergency needs assistance or care must be given reason for such denial in a written determination which sets forth the basis for such denial. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO REQUIRE THE SOCIAL SERVICES DISTRICT OR ANY STATE AGENCY TO PROVIDE MEDICAL ASSISTANCE, EXCEPT AS OTHERWISE REQUIRED BY TITLE ELEVEN OF THIS ARTICLE.

S 36. Subdivision 7 of section 364-i of the social services law, as added by section 34 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

7. Notwithstanding [section one hundred thirty-three of this chapter] ANY OTHER SECTION OF LAW, where care [or], services, OR SUPPLIES are

received prior to the date [the] AN individual is determined eligible for assistance under this title, medical assistance reimbursement, REGARDLESS OF FUNDING SOURCE, shall be available for such care [or], services, OR SUPPLIES only (a) if the care [or], services, OR SUPPLIES are received during the three month period preceding the month of application for medical assistance and the recipient is determined to have been eligible in the month in which the care [or], service, OR SUPPLY was received, or (b) [as] IF provided [for in] DURING A PERIOD OF PRESUMPTIVE ELIGIBILITY PURSUANT TO this section [or regulations of the department].

S 36-a. Paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by section 89 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(e) (i) personal care services, including personal emergency response services, shared aide and an individual aide, subject to the provisions of subparagraphs (ii), (iii), and (iv) of this paragraph, furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease, as determined to meet the recipient's needs for assistance when cost effective and appropriate, and when prescribed by a physician, in accordance with the recipient's plan of treatment and provided by individuals who are qualified to provide such services, who are supervised by a registered nurse and who are not members of the recipient's family, and furnished in the recipient's home or other location;

(ii) the commissioner is authorized to adopt standards, pursuant to emergency regulation, for the provision and management of services available under this paragraph for individuals whose need for such services exceeds a specified level to be determined by the commissioner;

(iii) the commissioner [is authorized to] SHALL provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law, CONSISTENT WITH SUBDIVISION THIRTY-ONE OF SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE;

(iv) personal care services available pursuant to this paragraph shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions;

S 36-b. Section 364-j of the social services law is amended by adding a new subdivision 31 to read as follows:

31. (A) THE COMMISSIONER SHALL REQUIRE MANAGED CARE PROVIDERS UNDER THIS SECTION, MANAGED LONG-TERM CARE PLANS UNDER SECTION FORTY-FOUR HUNDRED THREE-F THE PUBLIC HEALTH LAW AND OTHER APPROPRIATE LONG-TERM SERVICE PROGRAMS TO ADOPT EXPEDITED PROCEDURES FOR APPROVING PERSONAL CARE SERVICES FOR A MEDICAL ASSISTANCE RECIPIENT WHO REQUIRES IMMEDIATE PERSONAL CARE OR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES PURSUANT TO PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE OR SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE, RESPECTIVELY, OR OTHER LONG-TERM CARE, AND PROVIDE SUCH CARE OR SERVICES AS APPROPRIATE, PENDING APPROVAL BY SUCH PROVIDER OR PROGRAM.

S 36-c. Section 366-a of the social services law is amended by adding a new subdivision 12 to read as follows:

12. THE COMMISSIONER SHALL DEVELOP EXPEDITED PROCEDURES FOR DETERMINING MEDICAL ASSISTANCE ELIGIBILITY FOR ANY MEDICAL ASSISTANCE APPLICANT WITH AN IMMEDIATE NEED FOR PERSONAL CARE OR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES PURSUANT TO PARAGRAPH (E) OF SUBDIVISION TWO OF

SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE OR SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE, RESPECTIVELY. SUCH PROCEDURES SHALL REQUIRE THAT A FINAL ELIGIBILITY DETERMINATION BE MADE WITHIN SEVEN DAYS OF THE DATE OF A COMPLETE MEDICAL ASSISTANCE APPLICATION.

S 37. Notwithstanding any provision of law to the contrary, monies equal to the amount of enhanced federal medical assistance percentage monies available as a result of the state's participation in the community first choice state plan option under section 1915 of title XIX of the federal social security act, in each state fiscal year shall be made available as additional funds to be used to implement the state's comprehensive plan for serving New Yorkers with disabilities in the most integrated setting, also know as the state's Olmstead plan. Such monies shall be expended for the purposes consistent with the Olmstead plan, including, additional funding for services provided pursuant to section three hundred sixty-five-f of the social services law, supportive housing, wage supports for home and personal care workers, transportation supports, and the transition of behavioral health services to managed care. The department of health shall, after consultation with the senate finance committee and assembly ways and means committee, stakeholders, relevant state agencies, the division of budget and the Olmstead cabinet, submit a report to the temporary president of the senate, and the speaker of the assembly, the chair of the senate finance committee, the chair of the assembly ways and means committee, and the chairs of the senate and assembly health committees, setting forth the plan to allocate such investments, and shall notify the senate finance committee and the assembly ways and means committee at least forty-five days prior to implementation of such allocation. The commissioner of health shall report annually to the chairs of the assembly and senate committees on health, aging, and mental health, the chair of the senate committee on finance, the chair of the assembly ways and means committee, and the chair of the assembly task force on people with disabilities on the amount of funding received and disbursed pursuant to this section, the projects or proposals supported by these funds, and compliance with this section.

S 38. Section 2808 of the public health law is amended by adding a new subdivision 27 to read as follows:

27. THE COMMISSIONER IS AUTHORIZED TO CONDUCT AN ENERGY AUDIT AND/OR DISASTER PREPAREDNESS REVIEW OF RESIDENTIAL HEALTH CARE FACILITIES. SUCH AUDIT OR REVIEW SHALL EXPLORE THE ENERGY EFFICIENCY AND/OR DISASTER PREPAREDNESS OF THE REAL PROPERTY CAPITAL ASPECTS OF EACH FACILITY AND DEVELOP A COST/BENEFIT ANALYSIS OF POTENTIAL MODIFICATIONS FOR EACH FACILITY. SUCH AUDIT OR REVIEW SHALL SERVE AS THE BASIS FOR AN ENERGY EFFICIENCY AND/OR DISASTER PREPAREDNESS PROGRAM TO BE DEVELOPED BY THE DEPARTMENT IN REGULATIONS. PARTICIPATION IN SUCH AUDIT OR REVIEW SHALL BE A CONDITION TO PARTICIPATION IN ANY SUCH PROGRAM DEVELOPED AS A RESULT THEREOF, AND SHALL ALSO BE A CONDITION TO RECEIPT OF ANY FUNDING AVAILABLE UNDER SUCH PROGRAM. SUCH PROGRAM SHALL ONLY BE IMPLEMENTED IF IT IS IN THE BEST FINANCIAL INTERESTS OF THE STATE, AS DETERMINED BY THE COMMISSIONER. AT LEAST FORTY-FIVE DAYS PRIOR TO IMPLEMENTING SUCH PROGRAM, THE DEPARTMENT SHALL REPORT TO THE SENATE AND ASSEMBLY HEALTH COMMITTEES, THE ASSEMBLY WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE THE RESULTS OF THE ENERGY AUDIT AUTHORIZED HEREIN AND THE PROPOSED ELIGIBILITY CRITERIA, FUNDING SOURCES, THE MANNER IN WHICH SAVINGS MAY BE SHARED BETWEEN THE STATE AND FACILITIES AND ANY OTHER INFORMATION REQUESTED BY SUCH COMMITTEES ABOUT SUCH PROGRAM PRIOR TO THE TRANSMITTAL OF THE REPORT.

S 39. Intentionally omitted.
S 40. Intentionally omitted.
S 40-a. Subdivision 8 of section 4403-f of the public health law, as amended by section 21 of part C of chapter 58 of the laws of 2007, 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.
S 40-b. Intentionally omitted.
S 40-c. Subdivision 18 of section 364-j of the social services law is amended by adding a new paragraph (c) to read as follows:
(C) IN SETTING SUCH REIMBURSEMENT METHODOLOGIES, THE DEPARTMENT SHALL CONSIDER COSTS BORNE BY THE MANAGED CARE PROGRAM TO ENSURE ACTUARIALLY SOUND AND ADEQUATE RATES OF PAYMENT TO ENSURE QUALITY OF CARE.
S 41. Intentionally omitted.
S 42. Subdivision 12 of section 367-a of the social services law, as amended by section 63-a of part C of chapter 58 of the laws of 2007, is amended to read as follows:
12. Prior to receiving medical assistance under subparagraphs [twelve] FIVE and [thirteen] SIX of paragraph [(a)] (C) of subdivision one of section three hundred sixty-six of this title, a person whose net available income is at least one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, must pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium shall be twenty-five dollars for an individual who is otherwise eligible for medical assistance under such subparagraphs, and fifty dollars for a couple, both of whom are otherwise eligible for medical assistance under such subparagraphs. No premium shall be required from a person whose net available income is less than one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services.
S 43. Subparagraph 6 of paragraph (b) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:
(6) An individual who is not otherwise eligible for medical assistance under this section is eligible for coverage of family planning services reimbursed by the federal government at a rate of ninety percent, and for coverage of those services identified by the commissioner of health

as services generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement, including treatment for sexually transmitted diseases, if his or her income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services[.]; PROVIDED FURTHER THAT THE COMMISSIONER OF HEALTH IS AUTHORIZED TO ESTABLISH CRITERIA FOR PRESUMPTIVE ELIGIBILITY FOR SERVICES PROVIDED PURSUANT TO THIS SUBPARAGRAPH IN ACCORDANCE WITH ALL APPLICABLE REQUIREMENTS OF FEDERAL LAW OR REGULATION PERTAINING TO SUCH ELIGIBILITY.

S 44. Subdivision 1 of section 398-b of the social services law, as added by section 44 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law to the contrary and subject to the availability of federal financial participation, the commissioner is authorized to make grants [from] UP TO a gross amount of five million dollars FOR STATE FISCAL YEAR TWO THOUSAND FOURTEEN--FIFTEEN AND UP TO A GROSS AMOUNT OF FIFTEEN MILLION DOLLARS FOR STATE FISCAL YEAR TWO THOUSAND FIFTEEN--SIXTEEN to facilitate the transition of foster care children placed with voluntary foster care agencies to managed care. The use of such funds may include providing training and consulting services to voluntary agencies to [access] ASSESS readiness and make necessary infrastructure and organizational modifications, collecting service utilization and other data from voluntary agencies and other entities, and making investments in health information technology, including the infrastructure necessary to establish and maintain electronic health records. Such funds shall be distributed pursuant to a formula to be developed by the commissioner of health, in consultation with the commissioner of the office of CHILDREN AND family [and child] services. In developing such formula the commissioners may take into account size and scope of provider operations as a factor relevant to eligibility for such funds. Each recipient of such funds shall be required to document and demonstrate the effective use of funds distributed herein. IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE, THEN THE NONFEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

S 45. Paragraph (g) of subdivision 1 of section 366 of the social services law, as added by section 50 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(g) Coverage of certain noncitizens. (1) Applicants and recipients who are lawfully admitted for permanent residence, or who are permanently residing in the United States under color of law, OR WHO ARE NON-CITIZENS IN A VALID NONIMMIGRANT STATUS, AS DEFINED IN 8 U.S.C. 1101(A)(15); who are MAGI eligible pursuant to paragraph (b) of this subdivision; and who would be ineligible for medical assistance coverage under subdivisions one and two of section three hundred sixty-five-a of this title solely due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall only be eligible for assistance under this title if enrolled in a standard health plan offered by a basic health program established pursuant to section three hundred sixty-nine-gg of this article if such program is established and operating.

(2) With respect to a person described in subparagraph one of this paragraph who is enrolled in a standard health plan, medical assistance coverage shall mean:

(i) payment of required premiums and other cost-sharing obligations under the standard health plan that exceed the person's co-payment obligation under subdivision six of section three hundred sixty-seven-a of this title; and

(ii) payment for services and supplies described in subdivision one or two of section three hundred sixty-five-a of this title, as applicable, but only to the extent that such services and supplies are not covered by the standard health plan.

(3) Nothing in this subdivision shall prevent a person described in subparagraph one of this paragraph from qualifying for or receiving medical assistance while his or her enrollment in a standard health plan is pending, in accordance with applicable provisions of this title.

S 46. Subdivision 8 of section 369-gg of the social services law, as added by section 51 of part C of chapter 60 of the laws of 2014 and as renumbered by section twenty-eight of this act, is amended to read as follows:

8. An individual who is lawfully admitted for permanent residence [or], permanently residing in the United States under color of law, OR WHO IS A NON-CITIZEN IN A VALID NONIMMIGRANT STATUS, AS DEFINED IN 8 U.S.C. 1101(A)(15), and who would be ineligible for medical assistance under title eleven of this article due to his or her immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall be considered to be ineligible for medical assistance for purposes of paragraphs (b) and (c) of subdivision three of this section.

S 46-a. Section 365-d of the social services law is REPEALED and a new section 365-d is added to read as follows:

S 365-D. MEDICAID EVIDENCE BASED BENEFIT REVIEW ADVISORY COMMITTEE. 1. THE DEPARTMENT SHALL CONVENE A MEDICAID EVIDENCE BASED BENEFIT REVIEW ADVISORY COMMITTEE. THE COMMITTEE SHALL PROVIDE ADVICE AND MAKE RECOMMENDATIONS REGARDING COVERAGE OF HEALTH TECHNOLOGY OR SERVICE FOR PURPOSES OF THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER SHALL CONSULT SUCH COMMITTEE PRIOR TO ANY DETERMINATION MADE REGARDING THE COVERAGE STATUS OF A PARTICULAR ITEM, HEALTH TECHNOLOGY OR SERVICE BASED ON PROCEDURES ESTABLISHED IN SUBDIVISION FIVE OF THIS SECTION UNDER THE MEDICAL ASSISTANCE PROGRAM. FOR PURPOSES OF THIS SECTION, "HEALTH TECHNOLOGY" MEANS MEDICAL DEVICES AND SURGICAL PROCEDURES USED IN THE PREVENTION, DIAGNOSIS AND TREATMENT OF DISEASE AND OTHER MEDICAL CONDITIONS. FOR PURPOSES OF THIS SECTION "SERVICES" MEANS ANY MEDICAL OR BEHAVIORAL HEALTH PROCEDURE.

2. (A) THE MEMBERSHIP OF SUCH COMMITTEE SHALL, AT A MINIMUM, INCLUDE:

(I) AT LEAST THREE PERSONS LICENSED AND ACTIVELY ENGAGED IN THE PRACTICE OF MEDICINE IN THIS STATE;

(II) ONE PERSON LICENSED AND ACTIVELY ENGAGED IN THE PRACTICE OF NURSING AS A NURSE PRACTITIONER, OR IN THE PRACTICE OF MIDWIFERY IN THIS STATE;

(III) ONE PERSON WITH EXPERTISE IN HEALTH TECHNOLOGY ASSESSMENT OR EVIDENCE BASED MEDICAL REVIEW WHO IS PREFERABLY A HEALTH CARE PROFESSIONAL LICENSED UNDER TITLE EIGHT OF THE EDUCATION LAW;

(IV) THREE PERSONS WHO SHALL BE CONSUMERS OR REPRESENTATIVES OF ORGANIZATIONS WITH A REGIONAL OR STATEWIDE CONSTITUENCY AND WHO HAVE BEEN INVOLVED IN ACTIVITIES RELATED TO HEALTH CARE CONSUMER ADVOCACY;

(V) ONE PERSON WHO IS A REPRESENTATIVE OF A HOSPITAL ORGANIZATION WITH A REGIONAL, NATIONAL OR STATEWIDE CONSTITUENCY;

(VI) ONE PERSON WHO IS A REPRESENTATIVE OF A HEALTH INSURANCE OR MANAGED CARE ORGANIZATION WITH A REGIONAL, STATEWIDE OR NATIONAL CONSTITUENCY;

(VII) ONE PERSON WHO IS A HEALTH ECONOMIST;
(VIII) ONE PERSON WITH HEALTH CARE EXPERTISE WHO IS APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE;
(IX) ONE PERSON WITH HEALTH CARE EXPERTISE WHO IS APPOINTED BY THE SPEAKER OF THE ASSEMBLY;
(X) A MEMBER OF THE DEPARTMENT WHO SHALL ACT AS CHAIRPERSON AS DESIGNATED BY THE COMMISSIONER; AND
(XI) THE COMMITTEE MAY INVITE AND CONSULT WITH SCIENTIFIC, TECHNICAL, OR CLINICAL EXPERTS WITH DEMONSTRABLE EXPERIENCE OR KNOWLEDGE OF THE TECHNOLOGY OR MEDICAL SPECIALTY AREA UNDER REVIEW.
3. THE DEPARTMENT SHALL PROVIDE VIDEO OR AUDIO ACCESS TO ALL MEETINGS OF SUCH COMMITTEE THROUGH THE DEPARTMENT'S WEBSITE.
4. THE MEMBERS OF THE COMMITTEE SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES BUT SHALL BE REIMBURSED FOR EXPENSES ACTUALLY AND NECESSARILY INCURRED IN THE PERFORMANCE OF THEIR DUTIES UNLESS EXPRESSLY STATED OTHERWISE IN THIS SECTION, MEMBERS SHALL BE APPOINTED BY THE COMMISSIONER. MEMBERS SHALL SERVE THREE YEAR TERMS, AND MAY BE REAPPOINTED FOR SUBSEQUENT TERMS. COMMITTEE MEMBERS SHALL BE DEEMED TO BE EMPLOYEES OF THE DEPARTMENT FOR PURPOSES OF SECTION SEVENTEEN OF THE PUBLIC OFFICERS LAW, AND SHALL NOT PARTICIPATE IN ANY MATTER BEFORE THE COMMITTEE FOR WHICH A CONFLICT OF INTEREST EXISTS.
5. THE COMMITTEE SHALL CONSIDER ANY MATTER REGARDING MATERIAL CHANGES IN THE COVERAGE STATUS OF A PARTICULAR ITEM, HEALTH TECHNOLOGY OR SERVICE, AND ANY MATTER RELATIVE TO NEW HEALTH TECHNOLOGY ASSESSMENT OR MEDICAL EVIDENCE REVIEW FOR WHICH THE DEPARTMENT DETERMINES A SUFFICIENT BODY OF EVIDENCE EXISTS TO WARRANT COMMITTEE DELIBERATION. THE COMMISSIONER SHALL PROVIDE MEMBERS OF THE COMMITTEE WITH ANY EVIDENCE OR INFORMATION RELATED TO THE HEALTH TECHNOLOGY OR MEDICAL SERVICE ASSESSMENT INCLUDING BUT NOT LIMITED TO, INFORMATION SUBMITTED BY MEMBERS OF THE PUBLIC. THE DEPARTMENT SHALL REPORT TO THE COMMITTEE PROGRAMMATIC CHANGES TO BENEFITS THAT DO NOT RISE TO THE LEVEL OF A MATERIAL CHANGE, AS WELL AS DETERMINATIONS OF WHEN SUFFICIENT MEDICAL EVIDENCE EXISTS TO WARRANT COMMITTEE DELIBERATIONS. THE COMMISSIONER SHALL PROVIDE FORTY-FIVE DAYS PUBLIC NOTICE ON THE DEPARTMENT'S WEBSITE PRIOR TO ANY MEETING OF THE COMMITTEE TO DEVELOP RECOMMENDATIONS CONCERNING HEALTH TECHNOLOGY OR MEDICAL SERVICE COVERAGE DETERMINATIONS. SUCH NOTICE SHALL INCLUDE A DESCRIPTION OF THE PROPOSED HEALTH TECHNOLOGY OR SERVICE TO BE REVIEWED, THE CONDITIONS OR DISEASES IMPACTED BY THE HEALTH TECHNOLOGY OR SERVICE, THE PROPOSALS TO BE CONSIDERED BY THE COMMITTEE, AND THE SYSTEMATIC EVIDENCE-BASED ASSESSMENT PREPARED IN ACCORDANCE WITH THIS SUBDIVISION. THE COMMITTEE SHALL ALLOW INTERESTED PARTIES A REASONABLE OPPORTUNITY TO MAKE AN ORAL PRESENTATION TO THE COMMITTEE RELATED TO THE HEALTH TECHNOLOGY OR SERVICE TO BE REVIEWED AND TO SUBMIT WRITTEN INFORMATION. THE COMMITTEE SHALL CONSIDER ANY INFORMATION PROVIDED BY ANY INTERESTED PARTY, INCLUDING, BUT NOT LIMITED TO, HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, PATIENTS, CONSUMERS AND MANUFACTURERS. FOR ALL HEALTH TECHNOLOGIES OR SERVICES SELECTED FOR REVIEW, THE DEPARTMENT SHALL CONDUCT OR COMMISSION A SYSTEMATIC EVIDENCE-BASED ASSESSMENT OF THE HEALTH TECHNOLOGY'S OR SERVICE'S SAFETY AND CLINICAL EFFICACY. THE ASSESSMENT SHALL USE ESTABLISHED SYSTEMATIC REVIEW ELEMENTS, STUDY QUALITY ASSESSMENT, AND DATA SYNTHESIS. UPON COMPLETION, THE SYSTEMATIC, EVIDENCE-BASED ASSESSMENT SHALL BE MADE AVAILABLE TO THE PUBLIC.
6. THE COMMISSIONER SHALL PROVIDE NOTICE OF ANY COVERAGE RECOMMENDATIONS DEVELOPED BY THE COMMITTEE BY MAKING SUCH INFORMATION AVAILABLE ON THE DEPARTMENT'S WEBSITE. SUCH PUBLIC NOTICE SHALL INCLUDE: A SUMMARY OF THE DELIBERATIONS OF THE COMMITTEE; A SUMMARY OF THE POSITIONS OF

THOSE MAKING PUBLIC COMMENTS AT MEETINGS OF THE COMMITTEE AND ANY SAFETY AND HEALTH OUTCOMES DATA SUBMITTED BY ANY INTERESTED PARTY; THE RESPONSE OF THE COMMITTEE TO THOSE COMMENTS, IF ANY; THE CLINICAL EVIDENCE UPON WHICH THE COMMITTEE BASES ITS RECOMMENDATIONS; AND THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE INCLUDING A FINAL EVIDENCE-BASED SYSTEMATIC ASSESSMENT.

7. THE COMMISSIONER SHALL PROVIDE PUBLIC NOTICE ON THE DEPARTMENT'S WEBSITE OF THE COMMITTEE'S RECOMMENDATION AND THE DEPARTMENT'S FINAL DETERMINATION, INCLUDING: THE NATURE OF THE DETERMINATION; AN ANALYSIS OF THE IMPACT OF THE DEPARTMENT'S DETERMINATION ON THE STATE MEDICAID PLAN POPULATIONS AND PROVIDERS; AND THE PROJECTED FISCAL IMPACT TO THE STATE MEDICAID PROGRAM.

8. THE RECOMMENDATIONS OF THE COMMITTEE, MADE PURSUANT TO THIS SECTION, SHALL BE BASED ON A REVIEW OF THE EVIDENCE PRESENTED TO THE COMMITTEE, INCLUDING THE CLINICAL EFFECTIVENESS, PATIENT OUTCOMES, IMPACT ON AT RISK AND UNDERSERVED POPULATIONS, AND SAFETY. THE COMMITTEE SHALL REVIEW PREVIOUS RECOMMENDATIONS OF THE COMMITTEE AS NEW EVIDENCE BECOMES AVAILABLE AND PERMIT ORAL PRESENTATIONS AND THE SUBMISSION OF NEW EVIDENCE AT ANY COMMITTEE MEETING. SUCH REVIEW SHALL OCCUR PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISIONS FIVE AND SIX OF THIS SECTION. THE DEPARTMENT MAY ALTER OR REVOKE THE FINAL DETERMINATION AFTER SUCH REVIEW PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISION SEVEN OF THIS SECTION.

9. THE DEPARTMENT SHALL PROVIDE ADMINISTRATIVE SUPPORT TO THE COMMITTEE.

S 47. Young adult special populations demonstration programs. The commissioner of health shall establish up to three young adult special populations demonstration programs to provide cost effective, necessary services and enhanced quality of care for targeted populations in order to demonstrate the effectiveness of the programs. Eligible individuals shall have severe and chronic medical or health problems, or multiple disabling conditions which may be combined with developmental disabilities. The programs shall provide more appropriate settings and services for these individuals, help prevent out of state placements and allow repatriation back to their home communities. Eligible operator applicants shall have demonstrated expertise in caring for the targeted population including persons with severe and chronic medical or health problems or multiple disabling conditions and a record of providing quality care.

Funds may include, but not be limited to, start up funds, capital investments and enhanced rates.

Of the demonstrations:

(a) at least one shall be designed to serve persons aged twenty-one to thirty-five years of age who are aging out of pediatric acute care hospitals or pediatric nursing homes; and

(b) at least one shall be designed to serve persons aged twenty-one to thirty-five years of age who have a developmental disability in addition to their severe and chronic medical or health problems and are aging out of pediatric acute care hospitals, pediatric nursing homes or children's residential homes operated under the jurisdiction of the office for persons with developmental disabilities.

The department of health shall be responsible for monitoring the quality and appropriateness and effectiveness of the demonstration programs, and shall report to the legislature no later than December 31, 2015 on what efforts it has undertaken toward the establishment of these demonstration programs and shall report to the legislature two years follow-

ing the establishment of a demonstration program pursuant to this section.

S 48. The public health law is amended by adding a new section 2805-x to read as follows:

S 2805-X. HOSPITAL-HOME CARE-PHYSICIAN COLLABORATION PROGRAM. 1. THE PURPOSE OF THIS SECTION SHALL BE TO FACILITATE INNOVATION IN HOSPITAL, HOME CARE AGENCY AND PHYSICIAN COLLABORATION IN MEETING THE COMMUNITY'S HEALTH CARE NEEDS. IT SHALL PROVIDE A FRAMEWORK TO SUPPORT VOLUNTARY INITIATIVES IN COLLABORATION TO IMPROVE PATIENT CARE ACCESS AND MANAGEMENT, PATIENT HEALTH OUTCOMES, COST-EFFECTIVENESS IN THE USE OF HEALTH CARE SERVICES AND COMMUNITY POPULATION HEALTH. SUCH COLLABORATIVE INITIATIVES MAY ALSO INCLUDE PAYORS, SKILLED NURSING FACILITIES AND OTHER INTERDISCIPLINARY PROVIDERS, PRACTITIONERS AND SERVICE ENTITIES.

2. FOR PURPOSES OF THIS SECTION:

(A) "HOSPITAL" SHALL INCLUDE A GENERAL HOSPITAL AS DEFINED IN THIS ARTICLE OR OTHER INPATIENT FACILITY FOR REHABILITATION OR SPECIALTY CARE WITHIN THE DEFINITION OF HOSPITAL IN THIS ARTICLE.

(B) "HOME CARE AGENCY" SHALL MEAN A CERTIFIED HOME HEALTH AGENCY, LONG TERM HOME HEALTH CARE PROGRAM OR LICENSED HOME CARE SERVICES AGENCY AS DEFINED IN ARTICLE THIRTY-SIX OF THIS CHAPTER.

(C) "PAYOR" SHALL MEAN A HEALTH PLAN APPROVED PURSUANT TO ARTICLE FORTY-FOUR OF THIS CHAPTER, OR ARTICLE THIRTY-TWO OR FORTY-THREE OF THE INSURANCE LAW.

(D) "PRACTITIONER" SHALL MEAN ANY OF THE HEALTH, MENTAL HEALTH OR HEALTH RELATED PROFESSIONS LICENSED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW.

3. THE COMMISSIONER IS AUTHORIZED TO PROVIDE FINANCING INCLUDING, BUT NOT LIMITED TO, GRANTS OR POSITIVE ADJUSTMENTS IN MEDICAL ASSISTANCE RATES OR PREMIUM PAYMENTS, TO THE EXTENT OF FUNDS AVAILABLE AND ALLOCATED OR APPROPRIATED THEREFOR, INCLUDING FUNDS PROVIDED TO THE STATE THROUGH FEDERAL WAIVERS, FUNDS MADE AVAILABLE THROUGH STATE APPROPRIATIONS AND/OR FUNDING THROUGH SECTION TWENTY-EIGHT HUNDRED SEVEN-V OF THIS ARTICLE, AS WELL AS WAIVERS OF REGULATIONS UNDER TITLE TEN OF THE NEW YORK CODES, RULES AND REGULATIONS, TO SUPPORT THE VOLUNTARY INITIATIVES AND OBJECTIVES OF THIS SECTION.

4. HOSPITAL-HOME CARE-PHYSICIAN COLLABORATIVE INITIATIVES UNDER THIS SECTION MAY INCLUDE, BUT SHALL NOT BE LIMITED TO:

(A) HOSPITAL-HOME CARE-PHYSICIAN INTEGRATION INITIATIVES, INCLUDING BUT NOT LIMITED TO:

(I) TRANSITIONS IN CARE INITIATIVES TO HELP EFFECTIVELY TRANSITION PATIENTS TO POST-ACUTE CARE AT HOME, COORDINATE FOLLOW-UP CARE AND ADDRESS ISSUES CRITICAL TO CARE PLAN SUCCESS AND READMISSION AVOIDANCE;

(II) CLINICAL PATHWAYS FOR SPECIFIED CONDITIONS, GUIDING PATIENTS' PROGRESS AND OUTCOME GOALS, AS WELL AS EFFECTIVE HEALTH SERVICES USE;

(III) APPLICATION OF TELEHEALTH/TELEMEDICINE SERVICES IN MONITORING AND MANAGING PATIENT CONDITIONS, AND PROMOTING SELF-CARE/MANAGEMENT, IMPROVED OUTCOMES AND EFFECTIVE SERVICES USE;

(IV) FACILITATION OF PHYSICIAN HOUSE CALLS TO HOMEBOUND PATIENTS AND/OR TO PATIENTS FOR WHOM SUCH HOME VISITS ARE DETERMINED NECESSARY AND EFFECTIVE FOR PATIENT CARE MANAGEMENT;

(V) ADDITIONAL MODELS FOR PREVENTION OF AVOIDABLE HOSPITAL READMISSIONS AND EMERGENCY ROOM VISITS;

(VI) HEALTH HOME DEVELOPMENT;

(VII) DEVELOPMENT AND DEMONSTRATION OF NEW MODELS OF INTEGRATED OR COLLABORATIVE CARE AND CARE MANAGEMENT NOT OTHERWISE ACHIEVABLE THROUGH EXISTING MODELS; AND

(VIII) BUNDLED PAYMENT DEMONSTRATIONS FOR HOSPITAL-TO-POST-ACUTE-CARE FOR SPECIFIED CONDITIONS OR CATEGORIES OF CONDITIONS, IN PARTICULAR, CONDITIONS PREDISPOSED TO HIGH PREVALENCE OF READMISSION, INCLUDING THOSE CURRENTLY SUBJECT TO FEDERAL/STATE PENALTY, AND OTHER DISCHARGES WITH EXTENSIVE POST-ACUTE NEEDS;

(B) RECRUITMENT, TRAINING AND RETENTION OF HOSPITAL/HOME CARE DIRECT CARE STAFF AND PHYSICIANS, IN GEOGRAPHIC OR CLINICAL AREAS OF DEMONSTRATED NEED. SUCH INITIATIVES MAY INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING ACTIVITIES:

(I) OUTREACH AND PUBLIC EDUCATION ABOUT THE NEED AND VALUE OF SERVICE IN HEALTH OCCUPATIONS;

(II) TRAINING/CONTINUING EDUCATION AND REGULATORY FACILITATION FOR CROSS-TRAINING TO MAXIMIZE FLEXIBILITY IN THE UTILIZATION OF STAFF, INCLUDING:

(A) TRAINING OF HOSPITAL NURSES IN HOME CARE;

(B) DUAL CERTIFIED NURSE AIDE/HOME HEALTH AIDE CERTIFICATION; AND

(C) DUAL PERSONAL CARE AIDE/HHA CERTIFICATION;

(III) SALARY/BENEFIT ENHANCEMENT;

(IV) CAREER LADDER DEVELOPMENT; AND

(V) OTHER INCENTIVES TO PRACTICE IN SHORTAGE AREAS; AND

(C) HOSPITAL - HOME CARE - PHYSICIAN COLLABORATIVES FOR THE CARE AND MANAGEMENT OF SPECIAL NEEDS, HIGH-RISK AND HIGH-COST PATIENTS, INCLUDING BUT NOT LIMITED TO BEST PRACTICES, AND TRAINING AND EDUCATION OF DIRECT CARE PRACTITIONERS AND SERVICE EMPLOYEES.

5. HOSPITALS AND HOME CARE AGENCIES WHICH ARE PROVIDED FINANCING OR WAIVERS PURSUANT TO THIS SECTION SHALL REPORT TO THE COMMISSIONER ON THE PATIENT, SERVICE AND COST EXPERIENCES PURSUANT TO THIS SECTION, INCLUDING THE EXTENT TO WHICH THE PROJECT GOALS ARE ACHIEVED. THE COMMISSIONER SHALL COMPILE AND MAKE SUCH REPORTS AVAILABLE ON THE DEPARTMENT'S WEBSITE.

S 49. The public health law is amended by adding two new sections 3614-d and 3614-e to read as follows:

S 3614-D. UNIVERSAL STANDARDS FOR CODING OF PAYMENT FOR MEDICAL ASSISTANCE CLAIMS FOR LONG TERM CARE. CLAIMS FOR PAYMENT SUBMITTED UNDER CONTRACTS OR AGREEMENTS WITH INSURERS UNDER THE MEDICAL ASSISTANCE PROGRAM FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES PROVIDED UNDER THIS ARTICLE, BY FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, AND BY RESIDENTIAL HEALTH CARE FACILITIES OPERATING PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER SHALL HAVE STANDARD BILLING CODES. SUCH INSURERS SHALL INCLUDE BUT NOT BE LIMITED TO MEDICAID MANAGED CARE PLANS AND MANAGED LONG TERM CARE PLANS. SUCH PAYMENTS SHALL BE BASED ON UNIVERSAL BILLING CODES APPROVED BY THE DEPARTMENT OR A NATIONALLY ACCREDITED ORGANIZATION AS APPROVED BY THE DEPARTMENT; PROVIDED, HOWEVER, SUCH CODING SHALL BE CONSISTENT WITH ANY CODES DEVELOPED AS PART OF THE UNIFORM ASSESSMENT SYSTEM FOR LONG TERM CARE ESTABLISHED BY THE DEPARTMENT.

S 3614-E. ELECTRONIC PAYMENT OF CLAIMS. THE PAYMENT OF CLAIMS SUBMITTED UNDER CONTRACTS OR AGREEMENTS WITH INSURERS UNDER THE MEDICAL ASSISTANCE PROGRAM FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES PROVIDED UNDER THIS ARTICLE, BY FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, AND BY RESIDENTIAL HEALTH CARE FACILITIES OPERATING PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER SHALL BE PAID VIA ELECTRONIC FUNDS TRANSFER. SUCH INSURERS SHALL INCLUDE BUT NOT BE LIMITED TO MEDICAID MANAGED CARE PLANS AND MANAGED LONG-TERM CARE PLANS.

S 50. Subdivision 4 of section 365-h of the social services law, as amended by section 20 of part B of chapter 109 of the laws of 2010, is amended to read as follows:

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, OTHER THAN TRANSPORTATION SERVICES PROVIDED OR ARRANGED FOR ENROLLEES OF MANAGED LONG TERM CARE PLANS ISSUED CERTIFICATES OF AUTHORITY UNDER SECTION FORTY-FOUR HUNDRED THREE-F OF THE PUBLIC HEALTH LAW. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner. [Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under this subdivision without a competitive bid or request for proposal process, provided, however, that:

(a) the department shall post on its website, for a period of no less than thirty days:

(i) a description of the proposed services to be provided pursuant to the contract or contracts;

(ii) the criteria for selection of a contractor or contractors;

(iii) the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(iv) the manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(b) all reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner; and

(c) the commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.]

S 51. Section 2826 of the public health law is amended by adding a new subdivision (c-1) to read as follows:

(C-1) THE COMMISSIONER, UNDER APPLICATIONS SUBMITTED TO THE DEPARTMENT PURSUANT TO SUBDIVISION (D) OF THIS SECTION, SHALL CONSIDER CRITERIA THAT INCLUDES, BUT IS NOT LIMITED TO:

(I) SUCH APPLICANT'S FINANCIAL CONDITION AS EVIDENCED BY OPERATING MARGINS, NEGATIVE FUND BALANCE OR NEGATIVE EQUITY POSITION;

(II) THE EXTENT TO WHICH SUCH APPLICANT FULFILLS OR WILL FULFILL AN UNMET HEALTH CARE NEED FOR ACUTE INPATIENT, OUTPATIENT, PRIMARY OR RESIDENTIAL HEALTH CARE SERVICES IN A COMMUNITY;

(III) THE EXTENT TO WHICH SUCH APPLICATION WILL INVOLVE SAVINGS TO THE MEDICAID PROGRAM;

(IV) THE QUALITY OF THE APPLICATION AS EVIDENCED BY SUCH APPLICATION'S LONG TERM SOLUTIONS FOR SUCH APPLICANT TO ACHIEVE SUSTAINABLE HEALTH CARE SERVICES, IMPROVING THE QUALITY OF PATIENT CARE, AND/OR TRANSFORMING THE DELIVERY OF HEALTH CARE SERVICES TO MEET COMMUNITY NEEDS;

(V) THE EXTENT TO WHICH SUCH APPLICANT IS GEOGRAPHICALLY ISOLATED IN RELATION TO OTHER PROVIDERS; OR

(VI) THE EXTENT TO WHICH SUCH APPLICANT PROVIDES SERVICES TO AN UNDERSERVED AREA IN RELATION TO OTHER PROVIDERS.

S 52. Paragraph (d) of subdivision 2-a of section 2808 of the public health law, as added by chapter 483 of the laws of 1978, is amended to read as follows:

(d) For facilities granted operating certificates on or after March tenth, nineteen hundred seventy-five, recognition of real property costs in such regulations shall be based upon historical costs to the owner of the facility, provided that payment for real property costs shall not be in excess of the actual debt service, including principal and interest, and payment with respect to owner's equity, AND FURTHER PROVIDED THAT, SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, AND SUBJECT TO THE APPROVAL OF THE COMMISSIONER, EFFECTIVE APRIL FIRST, TWO THOUSAND FIFTEEN, THE COMMISSIONER MAY MODIFY SUCH PAYMENTS FOR REAL PROPERTY COSTS FOR PURPOSES OF EFFECTUATING A SHARED SAVINGS PROGRAM, WHEREBY FACILITIES SHARE A MINIMUM OF FIFTY PERCENT OF SAVINGS, FOR FACILITIES THAT ELECT TO REFINANCE THEIR MORTGAGE LOANS. For purposes of this subdivision, owner's equity shall be calculated without regard to any surplus created by revaluation of assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

S 53. The opening paragraph of subdivision 1 and subdivision 3 of section 367-s of the social services law, as amended by section 8 of part C of chapter 60 of the laws of 2014, are amended to read as follows:

Notwithstanding any provision of law to the contrary, a supplemental medical assistance payment shall be made on an annual basis to providers of emergency medical transportation services in an aggregate amount not to exceed four million dollars for two thousand six, six million dollars for two thousand seven, six million dollars for two thousand eight, [and] six million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, AND SIX MILLION DOLLARS ANNUALLY BEGINNING WITH THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN pursuant to the following methodology:

3. If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed two million dollars for two thousand six, three million dollars for two thousand seven, three million dollars

for two thousand eight [and], three million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, AND THREE MILLION DOLLARS ANNUALLY BEGINNING WITH THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be two million dollars or three million dollars as applicable to the annual period.

S 54. Paragraph (e) of subdivision 8 of section 2511 of the public health law is REPEALED.

S 55. Subdivision 18 of section 364-j of the social services law is amended by adding two new paragraphs (c) and (d) to read as follows:

(C) THE DEPARTMENT OF HEALTH SHALL REQUIRE THE INDEPENDENT ACTUARY SELECTED PURSUANT TO PARAGRAPH (B) OF THIS SUBDIVISION TO PROVIDE A COMPLETE ACTUARIAL MEMORANDUM, ALONG WITH ALL ACTUARIAL ASSUMPTIONS MADE AND ALL OTHER DATA, MATERIALS AND METHODOLOGIES USED IN THE DEVELOPMENT OF RATES, TO MANAGED CARE PROVIDERS THIRTY DAYS PRIOR TO SUBMISSION OF SUCH RATES TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR APPROVAL. MANAGED CARE PROVIDERS MAY REQUEST ADDITIONAL REVIEW OF THE ACTUARIAL SOUNDNESS OF THE RATE SETTING PROCESS AND/OR METHODOLOGY.

(D) THE DEPARTMENT OF HEALTH SHALL ANNUALLY PROVIDE TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY THE ANNUAL MEDICAID MANAGED CARE OPERATING REPORTS SUBMITTED TO THE DEPARTMENT FROM MANAGED CARE PLANS THAT CONTRACT WITH THE STATE TO MANAGE SERVICES PROVIDED UNDER THE MEDICAID PROGRAM.

S 56. Subdivisions 2 and 3 of section 19 of part B of chapter 58 of the laws of 2007 amending the elder law and other laws relating to authorizing the adjustment of the Medicaid nursing home capital reimbursement cap are amended to read as follows:

2. Notwithstanding subdivision one of this section, on a demonstration basis, without requirement for a request for proposals, the department may adjust the medicaid nursing home capital reimbursement cap in order to: (A) effectuate the construction of a residential health care facility described in subdivision one of this section, by the Capital Region Rehabilitation Center also known as the Eddy Cohoes Rehabilitation Center; AND (B) EFFECTUATE A RESIDENTIAL HEALTH CARE FACILITY CONSTRUCTION PROJECT BY THE JEWISH HOME OF ROCHESTER.

3. Upon completion and occupation of the [first] residential unit of a facility under this demonstration and annually thereafter, [the Capital Region Rehabilitation Center also known as the Eddy Cohoes Rehabilitation Center] THE ELIGIBLE FACILITIES shall report to the department on the number of patients served, the type of services provided, and outcome and financial data that demonstrates the efficacy of this residential model.

S 57. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 58. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 59. 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 60. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015 and provided that:

1. sections one and fifty-two of this act shall expire and be deemed repealed March 31, 2020;

2. sections nine, twelve and thirteen of this act shall take effect June 1, 2015;

3. section thirty-one of this act shall take effect July 1, 2015;

4. section fifteen-a of this act shall take effect October 1, 2015; provided however that such section shall not take effect if, on October 1, 2015: (a) federal law or regulation requires the department of health to calculate its Medicaid payments to managed care organizations to include cost sharing established under the State plan for medical assistance for enrollees who are not exempt from cost sharing; and (b) the department of health has obtained a waiver of such requirement from the Centers for Medicare and Medicaid Services; provided further that the commissioner of health shall notify the legislative bill drafting commission of the grant or denial of such waiver by the Centers for Medicare and Medicaid Services provided for in this section in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law.

5. section thirty-eight of this act shall expire and be deemed repealed March 31, 2018;

6. section forty-nine of this act shall apply to any coding of payment or claims for long term care on and after January 1, 2016;

7. sections twenty-eight and forty-six of this act shall take effect on the same date and in the same manner as section 51 of part C of chapter 60 of the laws of 2014 takes effect;

8. section forty-five of this act shall take effect on the same date and in the same manner as section 50 of part C of chapter 60 of the laws of 2014 takes effect;

9. the amendments made to section 364-j of the social services law by sections thirty-six-b, forty-c and fifty-five of this act shall not affect the repeal of such sections and shall be deemed repealed therewith;

9-a. the amendments made to section 4403-f of the public health law by section forty-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

9-b. the amendments made to section 365-h of the social services law by section fifty of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

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

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

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

13. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of the department of financial services and any appropriate council is authorized to adopt or amend or promulgate any regulation he or she or such council determines necessary to implement any provision of this act on its effective date; and

14. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of the department of financial services or any council to adopt or amend or promulgate regulations implementing this act.

PART C

Section 1. 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 13 of part C of chapter 60 of the laws of 2014, 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 [the] SECTION 13 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through [December 31, 2016] JUNE 30, 2017 for patients in the city of New York, for all rate periods on and after the effective date

of [the] SECTION 13 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through [June 30,] DECEMBER 31, 2017 for patients outside the city of New York, and for all rate periods on and after the effective date of such chapter [of the laws of 2014 which amended this section] through December 31, 2017 for all services provided to persons under the age of twenty-one; provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

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, 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 2. 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 15 of part C of chapter 60 of the laws of 2014, 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 arti-

cle 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 [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through [December 31, 2016] JUNE 30, 2017 for patients in the city of New York, for all rate periods on and after the effective date of [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through [June 30,] DECEMBER 31, 2017 for patients outside the city of New York, and for all rate periods on and after the effective date of [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through December 31, 2017 for all services provided to persons under the age of twenty-one; provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the 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, 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 3. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 4. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 5. 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 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015. Provided, however that:

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

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

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

4. notwithstanding any inconsistent provision of the state administrative procedure act or any other provision of law, rule or regulation, the commissioner of health and the superintendent of the department of financial services and any appropriate council is authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date;

5. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of the

department of financial services or any council to adopt or amend or promulgate regulations implementing this act; and

6. the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section one of this act and the amendments to section 1 of part H of chapter 111 of the laws of 2010 made by section two of this act shall not affect the expiration of such sections and shall be deemed to expire therewith.

PART D

Section 1. Section 11 of chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, as amended by section 3 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

S 11. This act shall take effect immediately and:

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

(b) sections four through ten shall expire on June 30, [2015] 2017, and

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

S 2. Subdivision 2 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 4 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

2. Sections five, seven through nine, twelve through fourteen, and eighteen of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2006 and on and after April 1, 2006 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and sections twelve, thirteen and fourteen of this act shall be deemed to be in full force and effect on and after April 1, 2011 through March 31, 2015 AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017;

S 3. Subparagraph (vi) of paragraph (b) of subdivision 2 of section 2807-d of the public health law, as amended by section 5 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine,

and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, AND FURTHER PROVIDED THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN SUCH ASSESSMENT SHALL BE SIX PERCENT.

S 4. Section 88 of chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, as amended by section 6 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

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

S 5. Subdivision 1 of section 194 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 9 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

S 6. Subdivision 1 of section 89-a of part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, as amended by section 10 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017 for inpatient and outpatient services provided by general hospitals and for inpatient services and

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

S 7. Paragraph (f) of subdivision 1 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 11 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(f) Prior to February 1, 2001, February 1, 2002, February 1, 2003, February 1, 2004, February 1, 2005, February 1, 2006, February 1, 2007, February 1, 2008, February 1, 2009, February 1, 2010, February 1, 2011, February 1, 2012, February 1, 2013 [and], February 1, 2014 [and], February 1, 2015, FEBRUARY 1, 2016 AND FEBRUARY 1, 2017 the commissioner of health shall calculate the result of the statewide total of residential health care facility days of care provided to beneficiaries of title XVIII of the federal social security act (medicare), divided by the sum of such days of care plus days of care provided to residents eligible for payments pursuant to title 11 of article 5 of the social services law minus the number of days provided to residents receiving hospice care, expressed as a percentage, for the period commencing January 1, through November 30, of the prior year respectively, based on such data for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide target percentage respectively.

S 8. Subparagraph (ii) of paragraph (b) of subdivision 3 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 12 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide target percentages are not for each year at least three percentage points higher than the statewide base percentage, the commissioner of health shall determine the percentage by which the statewide target percentage for each year is not at least three percentage points higher than the statewide base percentage. The percentage calculated pursuant to this paragraph shall be called the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide reduction percentage respectively. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013[;], 2014 [and], 2015, 2016 AND 2017 statewide target percentage for the respective year is at least three percentage points higher than the statewide base percentage, the statewide reduction percentage for the respective year shall be zero.

S 9. Subparagraph (iii) of paragraph (b) of subdivision 4 of section 64 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 13 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

(iii) The 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide reduction percentage shall be multiplied by one hundred two million dollars respectively to determine the 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide aggregate reduction amount. If the 1998 and the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide reduction percentage shall be zero respectively, there shall be no 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 reduction amount.

S 10. Section 228 of chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, as amended by section 14-a of part B of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

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

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

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean

January 1, 2013 through November 30, 2013, and the 2014 target period shall mean January 1, 2014 through November 30, 2014 and the 2015 target period shall mean January 1, 2015 through November 30, 2015 AND THE 2016 TARGET PERIOD SHALL MEAN JANUARY 1, 2016 THROUGH NOVEMBER 30, 2016 AND THE 2017 TARGET PERIOD SHALL MEAN JANUARY 1, 2017 THROUGH NOVEMBER 30, 2017.

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

(b) Prior to February 1, 1998, prior to February 1, 1999, prior to February 1, 2000, prior to February 1, 2001, prior to February 1, 2002, prior to February 1, 2003, prior to February 1, 2004, prior to February 1, 2005, prior to February 1, 2006, prior to February 1, 2007, prior to February 1, 2008, prior to February 1, 2009, prior to February 1, 2010, prior to February 1, 2011, prior to February 1, 2012, prior to February 1, 2013, prior to February 1, 2014 [and], prior to February 1, 2015, AND PRIOR TO FEBRUARY 1, 2016 AND PRIOR TO FEBRUARY 1, 2017 for each regional group the commissioner of health shall calculate the prior year's medicaid revenue percentages for the period commencing January 1 through November 30 of such prior year.

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

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

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 for each regional group, the target medicaid revenue percentage for the respective year shall be calculated by subtracting the respective year's medicaid revenue reduction percentage from the base period medicaid revenue percentage. The medicaid revenue reduction percentages for 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to for each such year:

(i) one and one-tenth percentage points for CHHAs located within the downstate region;

(ii) six-tenths of one percentage point for CHHAs located within the upstate region;

(iii) one and eight-tenths percentage points for LTHHCPs located within the downstate region; and

(iv) one and seven-tenths percentage points for LTHHCPs located within the upstate region.

(c) For each regional group, the 1999 target medicaid revenue percentage shall be calculated by subtracting the 1999 medicaid revenue reduction percentage from the base period medicaid revenue percentage. The 1999 medicaid revenue reduction percentages, taking into account regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

(i) eight hundred twenty-five thousandths (.825) of one percentage point for CHHAs located within the downstate region;

(ii) forty-five hundredths (.45) of one percentage point for CHHAs located within the upstate region;

(iii) one and thirty-five hundredths percentage points (1.35) for LTHHCPs located within the downstate region; and

(iv) one and two hundred seventy-five thousandths percentage points (1.275) for LTHHCPs located within the upstate region.

5. (a) For each regional group, if the 1996 medicaid revenue percentage is not equal to or less than the 1996 target medicaid revenue percentage, the commissioner of health shall compare the 1996 medicaid revenue percentage to the 1996 target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the 1996 medicaid revenue reduction percentage, shall be called the 1996 reduction factor. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 medicaid revenue percentage is equal to or less than the 1996 target medicaid revenue percentage, the 1996 reduction factor shall be zero.

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016, AND 2017, for each regional group, if the medicaid revenue percentage for the respective year is not equal to or less than the target medicaid revenue percentage for such respective year, the commissioner of health shall compare such respective year's medicaid revenue percentage to such respective year's target medicaid revenue percentage to determine the amount of the shortfall which, when divided by the respective year's medicaid revenue reduction percentage, shall be called the reduction factor for such respective year. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the medicaid revenue percentage for a particular year is equal to or less than the target medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

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

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

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

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

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

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

(b) For 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017, for each regional group, the reduction factor for the respective year shall be multiplied by the following amounts to determine each regional

group's applicable state share reduction amount for such respective year:

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

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

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

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

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

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

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

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

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

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

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

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

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 for each regional group, the state share reduction amount for the respective year shall be allocated by the commissioner of health among CHHAs and LTHHCPs on the basis of the extent of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHA's and LTHHCP's failure to achieve the target medicaid revenue percentage for the applicable year within the applicable regional group. This proportion shall be multiplied by the applicable year's state share reduction amount calculation pursuant to paragraph (b) or (c) of subdivision 6 of this section. This amount shall be called the provider specific state share reduction amount for the applicable year.

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

(b) The provider specific state share reduction amount for 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 respectively, shall be due to the state from each CHHA and LTHHCP and each year the amount due for such year may be recouped by the state by March 31 of the following year in a lump sum amount or amounts from payments due to the CHHA and LTHHCP pursuant to title 11 of article 5 of the social services law.

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

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

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

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

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

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

S 11. Subdivision 5-a of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 15 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31,

2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017;

S 12. Section 64-b of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 16 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

S 64-b. Notwithstanding any inconsistent provision of law, the provisions of subdivision 7 of section 3614 of the public health law, as amended, shall remain and be in full force and effect on April 1, 1995 through March 31, 1999 and on July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017.

S 13. Subdivision 1 of section 20 of chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, as amended by section 17 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

1. sections four, eleven and thirteen of this act shall take effect immediately and shall expire and be deemed repealed June 30, [2015] 2017;

S 14. The opening paragraph of subdivision 7-a of section 3614 of the public health law, as amended by section 18 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen and on and after April first, two thousand thirteen through March thirty-first, two thousand fifteen, AND ON AND AFTER APRIL 1ST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

S 15. Subdivision 12 of section 246 of chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, as amended by section 21 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

12. Sections one hundred five-b through one hundred five-f of this act shall expire March 31, [2015] 2017.

S 16. Section 3 of chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, as amended by section 30 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 3. This act shall take effect immediately, provided, however, that subdivision 15-a of section 5 of section 1 of chapter 392 of the laws of 1973, as added by section one of this act, shall expire and be deemed repealed June 30, [2015] 2019; and provided further, however, that the expiration and repeal of such subdivision 15-a shall not affect or impair in any manner any health facilities bonds issued, or any lease or purchase of a health facility executed, pursuant to such subdivision 15-a prior to its expiration and repeal and that, with respect to any such bonds issued and outstanding as of June 30, [2015] 2019, the provisions of such subdivision 15-a as they existed immediately prior to such expiration and repeal shall continue to apply through the latest maturity date of any such bonds, or their earlier retirement or redemption, for the sole purpose of authorizing the issuance of refunding bonds to refund bonds previously issued pursuant thereto.

S 17. Subdivision (c) of section 62 of chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, as amended by section 26 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

(c) section 364-j of the social services law, as amended by section eight of this act and subdivision 6 of section 367-a of the social services law as added by section twelve of this act shall expire and be deemed repealed on March 31, [2015] 2019 and provided further, that the amendments to the provisions of section 364-j of the social services law made by section eight of this act shall only apply to managed care programs approved on or after the effective date of this act;

S 18. Subdivision 3 of section 1680-j of the public authorities law, as amended by section 9 of part C of chapter 59 of the laws of 2011, is amended to read as follows:

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA) resources fund (061) to the general fund, upon the request of the director of the budget, up to $6,500,000 on or before March 31, 2006, and the comptroller is further hereby authorized and directed to transfer from the healthcare reform act (HCRA); Resources fund (061) to the Capital Projects Fund, upon the request of the director of budget, up to $139,000,000 for the period April 1, 2006 through March 31, 2007, up to $171,100,000 for the period April 1, 2007 through March 31, 2008, up to $208,100,000 for the period April 1, 2008 through March 31, 2009, up to $151,600,000 for the period April 1, 2009 through March 31, 2010, up to $215,743,000 for the period April 1, 2010 through March 31, 2011, up to $433,366,000 for the period April 1, 2011 through March 31, 2012, up to $150,806,000 for the period April 1, 2012 through March 31, 2013, up to $78,071,000 for the period April 1, 2013 through March 31, 2014, and up to $86,005,000 for the period April 1, 2014 through March 31, 2015, AND UP TO $86,005,000 FOR THE PERIOD APRIL 1, 2015 THROUGH DECEMBER 31, 2017.

S 19. Subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, relating to enacting into law major components of legislation necessary to implement the health and mental hygiene budget for the 2011-2012 state fiscal plan, is amended to read as follows:

(i) the amendments to paragraph (b) and subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section forty-one-b of this act shall expire and be repealed April 1, [2015] 2019;

S 20. Section 97 of chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, as amended by section 65-b of part A of chapter 57 of the laws of 2006, is amended to read as follows:

S 97. This act shall take effect immediately, provided, however, that the amendments to subdivision 4 of section 854 of the general municipal law made by section seventy of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith and provided further that sections sixty-seven and sixty-eight of this act shall apply to taxable years beginning on or after January 1, 1998 and provided further that sections eighty-one through eighty-seven of this act shall expire and be deemed repealed on December 31, [2015] 2019 and provided further, however, that the amendments to section ninety of this act shall take effect January 1, 1998 and shall apply to all policies, contracts, certificates, riders or other evidences of coverage of long term care insurance issued, renewed, altered or modified pursuant to section 3229 of the insurance law on or after such date.

S 21. Paragraph (b) of subdivision 17 of section 2808 of the public health law, as amended by section 98 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal [year] YEARS beginning April first, two thousand ten and ending March thirty-first, two thousand [fifteen] NINETEEN, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [fifteen] NINETEEN, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further, the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand [fifteen] NINETEEN. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

S 22. Paragraph (a) of subdivision 13 of section 3614 of the public health law, as added by section 4 of part H of chapter 59 of the laws of 2011, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first,

two thousand [fifteen] NINETEEN, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

S 23. Subdivision (a) of section 40 of part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, is amended to read as follows:

(a) sections two, three, three-a, three-b, three-c, three-d, three-e and twenty-one of this act shall take effect July 1, 2010; sections fifteen, sixteen, seventeen, eighteen and nineteen of this act shall take effect January 1, 2011; and provided further that section twenty of this act shall be deemed repealed [four] SIX years after the date the contract entered into pursuant to section 365-h of the social services law, as amended by section twenty of this act, is executed; provided that the commissioner of health shall notify the legislative bill drafting commission upon the execution of the contract entered into pursuant to section 367-h of the social services law in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law;

S 24. Subdivision 4 of section 365-h of the social services law, as added by section 20 of part B of chapter 109 of the laws of 2010, is amended to read as follows:

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner. [Notwith-

standing any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under this subdivision without a competitive bid or request for proposal process, provided, however, that:

(a) the department shall post on its website, for a period of no less than thirty days:

(i) a description of the proposed services to be provided pursuant to the contract or contracts;

(ii) the criteria for selection of a contractor or contractors;

(iii) the period of time during which a prospective contractor may seek selection, which shall be no less than thirty days after such information is first posted on the website; and

(iv) the manner by which a prospective contractor may seek such selection, which may include submission by electronic means;

(b) all reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner; and

(c) the commissioner shall select such contractor or contractors that, in his or her discretion, are best suited to serve the purposes of this section.]

S 25. Intentionally omitted.

S 26. Section 2 of chapter 459 of the laws of 1996, amending the public health law relating to recertification of persons providing emergency medical care, as amended by chapter 106 of the laws of 2011, is amended to read as follows:

S 2. This act shall take effect immediately and shall expire and be deemed repealed July 1, [2015] 2019.

S 27. Section 4 of chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, as amended by section 29 of part A of chapter 59 of the laws of 2011, is amended to read as follows:

S 4. This act shall take effect immediately; provided, however, that the provisions of paragraph (b) of subdivision 4 of section 409-c of the public health law, as added by section three of this act, shall take effect January 1, 1996 and shall expire and be deemed repealed [twenty] TWENTY-FOUR years from the effective date thereof.

S 28. Subdivision (o) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law relating to the statewide health information network of New York and the statewide planning and research cooperative system and general powers and duties, is amended to read as follows:

(o) sections thirty-eight and thirty-eight-a of this act shall expire and be deemed repealed March 31, [2015] 2017;

S 29. Section 4-a of part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, is amended to read as follows:

S 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [2015] 2017 through March 31, [2015] 2017, for inpatient and outpatient services provided by general hospitals, for

inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the [2015] 2017 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such [2015] 2017 calendar year shall also be applied to rates of payment provided on and after January 1, [2015] 2017 through March 31, [2015] 2017 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, [2015] 2017 through March 31, [2015] 2017, such trend factors attributable to the [2015] 2017 calendar year shall be established at no greater than zero percent.

S 29-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, 2015, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the 2015 and 2016 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such 2015 and 2016 calendar year shall also be applied to rates of payment provided on and after January 1, 2015 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, 2015, such trend factors attributable to the 2015 and 2016 calendar year shall be established at no greater than zero percent.

S 30. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the

federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 31. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 32. 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 33. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015 provided, that:

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

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

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

4. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of the department of financial services or any council to adopt or amend or promulgate regulations implementing this act.

PART E

Section 1. Subdivision 5-d of section 2807-k of the public health law, as added by section 1 of part C of chapter 56 of the laws of 2013, is amended to read as follows:

5-d. (a) Notwithstanding any inconsistent provision of this section, section twenty-eight hundred seven-w of this article or any other contrary provision of law, and subject to the availability of federal financial participation, for periods on and after January first, two thousand thirteen, through December thirty-first, two thousand [fifteen] EIGHTEEN, all funds available for distribution pursuant to this section, except for funds distributed pursuant to subparagraph (v) of paragraph (b) of subdivision five-b of this section, and all funds available for distribution pursuant to section twenty-eight hundred seven-w of this article, shall be reserved and set aside and distributed in accordance with the provisions of this subdivision.

(b) The commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing methodologies for the distribution of funds as described in paragraph (a) of this subdivision and such regulations shall include, but not be limited to, the following:

(i) Such regulations shall establish methodologies for determining each facility's relative uncompensated care need amount based on uninsured inpatient and outpatient units of service from the cost reporting year two years prior to the distribution year, multiplied by the applicable medicaid rates in effect January first of the distribution year, as summed and adjusted by a statewide cost adjustment factor and reduced by the sum of all payment amounts collected from such uninsured patients, and as further adjusted by application of a nominal need computation that shall take into account each facility's medicaid inpatient share.

(ii) Annual distributions pursuant to such regulations for the two thousand thirteen through two thousand [fifteen] EIGHTEEN calendar years shall be in accord with the following:

(A) one hundred thirty-nine million four hundred thousand dollars shall be distributed as Medicaid Disproportionate Share Hospital ("DSH") payments to major public general hospitals; and

(B) nine hundred ninety-four million nine hundred thousand dollars as Medicaid DSH payments to eligible general hospitals, other than major public general hospitals.

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph (ii) of this paragraph such that no facility experiences a reduction in indigent care pool payments pursuant to this subdivision that is greater than the percentages, as specified in clause (C) of this subparagraph as compared to the average distribution that each such facility received for the three calendar years prior to two thousand thirteen pursuant to this section and section twenty-eight hundred seven-w of this article.

(B) Such regulations shall also establish adjustments limiting the increases in indigent care pool payments experienced by facilities pursuant to this subdivision by an amount that will be, as determined by the commissioner and in conjunction with such other funding as may be available for this purpose, sufficient to ensure full funding for the transition adjustment payments authorized by clause (A) of this subparagraph.

(C) No facility shall experience a reduction in indigent care pool payments pursuant to this subdivision that: for the calendar year beginning January first, two thousand thirteen, is greater than two and one-half percent; for the calendar year beginning January first, two thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen, is greater than seven and one-half percent, AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND SIXTEEN, IS GREATER THAN TEN PERCENT; AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND SEVENTEEN, IS GREATER THAN TWELVE AND ONE-HALF PERCENT; AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND EIGHTEEN, IS GREATER THAN FIFTEEN PERCENT.

(iv) Such regulations shall reserve one percent of the funds available for distribution in the two thousand fourteen and two thousand fifteen calendar years, AND FOR CALENDAR YEARS THEREAFTER, pursuant to this subdivision, subdivision fourteen-f of section twenty-eight hundred seven-c of this article, and sections two hundred eleven and two hundred twelve of chapter four hundred seventy-four of the laws of nineteen hundred ninety-six, in a "financial assistance compliance pool" and shall establish methodologies for the distribution of such pool funds to facilities based on their level of compliance, as determined by the commissioner, with the provisions of subdivision nine-a of this section.

(c) The commissioner shall annually report to the governor and the legislature on the distribution of funds under this subdivision including, but not limited to:

(i) the impact on safety net providers, including community providers, rural general hospitals and major public general hospitals;

(ii) the provision of indigent care by units of services and funds distributed by general hospitals; and

(iii) the extent to which access to care has been enhanced.

S 2. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation pursuant to title XIX of the federal social security act, effective for periods on and after April 1, 2015, payments pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law may be made as outpatient upper payment limit payments for outpatient hospital services, not to exceed an amount of three hundred thirty-nine million dollars annually between payments authorized under this section and such section of the public health law. Such payments shall be made as medical assistance payments for outpatient services 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 for general hospital outpatient services and general hospital emergency room services issued pursuant to paragraph (g) of subdivision 2 of section 2807 of the public health law to general hospitals, other than major public general hospitals, providing emergency room services and including safety net hospitals, which shall, for the purpose of this paragraph, be defined as having either: a Medicaid share of total inpatient hospital discharges of at least thirty-five percent, including both fee-for-service and managed care discharges for acute and exempt services; or a Medicaid share of total discharges of at least thirty percent, including both fee-for-service and managed care discharges for acute and exempt services, and also providing obstetrical services. Eligibility to receive such additional payments shall be based on data from the period two years prior to the rate year, as reported on the institutional cost report submitted to the department as of October first of the prior rate year. No eligible general hospital's annual payment amount pursuant to this section shall exceed the lower of the sum of the annual amounts due that hospital pursuant to section twenty-eight hundred seven-k and section twenty-eight hundred seven-w of the public health law; or the hospital's facility specific projected disproportionate share hospital payment ceiling established pursuant to federal law, provided, however, that payment amounts to eligible hospitals in excess of the lower of such sum or payment ceiling shall be reallocated to eligible hospitals that do not have excess payment amounts. Such reallocations shall be proportional to each such hospital's aggregate payment amount pursuant to paragraph (i) of subdivision 35 of section 2807-c of the public health law and this section to the total of all payment amounts for such eligible hospitals. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible general hospitals other than major public general hospitals. The distribution of such payments shall be pursuant to a methodology approved by the commissioner of health in regulation.

S 3. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social

services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 4. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 5. 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 6. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015; provided, that:

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

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

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

d. the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of financial services or any council to adopt or amend or promulgate regulations implementing this act.

PART F

Intentionally Omitted

PART G

Intentionally Omitted

PART H

Intentionally Omitted

PART I

Section 1. Subdivision 2-a of section 2781 of the public health law is REPEALED.

S 2. The criminal procedure law is amended by adding a new section 60.47 to read as follows:

S 60.47 POSSESSION OF CONDOMS; RECEIPT INTO EVIDENCE.

EVIDENCE THAT A PERSON WAS IN POSSESSION OF ONE OR MORE CONDOMS MAY NOT BE ADMITTED AT ANY TRIAL, HEARING, OR OTHER PROCEEDING IN A PROSECUTION FOR SECTION 230.00 OR SECTION 240.37 OF THE PENAL LAW FOR THE PURPOSE OF ESTABLISHING PROBABLE CAUSE FOR AN ARREST OR PROVING ANY PERSON'S COMMISSION OR ATTEMPTED COMMISSION OF SUCH OFFENSE.

S 3. Section 220.45 of the penal law, as amended by chapter 284 of the laws of 2010, is amended to read as follows:

S 220.45 Criminally possessing a hypodermic instrument.

A person is guilty of criminally possessing a hypodermic instrument when he or she knowingly and unlawfully possesses or sells a hypodermic syringe or hypodermic needle. It shall not be a violation of this section when a person obtains and possesses a hypodermic syringe or hypodermic needle pursuant to section thirty-three hundred eighty-one of the public health law, WHICH INCLUDES THE STATE'S SYRINGE EXCHANGE AND PHARMACY AND MEDICAL PROVIDER-BASED EXPANDED SYRINGE ACCESS PROGRAMS.

Criminally possessing a hypodermic instrument is a class A misdemeanor.

S 4. Section 220.03 of the penal law, as amended by chapter 284 of the laws of 2010, the opening paragraph as amended by chapter 154 of the laws of 2011, is amended to read as follows:

S 220.03 Criminal possession of a controlled substance in the seventh degree.

A person is guilty of criminal possession of a controlled substance in the seventh degree when he or she knowingly and unlawfully possesses a controlled substance; provided, however, that it shall not be a violation of this section when a person possesses a residual amount of a controlled substance and that residual amount is in or on a hypodermic syringe or hypodermic needle obtained and possessed pursuant to section thirty-three hundred eighty-one of the public health law, WHICH INCLUDES THE STATE'S SYRINGE EXCHANGE AND PHARMACY AND MEDICAL PROVIDER-BASED EXPANDED SYRINGE ACCESS PROGRAMS; nor shall it be a violation of this section when a person's unlawful possession of a controlled substance is discovered as a result of seeking immediate health care as defined in paragraph (b) of subdivision three of section 220.78 of the penal law, for either another person or him or herself because such person is experiencing a drug or alcohol overdose or other life threatening medical emergency as defined in paragraph (a) of subdivision three of section 220.78 of the penal law.

Criminal possession of a controlled substance in the seventh degree is a class A misdemeanor.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. This act shall take effect immediately.

PART J

Intentionally Omitted

PART K

Section 1. Intentionally omitted.

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.
S 5. Intentionally omitted.
S 6. Intentionally omitted.
S 7. Subdivision 1 of section 2806-a of the public health law is amended by adding a new paragraph (g) to read as follows:
(G) "IMPROPER DELEGATION OF MANAGEMENT AUTHORITY BY THE GOVERNING AUTHORITY OR OPERATOR" OF A GENERAL HOSPITAL SHALL INCLUDE, BUT NOT BE LIMITED TO, THE DELEGATION TO AN ENTITY THAT HAS NOT BEEN ESTABLISHED AS AN OPERATOR OF THE GENERAL HOSPITAL OF (I) AUTHORITY TO HIRE OR FIRE THE ADMINISTRATOR OR OTHER KEY MANAGEMENT EMPLOYEES; (II) MAINTENANCE AND CONTROL OF THE BOOKS AND RECORDS; (III) AUTHORITY OVER THE DISPOSITION OF ASSETS AND THE INCURRING OF LIABILITIES ON BEHALF OF THE FACILITY; AND (IV) THE ADOPTION AND ENFORCEMENT OF POLICIES REGARDING THE OPERATION OF THE FACILITY. THE CRITERIA SET FORTH IN THIS PARAGRAPH SHALL NOT BE THE SOLE DETERMINING FACTORS, BUT INDICATORS TO BE CONSIDERED WITH SUCH OTHER FACTORS THAT MAY BE PERTINENT IN PARTICULAR INSTANCES. PROFESSIONAL EXPERTISE SHALL BE EXERCISED IN THE UTILIZATION OF THE CRITERIA. ALL OF THE LISTED INDICIA NEED NOT BE PRESENT IN A GIVEN INSTANCE FOR THERE TO BE AN IMPROPER DELEGATION OF AUTHORITY.
S 8. Paragraph (a) of subdivision 2 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, is amended to read as follows:
(a) In the event that: (i) a facility seeks extraordinary financial assistance and the commissioner finds that the facility is experiencing serious financial instability that is jeopardizing existing or continued access to essential services within the community, or (ii) the commissioner finds that there are conditions within the facility that seriously endanger the life, health or safety of residents or patients, the commissioner may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility, OR (III) THE COMMISSIONER FINDS THAT THERE HAS BEEN AN IMPROPER DELEGATION OF MANAGEMENT AUTHORITY BY THE GOVERNING AUTHORITY OR OPERATOR OF A GENERAL HOSPITAL, THE COMMISSIONER SHALL APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND SOLE RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY. The appointment of the temporary operator shall be effectuated pursuant to this section and shall be in addition to any other remedies provided by law.
S 9. Subparagraph (iii) of paragraph (c) of subdivision 5 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, is amended to read as follows:
(iii) recommended actions for the ongoing operation of the facility subsequent to the term of the temporary operator INCLUDING RECOMMENDATIONS REGARDING THE PROPER MANAGEMENT OF THE FACILITY AND ONGOING AGREEMENTS WITH INDIVIDUALS OR ENTITIES WITH PROPER DELEGATION OF MANAGEMENT AUTHORITY; and
S 10. Subdivision 4 of section 2801-a of the public health law is amended by adding a new paragraph (i) to read as follows:
(I) UPON RECOMMENDATION BY THE COMMISSIONER, IF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL FINDS BY SUBSTANTIAL EVIDENCE THAT AN IMPROPER DELEGATION OF MANAGEMENT AUTHORITY BY A GOVERNING AUTHORITY OR OPERATOR OF A GENERAL HOSPITAL HAS OCCURRED AS DEFINED BY PARAGRAPH (G) OF SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED SIX-A OF THIS ARTICLE, THE ESTABLISHMENT APPROVAL OF SUCH HOSPITAL SHALL BE SUBJECT TO REVOCATION OR SUSPENSION.
S 11. This act shall take effect immediately; provided, however, that the amendments to section 2806-a of the public health law, made by

sections seven, eight and nine of this act, shall not affect the expiration and repeal of such section, and shall be deemed repealed therewith.

PART L

Section 1. Paragraph (b) of subdivision 1 of section 230-d of the public health law, as added by chapter 365 of the laws of 2007, is amended to read as follows:

(b) "Adverse event" means (i) patient death within thirty days; (ii) unplanned transfer to a hospital OR EMERGENCY DEPARTMENT VISIT WITHIN SEVENTY-TWO HOURS OF OFFICE-BASED SURGERY FOR REASONS RELATED TO THE OFFICE-BASED SURGERY ENCOUNTER; (iii) unscheduled hospital admission OR ASSIGNMENT TO OBSERVATION SERVICES, within seventy-two hours of the office-based surgery, for longer than twenty-four hours; or (iv) any other serious or life-threatening event.

S 2. Subdivision 4 of section 230-d of the public health law, as amended by chapter 477 of the laws of 2008, is amended to read as follows:

4. (A) Licensees shall report adverse events to the department's patient safety center within [one] THREE business [day] DAYS of the occurrence of such adverse event. Licensees shall also report any suspected health care disease transmission originating in their practices to the patient safety center within [one] THREE business [day] DAYS of becoming aware of such suspected transmission. For purposes of this section, health care disease transmission shall mean the transmission of a reportable communicable disease that is blood borne from a health care professional to a patient or between patients as a result of improper infection control practices by the health care professional.

(B) THE DEPARTMENT MAY ALSO REQUIRE LICENSEES TO REPORT ADDITIONAL DATA SUCH AS PROCEDURAL INFORMATION AS NEEDED FOR THE INTERPRETATION OF ADVERSE EVENTS.

(C) The DATA reported [data] UNDER THIS SUBDIVISION shall be subject to all confidentiality provisions provided by section twenty-nine hundred ninety-eight-e of this chapter.

S 3. The section heading and subdivisions 1 and 2 of section 2998-e of the public health law, as added by chapter 365 of the laws of 2007, are amended to read as follows:

Reporting [of adverse events] in office based surgery. 1. The commissioner [shall] MAY enter into agreements with accrediting agencies [pursuant] to [which the accrediting agencies shall] REQUIRE ALL OFFICE-BASED SURGICAL PRACTICES TO CONDUCT QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES AND UTILIZE CERTIFICATION BY AN APPROPRIATE CERTIFYING ORGANIZATION, HOSPITAL PRIVILEGING OR OTHER EQUIVALENT METHODS TO DETERMINE COMPETENCY OF PRACTITIONERS TO PERFORM OFFICE-BASED SURGERY, CARRY OUT SURVEYS OR COMPLAINT/INCIDENT INVESTIGATIONS AND SHALL report, at a minimum, [aggregate data on adverse events] FINDINGS OF SURVEYS AND COMPLAINT/INCIDENT INVESTIGATIONS, AND DATA for all office-based surgical practices accredited by the accrediting agencies to the department. The department may disclose reports of aggregate data to the public.

2. The information required to be collected, maintained and reported directly to the department AND THE ACCREDITING AGENCIES AND MAINTAINED BY OFFICE-BASED SURGERY PRACTICES UNDER ADVERSE EVENT REPORTING, QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES pursuant to section two hundred thirty-d of this chapter shall be kept confidential and shall not be released, except to the department and except as required or

permitted under subdivision nine-a and subparagraph (v) of paragraph (a) of subdivision ten of section two hundred thirty of this chapter. Notwithstanding any other provision of law, none of [such information] THE INFORMATION COLLECTED, MAINTAINED AND REPORTED TO THE DEPARTMENT OR THE ACCREDITING AGENCIES, AND MAINTAINED BY THE OFFICE-BASED SURGERY PRACTICES UNDER ADVERSE EVENT REPORTING, QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES PURSUANT TO THIS SECTION shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules.

S 4. This act shall take effect one year after it shall have become a law.

PART M

Section 1. Subdivisions 1 and 2 of section 1100-a of the public health law, as added by chapter 258 of the laws of 1996, are amended and two new subdivisions 3 and 4 are added to read as follows:

1. Notwithstanding any contrary provision of law, rule, regulation or code, any county, city, town or village that owns both its public water system and the water supply for such system may by local law provide whether a fluoride compound shall [or shall not] be added to such public water supply.

2. Any county, wherein a public authority owns both its public water system and the water supply for such system, may by local law provide whether a fluoride compound shall [or shall not] be added to such public water supply.

3. NO COUNTY, CITY, TOWN OR VILLAGE, INCLUDING A COUNTY WHEREIN A PUBLIC AUTHORITY OWNS BOTH ITS PUBLIC WATER SYSTEM AND THE WATER SUPPLY FOR SUCH SYSTEM, THAT FLUORIDATES A PUBLIC WATER SUPPLY OR CAUSES A PUBLIC WATER SUPPLY TO BE FLUORIDATED, SHALL DISCONTINUE THE ADDITION OF A FLUORIDE COMPOUND TO SUCH PUBLIC WATER SUPPLY UNLESS IT HAS FIRST COMPLIED WITH THE FOLLOWING REQUIREMENTS:

(A) ISSUE A NOTICE TO THE PUBLIC OF THE PRELIMINARY DETERMINATION TO DISCONTINUE FLUORIDATION FOR COMMENT, WHICH SHALL INCLUDE THE JUSTIFICATION FOR THE PROPOSED DISCONTINUANCE, ALTERNATIVES TO FLUORIDATION AVAILABLE, AND A SUMMARY OF CONSULTATIONS WITH HEALTH PROFESSIONALS AND THE DEPARTMENT CONCERNING THE PROPOSED DISCONTINUANCE. SUCH NOTICE MAY, BUT IS NOT REQUIRED TO, INCLUDE PUBLICATION IN LOCAL NEWSPAPERS. "CONSULTATIONS WITH HEALTH PROFESSIONALS" MAY INCLUDE FORMAL STUDIES BY HIRED PROFESSIONALS, INFORMAL CONSULTATIONS WITH LOCAL PUBLIC HEALTH OFFICIALS OR OTHER HEALTH PROFESSIONALS, OR OTHER CONSULTATIONS, PROVIDED THAT THE NATURE OF SUCH CONSULTATIONS AND THE IDENTITY OF SUCH PROFESSIONALS SHALL BE IDENTIFIED IN THE PUBLIC NOTICE. "ALTERNATIVES TO FLUORIDATION" MAY INCLUDE FORMAL ALTERNATIVES PROVIDED BY OR AT THE EXPENSE OF THE COUNTY, CITY, TOWN OR VILLAGE, OR OTHER ALTERNATIVES AVAILABLE TO THE PUBLIC. ANY PUBLIC COMMENTS RECEIVED IN RESPONSE TO SUCH NOTICE SHALL BE ADDRESSED BY THE COUNTY, CITY, TOWN OR VILLAGE IN THE ORDINARY COURSE OF BUSINESS; AND

(B) PROVIDE THE DEPARTMENT AT LEAST NINETY DAYS PRIOR WRITTEN NOTICE OF THE INTENT TO DISCONTINUE AND SUBMIT A PLAN FOR DISCONTINUANCE THAT INCLUDES BUT IS NOT LIMITED TO THE NOTICE THAT WILL BE PROVIDED TO THE PUBLIC, CONSISTENT WITH PARAGRAPH (A) OF THIS SUBDIVISION, OF THE DETERMINATION TO DISCONTINUE FLUORIDATION OF THE WATER SUPPLY, INCLUDING THE DATE OF SUCH DISCONTINUANCE AND ALTERNATIVES TO FLUORIDATION, IF ANY, THAT WILL BE MADE AVAILABLE IN THE COMMUNITY, AND THAT INCLUDES INFORMATION AS MAY BE REQUIRED UNDER THE SANITARY CODE.

4. THE COMMISSIONER IS HEREBY AUTHORIZED, WITHIN AMOUNTS APPROPRIATED THEREFOR, TO MAKE GRANTS TO COUNTIES, CITIES, TOWNS OR VILLAGES THAT OWN THEIR PUBLIC WATER SYSTEM AND THE WATER SUPPLY FOR SUCH SYSTEM, INCLUDING A COUNTY WHEREIN A PUBLIC AUTHORITY OWNS BOTH ITS PUBLIC WATER SYSTEM AND THE WATER SUPPLY FOR SUCH SYSTEM, FOR THE PURPOSE OF PROVIDING ASSISTANCE TOWARDS THE COSTS OF INSTALLATION, INCLUDING BUT NOT LIMITED TO TECHNICAL AND ADMINISTRATIVE COSTS ASSOCIATED WITH PLANNING, DESIGN AND CONSTRUCTION, AND START-UP OF FLUORIDATION SYSTEMS, AND REPLACING, REPAIRING OR UPGRADING OF FLUORIDATION EQUIPMENT FOR SUCH PUBLIC WATER SYSTEMS. GRANT FUNDING SHALL NOT BE AVAILABLE FOR ASSISTANCE TOWARDS THE COSTS AND EXPENSES OF OPERATION OF THE FLUORIDATION SYSTEM, AS DETERMINED BY THE DEPARTMENT. THE GRANT APPLICATIONS SHALL INCLUDE SUCH INFORMATION AS REQUIRED BY THE COMMISSIONER. IN MAKING THE GRANT AWARDS, THE COMMISSIONER SHALL CONSIDER THE DEMONSTRATED NEED FOR INSTALLATION OF NEW FLUORIDATION EQUIPMENT OR REPLACING, REPAIRING OR UPGRADING OF EXISTING FLUORIDATION EQUIPMENT, AND SUCH OTHER CRITERIA AS DETERMINED BY THE COMMISSIONER. GRANT AWARDS SHALL BE MADE ON A COMPETITIVE BASIS AND BE SUBJECT TO SUCH CONDITIONS AS MAY BE DETERMINED BY THE COMMISSIONER.

S 2. This act shall take effect immediately.

PART N

Section 1. Purpose. The purpose of this act is to seek public input about the creation of an office of community living with the goal of providing improvements in service delivery and improved program outcomes that would result from the expansion of community living integration services for older adults and persons of all ages with disabilities.

S 2. Data and information collection. (1) The director of the state office for the aging, in collaboration with other state agencies, will consult with stakeholders, providers, individuals and their families to gather data and information on the creation of an office for community living. Areas of focus shall include, but not be limited to, furthering the goals of the governor's Olmstead plan, strengthening the No Wrong Door approach to accessing information and services, reinforcing initiatives of the Balancing Incentive Program, creating opportunities to better leverage resources, evaluating methods for service delivery improvements, and analyzing the fiscal impact of creating such an office on services, individuals and providers. The state office for the aging shall also examine recent federal initiatives to create an administration on community living; and examine other states' efforts to expand services supporting community living integration, and local and/or regional coordination efforts within New York.

(2) In order to ensure meaningful public input and comment regarding the activities of subdivision one of this section, there shall be a series of public meetings held across the state, organized to ensure that stakeholders in all regions of the state are afforded an opportunity to comment.

S 3. Reporting. The director of the state office for the aging shall submit to the governor, and to the temporary president of the senate and the speaker of the assembly, a report and recommendations by December 15, 2015, that outlines the results and findings associated with the aforementioned collection of data and solicitation of feedback. Such report shall include, but not be limited to, the director's assessment, after taking into consideration input from all stakeholders, whether establishment of such an office would be beneficial to the populations

served and the state as a whole, the information gathered to make such assessment, an analysis of all information gathered, all alternatives considered, the impact and effect any proposed change may have on existing programs and services, and an assessment of related fiscal impacts on localities, the state and non-governmental entities serving the elderly and disabled communities in each of the respective communities.

S 4. This act shall take effect immediately.

PART O

Intentionally Omitted

PART P

Intentionally Omitted

PART Q

Intentionally Omitted

PART R

Intentionally Omitted

PART S

Intentionally Omitted

PART T

Intentionally Omitted

PART U

Intentionally Omitted

PART V

Section 1. Subparagraph (iv) of paragraph (a) of subdivision 3 of section 3309 of the public health law, as added by chapter 42 of the laws of 2014, is amended to read as follows:

(iv) "Opioid antagonist recipient" or "recipient" means a person at risk of experiencing an opioid-related overdose, or a family member, friend or other person in a position to assist a person experiencing or at risk of experiencing an opioid-related overdose, or an organization registered as an opioid overdose prevention program pursuant to this section OR A SCHOOL DISTRICT, BOARD OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARD, CHARTER SCHOOL,

NON-PUBLIC ELEMENTARY AND/OR SECONDARY SCHOOL IN THIS STATE OR ANY PERSON EMPLOYED BY SUCH DISTRICT, BOARD OR SCHOOL.

S 2. Subdivision 4 of section 3309 of the public health law, as amended by chapter 42 of the laws of 2014, is amended to read as follows:

4. Use of an opioid antagonist pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.

A recipient [or], opioid overdose prevention program, SCHOOL DISTRICT, BOARD OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARD, CHARTER SCHOOL, NON-PUBLIC ELEMENTARY SCHOOL AND/OR SECONDARY SCHOOL IN THE STATE, OR ANY PERSON EMPLOYED BY SUCH DISTRICT, BOARD OR SCHOOL under this section, acting reasonably and in good faith in compliance with this section, shall not be subject to criminal, civil or administrative liability solely by reason of such action.

S 3. Subdivision 3 of section 3309 of the public health law, as added by chapter 34 of the laws of 2014, is renumbered subdivision 3-a.

S 4. The education law is amended by adding a new section 922 to read as follows:

S 922. OPIOID OVERDOSE PREVENTION. 1. SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARDS, CHARTER SCHOOLS, AND NON-PUBLIC ELEMENTARY AND SECONDARY SCHOOLS IN THIS STATE MAY PROVIDE AND MAINTAIN ON-SITE IN EACH INSTRUCTIONAL SCHOOL FACILITY OPIOID ANTAGONISTS, AS DEFINED IN SECTION THREE THOUSAND THREE HUNDRED NINE OF THE PUBLIC HEALTH LAW, IN QUANTITIES AND TYPES DEEMED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, TO BE ADEQUATE TO ENSURE READY AND APPROPRIATE ACCESS FOR USE DURING EMERGENCIES TO ANY STUDENT OR STAFF SUSPECTED OF HAVING OPIOID OVERDOSE WHETHER OR NOT THERE IS A PREVIOUS HISTORY OF OPIOID ABUSE.

2. SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARDS, CHARTER SCHOOLS, AND NON-PUBLIC ELEMENTARY AND SECONDARY SCHOOLS IN THIS STATE MAY ELECT TO PARTICIPATE AS AN OPIOID ANTAGONIST RECIPIENT AND ANY PERSON EMPLOYED BY ANY SUCH ENTITY THAT HAS ELECTED TO PARTICIPATE MAY ADMINISTER AN OPIOID ANTAGONIST IN THE EVENT OF AN EMERGENCY, PROVIDED THAT SUCH PERSON SHALL HAVE BEEN TRAINED BY A PROGRAM APPROVED UNDER SECTION THREE THOUSAND THREE HUNDRED NINE OF THE PUBLIC HEALTH LAW. ANY SCHOOL DISTRICT, BOARD OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARD, CHARTER SCHOOL, AND NON-PUBLIC ELEMENTARY AND SECONDARY SCHOOL THAT HAS EMPLOYEES TRAINED IN ACCORDANCE WITH THIS SECTION SHALL COMPLY WITH THE REQUIREMENTS OF SECTION THREE THOUSAND THREE HUNDRED NINE OF THE PUBLIC HEALTH LAW INCLUDING, BUT NOT LIMITED TO, APPROPRIATE CLINICAL OVERSIGHT, RECORD KEEPING AND REPORTING. NO PERSON SHALL BE REQUIRED TO PARTICIPATE IN THE PROGRAM AND ANY PARTICIPATION BY AN INDIVIDUAL SHALL BE VOLUNTARY.

S 5. Subdivision 4 of section 6909 of the education law is amended by adding a new paragraph (f) to read as follows:

(F) THE URGENT OR EMERGENCY TREATMENT OF OPIOID RELATED OVERDOSE OR SUSPECTED OPIOID RELATED OVERDOSE.

S 6. Subdivision 6 of section 6527 of the education law is amended by adding a new paragraph (f) to read as follows:

(F) THE URGENT OR EMERGENCY TREATMENT OF OPIOID RELATED OVERDOSE OR SUSPECTED OPIOID RELATED OVERDOSE.

S 7. This act shall take effect on the one hundred twentieth day after it shall have become a law, provided that any rules and regulations necessary to implement the provisions of this act on its effective date

are authorized and directed to be promulgated, repealed, and/or amended by such effective date.

PART W

Section 1. Subdivision 2 of section 2807-y of the public health law, as added by section 67 of part B of chapter 58 of the laws of 2005, is amended to read as follows:

2. In the event contracts with the article forty-three insurance law plans or other commissioner's designees are effectuated, the commissioner shall conduct annual audits of the receipt and distribution of the funds AND BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN SHALL PROVIDE RECORDS OF ALL REVENUES AND DISBURSEMENTS MADE FROM ALLOCATIONS AND ASSESSMENTS LISTED IN SUBDIVISION ONE OF THIS SECTION TO THE TEMPORARY PRESIDENT OF THE SENATE AND SPEAKER OF THE ASSEMBLY ON AN ANNUAL BASIS.

S 2. HCRA modernization task force: the commissioner of health shall convene a task force to evaluate and make recommendations regarding the efficacy and transparency of the Health Care Reform Act resources fund (HCRA fund) and to evaluate and modernize the provisions of law related to the Health Care Reform Acts of 1996 and 2000 (HCRA). The task force shall consist of the commissioner of health, or his or her designee, employees of the department of health with expertise in health care financing, the director of the division of budget, or his or her designee, an individual to be appointed by the temporary president of the senate, an individual to be appointed by the speaker of the assembly, and stakeholders impacted by charges and disbursements of HCRA and the HCRA fund, including, but not limited to: representatives of health plans, consumers, managed care plans, hospitals, health care practitioners, and other health care providers. The commissioner of health, or his or her designee, shall chair the task force. The HCRA pool administrator shall provide material support to the task force and submit documentation and analysis necessary for deliberations by such task force, including, but not limited to, an accounting of revenues collected and disbursements made through HCRA and the HCRA fund. The task force shall consider and evaluate: the purposes for which the HCRA fund was established and whether such purposes may be continually served by such fund; the impact that any reduction or recalculation of indigent care and disproportionate share payments pursuant to federal law may have on the HCRA fund, and the cost that such reductions or recalculations will have to the state; the extent to which provisions of law in the HCRA statutes have become obsolete; the extent to which the Balanced Budget Act of 1997, Public Health Law 105-33, mandates a particular form of charges or assessments under HCRA and the impact any proposed change would have on the protections by such law; and any other purpose that would contribute to the streamlining and modernization of HCRA and the HCRA fund. The task force shall convene no later than June 30, 2015. The task force shall report to the governor, the temporary president of the senate and the speaker of the assembly its considerations, evaluations, and findings and make recommendations of changes to any rule, regulation, law or practice necessary to effectuate its conclusions. Such report shall be submitted no later than December 31, 2015, at which time such task force shall be disbanded and its work completed.

S 3. Intentionally omitted.

S 4. Paragraph (d) of subdivision 5-a of section 2807-m of the public health law is amended by adding three new subparagraphs (iv), (v) and (vi) to read as follows:

(IV) IN ADDITION TO THE FUNDS ALLOCATED UNDER THIS PARAGRAPH, FOR THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN, TWO MILLION DOLLARS SHALL BE AVAILABLE FOR THE PURPOSES DESCRIBED IN SUBDIVISION TEN OF THIS SECTION;

(V) IN ADDITION TO THE FUNDS ALLOCATED UNDER THIS PARAGRAPH, FOR THE PERIOD APRIL FIRST, TWO THOUSAND SIXTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN, TWO MILLION DOLLARS SHALL BE AVAILABLE FOR THE PURPOSES DESCRIBED IN SUBDIVISION TEN OF THIS SECTION;

(VI) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO THE EXTENSION OF THE HEALTH CARE REFORM ACT OF 1996, SUFFICIENT FUNDS SHALL BE AVAILABLE FOR THE PURPOSES DESCRIBED IN SUBDIVISION TEN OF THIS SECTION IN AMOUNTS NECESSARY TO FUND THE REMAINING YEAR COMMITMENTS FOR AWARDS MADE PURSUANT TO SUBPARAGRAPHS (IV) AND (V) OF THIS PARAGRAPH.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 7. Intentionally omitted.

S 8. This act shall take effect immediately.

PART X

Section 1. Section 1325 of the insurance law, as added by chapter 489 of the laws of 2012, is amended to read as follows:

S 1325. Exemption. For the purposes of exempting certain insurance companies from the provisions of section one thousand three hundred twenty-four of this article, the superintendent shall exempt, through December thirty-first, two thousand [sixteen] NINETEEN, those stock and non-stock insurance companies to which subparagraph (B) of paragraph two of subsection (b) of such section applies.

S 2. Subsection (c) of section 2343 of the insurance law, as amended by chapter 489 of the laws of 2012, is amended to read as follows:

(c) Notwithstanding any other provision of this chapter, no application for an order of rehabilitation or liquidation of a domestic insurer whose primary liability arises from the business of medical malpractice insurance, as that term is defined in subsection (b) of section five thousand five hundred one of this chapter, shall be made on the grounds specified in subsection (a) or (c) of section seven thousand four hundred two of this chapter at any time prior to December thirty-first, two thousand [sixteen] NINETEEN.

S 3. This act shall take effect immediately.

PART Y

Section 1. 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 18 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(a) The superintendent of [insurance] 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 [insurance] 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, [and] between July 1, 2014 and June 30, 2015, AND BETWEEN JULY 1, 2015 AND JUNE 30, 2016 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, [and] between July 1, 2014 and June 30, 2015, AND BETWEEN JULY 1, 2015 AND JUNE 30, 2016 for physicians or dentists certified as eligible for each such period or periods pursuant to subdivision 2 of this section by a general hospital licensed pursuant to article 28 of the public health law; provided that no single insurer shall write more than fifty percent of the total excess premium for a given policy year; and provided, however, that such eligible physicians or dentists must have in force an individual policy, from an insurer licensed in this state of primary malpractice insurance coverage in amounts of no less than one million three hundred thousand dollars for each claimant and three million nine hundred thousand dollars for all claimants under that policy during the period of such excess coverage for such occurrences or be endorsed as additional insureds under a hospital professional liability policy which is offered through a voluntary attending physician ("channeling") program previously permitted by the superintendent of [insurance] 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 2. 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 19 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(3)(a) The superintendent of [insurance] 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, [and] between July 1, 2014 and June 30, 2015, AND BETWEEN JULY 1, 2015 AND JUNE 30, 2016 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

(b) The superintendent of [insurance] 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, [and] between July 1, 2014 and June 30, 2015, AND BETWEEN JULY 1, 2015 AND JUNE 30, 2016 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary. The superintendent of [insurance] 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, [and] to the period July 1, 2014 and June 30, 2015, AND TO THE PERIOD JULY 1, 2015 AND JUNE 30, 2016.

S 3. 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 20 of part B of chapter 60 of the laws of 2014, 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, [and] during the period July 1, 2014 to June 30, 2015, AND DURING THE PERIOD JULY 1, 2015 AND JUNE 30, 2016 allocated or reallocated in accordance with paragraph (a) of subdivision 4-a of this section to rates of payment applicable to state governmental agencies, each physician or dentist for whom a policy for excess insurance coverage or equivalent excess coverage is purchased for such period shall be responsible for payment to the provider of excess insurance coverage or equivalent excess coverage of an allocable share of such insufficiency, based on the ratio of the total cost of such coverage for such physician to the sum of the total cost of such coverage for all physicians applied to such insufficiency.

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to June 30, 2015, OR COVERING THE PERIOD JULY 1, 2015 TO JUNE 30, 2016 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or

equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of [insurance] 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 determined in accordance with paragraph (a) of this subdivision fails, refuses or neglects to make payment to the provider of excess insurance coverage or equivalent excess coverage in such time and manner as determined by the superintendent of [insurance] 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 [insurance] 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 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 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 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 4. 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 21 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

S 40. The superintendent of [insurance] 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, [2015] 2016; 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, [2015] 2016, 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, [2015] 2016 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already estab-

lished 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 5. 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 22 of part B of chapter 60 of the laws of 2014, are amended to read as follows:

S 5. The superintendent of [insurance] 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, [and] June 15, 2015, AND JUNE 15, 2016 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, as applicable.

(a) This section shall be effective only upon a determination, pursuant to section five of this act, by the superintendent of [insurance] 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, as applicable.

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of [insurance] 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, [and] June 15, 2015, AND JUNE 15, 2016, as applicable.

S 6. 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 fifteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand fifteen; 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 fifteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand fifteen, 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 fifteen, 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 fifteen and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess for the coverage period beginning the first of July, two thousand fifteen.

S 7. This act shall take effect immediately.

S 2. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair, or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 3. This act shall take effect immediately provided, however, that the applicable effective date of Parts A through Y of this act shall be as specifically set forth in the last section of such Parts.