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

S. 2007 A. 3007

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

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

AN ACT to amend the public health law, in relation to program pamphlets developed and distributed by the department of health and the disposition of results of professional misconduct proceedings; to repeal section 2995-a of the public health law relating to the physician profile website; to repeal subdivision 11 of section 6524 of the education law, relating to physician license qualification requirements; to repeal subdivision 9 of section 2803 of the public health law relating to reports to the commissioner of health by general hospitals regarding working conditions and limits on working hours for certain members of the hospital's staff; and to repeal section 461-s of the social services law, relating to enhancing the quality of adult living program for adult care facilities (Part A); to amend the social services law, in relation to statewide supplemental rebates; to amend the social services law, in relation to pharmacy dispensing fees; to amend the public health law, in relation to the clinical drug review program; to amend the public health law, in relation to the prescriber prevails provision; to amend the social services law, in relation to outpatient prescription drugs; to amend the social services law, in relation to the codification of the global cap; to amend the public health law, in relation to hospital quality contributions; to amend the public health law, in relation to hospital payments; to amend parts A and 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 noticing of hospitals; to amend the social services law, in relation to health homes; to amend the public health law, in relation to family planning; 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; to amend part H of chapter 59 of the laws of 2011, amending the public health law relating to general hospital

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

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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 payments for Medicare beneficiaries; to amend the social services law, in relation to personal care; to authorize a mobility management contractor; to amend the public health law, in relation to energy efficiency; to amend the public health law, in relation to recruitment and retention; to amend the civil service law, in relation to term appointments in health insurance program-related positions; to amend the social services law, in relation to working disabled eligibility; to amend the social services law, in relation to family planning benefits; to amend the social services law, in relation to foster care; to amend the public health law, in relation to certified home health agencies; to amend the public health law, in relation to value based payments; to amend the social services law, in relation to the basic health plan program; 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 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 repeal subdivision (i) of section III 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, relating 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 21 of the laws of 2011 amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, in relation to extending the provisions of such chapter; 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 making such provisions permanent; and to repeal 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 (Part D); to amend the public health law, in relation to the payment of certain funds for uncompensated care (Part E); to amend the public health law, in relation to the establishment of value based payments within the delivery system reform incentive payment program (Part F); to amend the financial services law, in relation to the financial assessment that offsets the operational costs of the health insurance exchange; and to amend the public health law, in relation to health care reform act pool administration (Part G); to amend the public health law, in relation to the establishment and operation of limited services clinics, standardizing urgent care centers and enhanced oversight of office-based surgery; and to repeal subdivision 4 of section 2951 and section 2956 of such law relating to the statutory authority of upgraded diagnostic and treatment centers (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; to amend the general business law, in relation to the definition of drug related paraphernalia; to amend the public health law, in relation to the sale and furnishing of hypodermic needles and syringes; to amend the public health law in relation to simplifying consent for HIV testing; 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); to amend the education law and the public health law, in relation to establishing a program for home health aides authorizing them to perform advanced tasks (Part J); to amend the public health

law, in relation to streamlining the certificate of need process for hospitals and diagnostic and treatment clinics providing primary care; and to amend the public health law, in relation to public health and health planning council reviews (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); to amend chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part O); to amend the education law, in relation to authorizing contracts for the provision of special education and related services for certain patients hospitalized in hospitals operated by the office of mental health; and to amend part M of chapter 56 of the laws of 2012 amending the education law, relating to authorizing contracts for the provision of special education and related services for certain patients hospitalized in hospitals operated by the office of mental health, in relation to the effectiveness thereof (Part P); to amend the public health law and the public authorities law, in relation to establishing a private equity pilot program (Part Q); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part R); and to amend the social services law, the executive law and the mental hygiene law, in relation to providing professional services to individuals with developmental disabilities in non-certified settings; in relation to the exemption of the nurse practice act for direct care staff in non-certified settings funded, authorized or approved by the office for people with developmental disabilities; and to repeal certain provisions of the mental hygiene law relating thereto (Part S)

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. This act enacts into law major components of legislation which are necessary to implement the state fiscal plan for the 2015-2016 state fiscal year. Each component is wholly contained within a Part identified as Parts A through S. The effective date for each particular provision contained within such Part is set forth in the last section of such Part. Any provision in any section contained within a Part, including the effective date of the Part, which makes a reference to a section "of this act", when used in connection with that particular component, shall be deemed to mean and refer to the corresponding section of the Part in which it is found. Section three of this act sets forth the general effective date of this act.

PART A

Section 1. Section 2995-a of the public health law is REPEALED.

S 2. Section 2997-b of the public health law, as added by chapter 477 of the laws of 2008, is amended to read as follows:

S 2997-b. Pamphlet of department programs. The commissioner shall develop and transmit to physicians in the state a pamphlet describing a variety of department programs and initiatives, including but not limited to smoking cessation programs, public health insurance programs, health and quality improvement information, AND the patient safety center [and physician profiles]. Each physician practicing in the state shall make the pamphlet available in his or her practice reception area so that it is accessible to patients.

S 3. Subparagraph (i) of paragraph (h) of subdivision 10 of section 230 of the public health law, as amended by chapter 477 of the laws of 2008, is amended to read as follows:

(i) The findings, conclusions, determination and the reasons for the determination of the committee shall be served upon the licensee, the department, [and any hospitals, primary practice settings or health care plans required to be identified in publicly disseminated physician data pursuant to paragraph (j), (n), or (q) of subdivision one of section twenty-nine hundred ninety-five-a of this chapter] ANY HOSPITALS WHERE THE LICENSEE HAS PRACTICE PRIVILEGES, THE PRIMARY PRACTICE SETTING OF THE LICENSEE, THE LICENSED PHYSICIANS WITH WHOM THE LICENSEE SHARES A GROUP PRACTICE, AND ANY HEALTH CARE PLANS WITH WHICH THE LICENSEE HAS CONTRACTS, EMPLOYMENT OR OTHER AFFILIATIONS, within sixty days of the last day of hearing. Service shall be either by certified mail upon the licensee at the licensee's last known address and such service shall be effective upon receipt or seven days after mailing by certified mail whichever is earlier or by personal service and such service shall be effective upon receipt. The licensee shall deliver to the board the license which has been revoked, annulled, suspended or surrendered, together with the registration certificate, within five days after receipt of the order. If the license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, the licensee shall submit an affidavit to that effect and shall deliver such license or certificate to the board when located. The director of the office shall promptly transmit a copy of the order to the division of professional licensing services of the state education department and to each hospital at which the licensee has privileges.

S 4. Subdivision 11 of section 6524 of the education law is REPEALED.

S 5. Subdivision 9 of section 2803 of the public health law is REPEALED.

S 6. Section 461-s of the social services law is REPEALED.

S 7. This act shall take effect immediately.

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) NOTWITHSTANDING SECTION TWO HUNDRED SEVENTY-TWO OF THE PUBLIC HEALTH LAW OR ANY OTHER INCONSISTENT PROVISION OF LAW, THE COMMISSIONER MAY NEGOTIATE DIRECTLY WITH A PHARMACEUTICAL MANUFACTURER FOR THE PROVISION OF SUPPLEMENTAL REBATES, INCLUDING SUPPLEMENTAL REBATES RELATING TO PHARMACEUTICAL UTILIZATION BY ENROLLEES OF MANAGED CARE PROVIDERS PURSUANT TO SECTION THREE HUNDRED SIXTY-FOUR-J OF THIS TITLE, RELATING TO ANY OF THE DRUGS IT MANUFACTURES FOR THE PURPOSE OF FUNDING MEDICAL ASSISTANCE PROGRAM BENEFITS; PROVIDED, HOWEVER, THAT THIS PARAGRAPH SHALL APPLY ONLY TO COVERED OUTPATIENT DRUGS FOR WHICH THE MANUFACTURER

HAS IN EFFECT A REBATE AGREEMENT WITH THE FEDERAL SECRETARY OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 U.S.C. S1396R-8.

S 2. Subparagraph (ii) of paragraph (b) of subdivision 9 of section 367-a of the social services law, as amended by section 2 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(ii) if the drug dispensed is a multiple source prescription drug or a brand-name prescription drug for which no specific upper limit has been set by such federal agency, the lower of the estimated acquisition cost of such drug to pharmacies or the dispensing pharmacy's usual and customary price charged to the general public. For sole and multiple source brand name drugs, estimated acquisition cost means the average wholesale price of a prescription drug based upon the package size dispensed from, as reported by the prescription drug pricing service used by the department, less [seventeen] TWENTY-FOUR percent thereof or the wholesale acquisition cost of a prescription drug based upon package size dispensed from, as reported by the prescription drug pricing service used by the department, minus [zero and forty-one hundredths] NINE percent thereof, and updated monthly by the department. For multiple source generic drugs, estimated acquisition cost means the lower of the average wholesale price of a prescription drug based on the package size dispensed from, as reported by the prescription drug pricing service used by the department, less twenty-five percent thereof, or the maximum acquisition cost, if any, established pursuant to paragraph (e) of this subdivision, provided that the methodology used by the department to establish a maximum acquisition cost shall not include average acquisition cost as determined by department surveys.

S 3. Subparagraph (ii) of paragraph (d) of subdivision 9 of section 367-a of the social services law, as amended by section 48 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(ii) for prescription drugs categorized as brand-name prescription drugs by the prescription drug pricing service used by the department, [three] EIGHT dollars [and fifty cents] per prescription[, provided, however, that for brand name prescription drugs reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title, the dispensing fee shall be four dollars and fifty cents per prescription].

S 4. Section 274 of the public health law is amended by adding a new subdivision 15 to read as follows:

15. NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, THE COMMISSIONER MAY REQUIRE PRIOR AUTHORIZATION FOR ANY DRUG AFTER EVALUATING THE FACTORS SET FORTH IN SUBDIVISION THREE OF THIS SECTION AND PRIOR TO OBTAINING THE BOARD'S EVALUATION AND RECOMMENDATION REQUIRED BY SUBDIVISION FOUR OF THIS SECTION. THE BOARD MAY RECOMMEND TO THE COMMISSIONER, PURSUANT TO SUBDIVISION SIX OF THIS SECTION, THAT ANY SUCH PRIOR AUTHORIZATION REQUIREMENT BE MODIFIED, CONTINUED OR REMOVED.

S 5. Subdivision 11 of section 272 of the public health law is amended by adding a new paragraph (a-1) to read as follows:

(A-1) THE COMMISSIONER MAY REQUIRE A PHARMACEUTICAL MANUFACTURER TO PROVIDE A MINIMUM SUPPLEMENTAL REBATE FOR DRUGS THAT ARE ELIGIBLE FOR STATE PUBLIC HEALTH PLAN REIMBURSEMENT, INCLUDING SUCH DRUGS AS SET FORTH IN PARAGRAPH (G-1) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THE SOCIAL SERVICES LAW. IF SUCH A MINIMUM SUPPLEMENTAL REBATE IS NOT PROVIDED BY THE MANUFACTURER, PRIOR AUTHORIZATION MAY BE REQUIRED BY THE COMMISSIONER.

S 6. Paragraph (b) of subdivision 3 of section 273 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the preferred drug list is warranted, the prescriber's determination shall be final.] THE PROGRAM WILL CONSIDER THE ADDITIONAL INFORMATION AND THE JUSTIFICATION PRESENTED BY THE PRESCRIBER TO DETERMINE WHETHER THE USE OF A PRESCRIPTION DRUG THAT IS NOT ON THE PREFERRED DRUG LIST IS WARRANTED. NOTHING HEREIN SHALL BE CONSTRUED AS LIMITING THE RIGHT OF A MEDICAID RECIPIENT TO APPEAL THE DENIAL OF A REQUEST FOR PRIOR AUTHORIZATION OF A PRESCRIPTION DRUG THAT IS NOT ON THE PREFERRED DRUG LIST.

S 7. Section 364-j of the social services law is amended by adding a new subdivision 24-a to read as follows:

24-A. CLAIMS FOR PAYMENT OF OUTPATIENT PRESCRIPTION DRUGS SUBMITTED TO A MANAGED CARE PROVIDER BY A COVERED ENTITY PURSUANT TO SECTION 340B OF THE FEDERAL PUBLIC HEALTH SERVICE ACT (42 USCA S 256B) OR BY SUCH COVERED ENTITY'S AUTHORIZED CONTRACT PHARMACY SHALL BE AT SUCH COVERED ENTITY'S OR CONTRACT PHARMACY'S ACTUAL ACQUISITION COST FOR THE DRUG. FOR PURPOSES OF THIS SUBDIVISION, "ACTUAL ACQUISITION COST" MEANS THE INVOICE PRICE FOR THE DRUG TO THE COVERED ENTITY OR THE COVERED ENTITY'S AUTHORIZED CONTRACT PHARMACY MINUS THE AMOUNT OF ALL DISCOUNTS AND OTHER COST-REDUCTIONS ATTRIBUTABLE TO THE DRUG.

S 8. The social services law is amended by adding a new section 368-g to read as follows:

S 368-G. LIMITATION ON GROWTH OF MEDICAL ASSISTANCE EXPENDITURES. 1. CAP ESTABLISHED. (A) NOTWITHSTANDING SECTION NINETY-ONE OF PART H OF CHAPTER FIFTY-NINE OF THE LAWS OF TWO THOUSAND ELEVEN, AS AMENDED, OR ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO FEDERAL APPROVALS, THE YEAR TO YEAR RATE OF GROWTH OF DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE SPENDING SHALL NOT EXCEED THE TEN YEAR ROLLING AVERAGE OF THE MEDICAL COMPONENT OF THE CONSUMER PRICE INDEX AS PUBLISHED BY THE UNITED STATES DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS, FOR THE PRECEDING TEN YEARS; PROVIDED, HOWEVER, THAT FOR STATE FISCAL YEAR TWO THOUSAND THIRTEEN-TWO THOUSAND FOURTEEN OR ANY FISCAL YEAR THEREAFTER, THE MAXIMUM ALLOWABLE ANNUAL INCREASE IN THE AMOUNT OF THE DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE SPENDING SHALL BE CALCULATED BY MULTIPLYING THE DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE SPENDING FOR THE PREVIOUS YEAR, LESS THE AMOUNT OF ANY DEPARTMENT STATE OPERATIONS SPENDING INCLUDED THEREIN, BY SUCH TEN YEAR ROLLING AVERAGE.

(B) EXCEPT AS PROVIDED IN PARAGRAPH (C) OF THIS SUBDIVISION, FOR STATE FISCAL YEAR TWO THOUSAND THIRTEEN-TWO THOUSAND FOURTEEN OR ANY FISCAL YEAR THEREAFTER, THE SPENDING LIMIT CALCULATED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE INCREASED BY AN AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE TOTAL SOCIAL SERVICES DISTRICT MEDICAL ASSISTANCE EXPENDITURE AMOUNTS CALCULATED FOR SUCH PERIOD IN CONFORMANCE WITH SUBDIVISIONS (B), (C), (C-1), AND (D) OF SECTION ONE OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE AND THE TOTAL SOCIAL SERVICES DISTRICT MEDICAL EXPENDITURE AMOUNTS THAT WOULD HAVE RESULTED

IF THE PROVISIONS OF SUBDIVISION (C-1) OF SUCH SECTION HAD NOT BEEN APPLIED.

(C) WITH RESPECT TO A SOCIAL SERVICES DISTRICT THAT RESCINDS THE EXERCISE OF THE OPTION PROVIDED IN PARAGRAPH (I) OF SUBDIVISION (B) OF SECTION TWO OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE, FOR STATE FISCAL YEAR TWO THOUSAND THIRTEEN-TWO THOUSAND FOURTEEN OR ANY FISCAL YEAR THEREAFTER, THE SPENDING LIMIT CALCULATED PURSUANT TO SUBDIVISION ONE OF THIS SECTION SHALL BE REDUCED BY THE AMOUNT OF THE MEDICAL ASSISTANCE EXPENDITURE AMOUNT CALCULATED FOR SUCH DISTRICT FOR SUCH PERIOD.

2. SAVINGS ALLOCATION PLAN. NOTWITHSTANDING SECTION NINETY-TWO OF PART H OF CHAPTER FIFTY-NINE OF THE LAWS OF TWO THOUSAND ELEVEN, AS AMENDED, AND ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR STATE FISCAL YEARS ON AND AFTER TWO THOUSAND ELEVEN-TWO THOUSAND TWELVE, THE DIRECTOR OF THE BUDGET, IN CONSULTATION WITH THE COMMISSIONER, SHALL ASSESS ON A MONTHLY BASIS, AS REFLECTED IN MONTHLY REPORTS ISSUED PURSUANT TO SUBDIVISION FIVE OF THIS SECTION, KNOWN AND PROJECTED DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE 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 MEDICAL ASSISTANCE DISBURSEMENTS FOR SUCH PERIOD TO EXCEED THE PROJECTED DEPARTMENT MEDICAL ASSISTANCE STATE FUNDS DISBURSEMENTS IN THE ENACTED BUDGET FINANCIAL PLAN PURSUANT TO SUBDIVISION THREE OF SECTION TWENTY-THREE OF THE STATE FINANCE LAW, THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL DEVELOP A MEDICAL ASSISTANCE 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 FIRST, TWO THOUSAND TWELVE, 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 MEDICAL ASSISTANCE EXPENDITURES AS A RESULT OF A NATURAL OR OTHER TYPE OF DISASTER, INCLUDING A GOVERNMENTAL DECLARATION OF EMERGENCY. SUCH MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN SHALL BE DESIGNED TO REDUCE THE DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE DISBURSEMENTS AUTHORIZED BY APPROPRIATIONS IN COMPLIANCE WITH THE FOLLOWING GUIDELINES:

(A) REDUCTIONS SHALL BE MADE IN COMPLIANCE WITH APPLICABLE FEDERAL LAW, INCLUDING THE PROVISIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152) (COLLECTIVELY "AFFORDABLE CARE ACT") AND ANY SUBSEQUENT AMENDMENTS THERETO OR REGULATIONS PROMULGATED THEREUNDER;

(B) REDUCTIONS SHALL BE MADE IN A MANNER THAT COMPLIES WITH THE STATE MEDICAL ASSISTANCE PLAN APPROVED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES, PROVIDED, HOWEVER, THAT THE COMMISSIONER IS AUTHORIZED TO SUBMIT ANY STATE PLAN AMENDMENT OR SEEK OTHER FEDERAL APPROVAL, INCLUDING WAIVER AUTHORITY, TO IMPLEMENT THE PROVISIONS OF THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN THAT MEETS THE OTHER CRITERIA SET FORTH HEREIN;

(C) REDUCTIONS SHALL BE MADE IN A MANNER THAT MAXIMIZES FEDERAL FINANCIAL PARTICIPATION, TO THE EXTENT PRACTICABLE, INCLUDING ANY FEDERAL FINANCIAL PARTICIPATION THAT IS AVAILABLE OR IS REASONABLY EXPECTED TO BECOME AVAILABLE, IN THE DISCRETION OF THE COMMISSIONER, UNDER THE AFFORDABLE CARE ACT;

(D) REDUCTIONS SHALL BE MADE UNIFORMLY AMONG CATEGORIES OF SERVICES AND GEOGRAPHIC REGIONS OF THE STATE, TO THE EXTENT PRACTICABLE, AND SHALL BE MADE UNIFORMLY WITHIN A CATEGORY OF SERVICE, TO THE EXTENT PRACTICABLE, EXCEPT WHERE THE COMMISSIONER DETERMINES THAT THERE ARE SUFFICIENT GROUNDS FOR NON-UNIFORMITY, INCLUDING, BUT NOT LIMITED TO: (I) THE EXTENT TO WHICH SPECIFIC CATEGORIES OF SERVICES CONTRIBUTED TO DEPARTMENT MEDICAL ASSISTANCE STATE FUNDS SPENDING IN EXCESS OF THE LIMITS SPECIFIED HEREIN; (II) THE NEED TO MAINTAIN SAFETY NET SERVICES IN UNDERSERVED COMMUNITIES; OR (III) THE POTENTIAL BENEFITS OF PURSUING INNOVATIVE PAYMENT MODELS CONTEMPLATED BY THE AFFORDABLE CARE ACT, IN WHICH CASE SUCH GROUNDS SHALL BE SET FORTH IN THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN;

(E) REDUCTIONS SHALL BE MADE IN A MANNER THAT DOES NOT UNNECESSARILY CREATE ADMINISTRATIVE BURDENS FOR MEDICAL ASSISTANCE APPLICANTS AND RECIPIENTS OR FOR PROVIDERS;

(F) THE COMMISSIONER SHALL SEEK THE INPUT OF THE LEGISLATURE, AS WELL AS INPUT FROM ORGANIZATIONS REPRESENTING HEALTH CARE PROVIDERS, CONSUMERS, BUSINESSES, WORKERS, HEALTH INSURERS, AND OTHERS WITH RELEVANT EXPERTISE, IN DEVELOPING SUCH MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN TO THE EXTENT THAT ALL OR PART OF SUCH PLAN IS LIKELY, AS DETERMINED BY THE COMMISSIONER, TO HAVE A MATERIAL IMPACT ON THE OVERALL MEDICAL ASSISTANCE PROGRAM, OR ON PARTICULAR CATEGORIES OF SERVICE, OR ON PARTICULAR GEOGRAPHIC REGIONS OF THE STATE;

(G)(I) THE COMMISSIONER SHALL POST THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN ON THE DEPARTMENT'S WEBSITE AND SHALL PROVIDE WRITTEN COPIES OF SUCH PLAN TO THE CHAIRS OF THE SENATE FINANCE AND THE ASSEMBLY WAYS AND MEANS COMMITTEES AT LEAST THIRTY DAYS BEFORE THE DATE ON WHICH IMPLEMENTATION IS EXPECTED TO BEGIN;

(II) THE COMMISSIONER MAY REVISE THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN SUBSEQUENT TO THE PROVISION OF NOTICE AND PRIOR TO IMPLEMENTATION BUT IS REQUIRED TO PROVIDE A NEW NOTICE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH ONLY IF THE COMMISSIONER DETERMINES, IN HIS OR HER DISCRETION, THAT SUCH REVISIONS MATERIALLY ALTER THE PLAN;

(H) NOTWITHSTANDING THE PROVISIONS OF PARAGRAPHS (F) AND (G) OF THIS SUBDIVISION, THE COMMISSIONER NEED NOT SEEK THE INPUT DESCRIBED IN PARAGRAPH (F) OF THIS SUBDIVISION OR PROVIDE NOTICE PURSUANT TO PARAGRAPH (G) OF THIS SUBDIVISION IF, IN THE DISCRETION OF THE COMMISSIONER, EXPEDITED DEVELOPMENT AND IMPLEMENTATION OF A MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN IS NECESSARY DUE TO A PUBLIC HEALTH EMERGENCY; FOR PURPOSES OF THIS SECTION, A PUBLIC HEALTH EMERGENCY IS DEFINED AS:

(I) A DISASTER, NATURAL OR OTHERWISE, THAT SIGNIFICANTLY INCREASES THE IMMEDIATE NEED FOR HEALTH CARE PERSONNEL IN AN AREA OF THE STATE;

(II) AN EVENT OR CONDITION THAT CREATES A WIDESPREAD RISK OF EXPOSURE TO A SERIOUS COMMUNICABLE DISEASE, OR THE POTENTIAL FOR SUCH WIDESPREAD RISK OF EXPOSURE; OR

(III) ANY OTHER EVENT OR CONDITION DETERMINED BY THE COMMISSIONER TO CONSTITUTE AN IMMINENT THREAT TO PUBLIC HEALTH; AND

(I) NOTHING IN THIS SECTION SHALL BE DEEMED TO PREVENT ALL OR PART OF SUCH MEDICAL SAVINGS ALLOCATION PLAN FROM TAKING EFFECT RETROACTIVELY, TO THE EXTENT PERMITTED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

3. POWERS OF THE COMMISSIONER TO ENACT SAVINGS ALLOCATION PLAN. IN ACCORDANCE WITH THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN, THE COMMISSIONER SHALL REDUCE DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE DISBURSEMENTS BY THE AMOUNT OF THE PROJECTED OVERSPENDING THROUGH, ACTIONS INCLUDING, BUT NOT LIMITED TO MODIFYING OR SUSPENDING REIMBURSEMENT METHODS, INCLUDING BUT NOT LIMITED TO ALL FEES, PREMIUM LEVELS AND RATES OF PAYMENT, NOTWITHSTANDING ANY PROVISION OF LAW THAT SETS A SPECIFIC AMOUNT OR METHODOLOGY FOR ANY SUCH PAYMENTS OR RATES OF PAYMENT; MODIFYING MEDICAL ASSISTANCE PROGRAM BENEFITS; SEEKING ALL NECESSARY FEDERAL APPROVALS, INCLUDING, BUT NOT LIMITED TO WAIVERS, WAIVER AMENDMENTS; AND SUSPENDING TIME FRAMES FOR NOTICE, APPROVAL OR CERTIFICATION OF RATE REQUIREMENTS, NOTWITHSTANDING ANY PROVISION OF LAW, RULE OR REGULATION TO THE CONTRARY, INCLUDING, BUT NOT LIMITED TO, SECTIONS TWENTY-EIGHT HUNDRED SEVEN AND THIRTY-SIX HUNDRED FOURTEEN OF THE PUBLIC HEALTH LAW, SECTION EIGHTEEN OF CHAPTER TWO OF THE LAWS OF NINETEEN HUNDRED EIGHTY-EIGHT, AND SECTION 505.14(H) OF TITLE 18 OF THE OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK.

4. CAP DIVIDEND. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR STATE FISCAL YEARS BEGINNING ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL, PRIOR TO JANUARY FIRST OF EACH YEAR, DETERMINE THE EXTENT OF SAVINGS THAT HAVE BEEN ACHIEVED AS A RESULT OF THE APPLICATION OF THE PROVISIONS OF SUBDIVISIONS ONE AND TWO OF THIS SECTION, AND SHALL FURTHER DETERMINE THE AVAILABILITY OF SUCH SAVINGS FOR DISTRIBUTION DURING THE LAST QUARTER OF SUCH STATE FISCAL YEAR. IN DETERMINING SUCH SAVINGS THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, MAY EXEMPT THE MEDICAL ASSISTANCE ADMINISTRATION PROGRAM FROM DISTRIBUTIONS UNDER THIS SECTION. THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, MAY DISTRIBUTE FUNDS UP TO AN AMOUNT EQUAL TO SUCH AVAILABLE SAVINGS IN ACCORDANCE WITH AN ALLOCATION PLAN THAT UTILIZES A METHODOLOGY THAT DISTRIBUTES SUCH FUNDS PROPORTIONATELY AMONG PROVIDERS AND PLANS IN NEW YORK'S MEDICAL ASSISTANCE PROGRAM. IN DEVELOPING SUCH ALLOCATION PLAN THE COMMISSIONER OF HEALTH SHALL SEEK THE INPUT OF THE LEGISLATURE, AS WELL AS ORGANIZATIONS REPRESENTING HEALTH CARE PROVIDERS, CONSUMERS, BUSINESSES, WORKERS, HEALTH CARE INSURERS AND OTHERS WITH RELEVANT EXPERTISE. SUCH ALLOCATION PLAN SHALL UTILIZE THREE YEARS OF THE MOST RECENTLY AVAILABLE SYSTEM-WIDE EXPENDITURE DATA REFLECTING BOTH MMIS AND MANAGED CARE ENCOUNTERS. DISTRIBUTIONS TO MANAGED CARE PLANS SHALL BE BASED ON THE ADMINISTRATIVE OUTLAYS STEMMING FROM PARTICIPATION IN THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER OF HEALTH MAY IMPOSE MINIMUM THRESHOLD AMOUNTS IN DETERMINING PROVIDER ELIGIBILITY FOR DISTRIBUTIONS PURSUANT TO THIS SECTION. NO LESS THAN FIFTY PERCENT OF THE AMOUNT AVAILABLE FOR DISTRIBUTION SHALL BE MADE AVAILABLE FOR THE PURPOSE OF ASSISTING ELIGIBLE PROVIDERS UTILIZING THE METHODOLOGY OUTLINED ABOVE. THE REMAINDER OF THE DISTRIBUTIONS PURSUANT TO THIS SECTION SHALL BE MADE AVAILABLE FOR THE PURPOSES OF ENSURING A MINIMUM LEVEL OF ASSISTANCE TO FINANCIALLY DISTRESSED AND CRITICALLY NEEDED PROVIDERS AS IDENTIFIED BY THE COMMISSIONER. THE COMMISSIONER OF HEALTH SHALL POST THE MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN ON THE DEPARTMENT OF HEALTH'S WEBSITE AND SHALL PROVIDE WRITTEN COPIES OF SUCH PLAN TO THE CHAIRS OF THE SENATE FINANCE AND THE ASSEMBLY WAYS AND MEANS COMMITTEES AT LEAST THIRTY DAYS BEFORE THE DATE ON WHICH IMPLEMENTATION IS EXPECTED TO BEGIN. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO SEEK SUCH FEDERAL

APPROVALS AS MAY BE REQUIRED TO EFFECTUATE THE PROVISIONS OF THIS SECTION, INCLUDING, BUT NOT LIMITED TO, TO PERMIT PAYMENT OF SUCH DISTRIBUTIONS AS LUMPS SUMS AND TO SECURE WAIVERS FROM OTHERWISE APPLICABLE FEDERAL UPPER PAYMENT LIMIT RESTRICTIONS ON SUCH PAYMENTS. THE PROVISIONS OF THIS SECTION ARE SUBJECT TO THE REPORTING REQUIREMENTS SET FORTH IN SUBDIVISION SEVEN OF THIS SECTION.

5. MONTHLY REPORTS. THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL PREPARE A MONTHLY REPORT THAT SETS FORTH:

(A) KNOWN AND PROJECTED DEPARTMENT MEDICAL ASSISTANCE EXPENDITURES AS DESCRIBED IN SUBDIVISION ONE OF THIS SECTION, AND FACTORS THAT COULD RESULT IN MEDICAL ASSISTANCE DISBURSEMENTS FOR THE RELEVANT STATE FISCAL YEAR TO EXCEED THE PROJECTED DEPARTMENT STATE FUNDS DISBURSEMENTS IN THE ENACTED BUDGET FINANCIAL PLAN PURSUANT TO SUBDIVISION THREE OF SECTION TWENTY-THREE OF THE STATE FINANCE LAW, INCLUDING SPENDING INCREASES OR DECREASES DUE TO ENROLLMENT FLUCTUATIONS, RATE CHANGES, UTILIZATION CHANGES, MEDICAL ASSISTANCE REDESIGN TEAM (MRT) INVESTMENTS, A SHIFT OF BENEFICIARIES TO MANAGED CARE AND VARIATIONS IN OFFLINE MEDICAL ASSISTANCE PAYMENTS;

(B) THE ACTIONS TAKEN TO IMPLEMENT ANY MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN IMPLEMENTED PURSUANT TO SUBDIVISION FOUR OF THIS SECTION, INCLUDING INFORMATION CONCERNING THE IMPACT OF SUCH ACTIONS ON EACH CATEGORY OF SERVICE AND EACH GEOGRAPHIC REGION OF THE STATE;

(C) AS APPLICABLE; THE PRICE, INCLUDING, THE BASE RATE PLUS ANY UPCOMING RATE ADJUSTMENT; UTILIZATION, INCLUDING CURRENT ENROLLMENT, PROJECTED ENROLLMENT CHANGES AND ACUITY; MEDICAL ASSISTANCE REDESIGN TEAM INITIATIVES; ONE-TIME INITIATIVES AND OTHER INITIATIVES DESCRIBING THE PROPOSED BUDGET ACTION IMPACT; AND ANY PRIOR YEAR INITIATIVE WITH CURRENT AND FUTURE YEAR IMPACTS FOR THE FOLLOWING CATEGORIES:

(I) INPATIENT;
(II) OUTPATIENT;
(III) EMERGENCY ROOM;
(IV) CLINIC;
(V) NURSING HOMES;
(VI) OTHER LONG TERM CARE;
(VII) MEDICAID MANAGED CARE;
(VIII) FAMILY HEALTH PLUS;
(IX) PHARMACY;
(X) TRANSPORTATION;
(XI) DENTAL;
(XII) NON-INSTITUTIONAL AND OTHER CATEGORIES;
(XIII) AFFORDABLE HOUSING;
(XIV) VITAL ACCESS PROVIDER SERVICES;
(XV) BEHAVIORAL HEALTH VITAL ACCESS PROVIDER SERVICES;
(XVI) FINGER LAKES HEALTH SERVICES AGENCY;
(XVII) AUDIT RECOVERIES AND SETTLEMENTS;

(D) INFORMATION AND DISBURSEMENTS OF GRANTS TO PROVIDERS, INCLUDING BUT NOT LIMITED TO:

(I) DEMOGRAPHIC INFORMATION OF TARGETED RECIPIENTS;
(II) NUMBER OF RECIPIENTS;
(III) AWARD AMOUNTS AND TIMING OF AWARDS; AND

(E) ANY PROJECTED MEDICAL ASSISTANCE SAVINGS DETERMINED BY THE COMMISSIONER PURSUANT TO SUBDIVISION SIX OF THIS SECTION AND THE PROPOSED ALLOCATION PLAN WITH REGARD TO SUCH SAVINGS.

(F) THE MONTHLY REPORTS REQUIRED BY THIS SUBDIVISION SHALL BE PROVIDED TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF

THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES. SUCH REPORTS AND RELATED DOCUMENTS PROVIDED TO THE LEGISLATURE SHALL ALSO BE POSTED ON THE WEBSITE AS MAINTAINED BY THE DEPARTMENT.

6. EXECUTIVE BUDGET SUMMARY. THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET SHALL, UPON SUBMISSION OF THE EXECUTIVE BUDGET TO THE LEGISLATURE, PROVIDE TO THE LEGISLATURE A DETAILED ACCOUNTING OF:

(A) THE STATE MEDICAL ASSISTANCE STATE FUNDS EXPENDITURES ON THE CLOSE OUT OF THE PRIOR YEAR;

(B) A CURRENT YEAR RE-ESTIMATE;

(C) THE PROSPECTIVE TWO-YEAR ESTIMATE; AND

(D) ANY OTHER INFORMATION DEEMED NECESSARY AND APPROPRIATE.

7. STAFF AVAILABILITY AND TRAINING. (A) THE COMMISSIONER AND THE DIRECTOR OF THE BUDGET SHALL MAKE APPROPRIATE STAFF AVAILABLE TO MEET WITH THE CHAIRS OF THE HEALTH COMMITTEES OF THE SENATE AND THE ASSEMBLY, OR THEIR DESIGNEES, UPON THEIR REQUEST AND WITH REASONABLE NOTICE, TO REVIEW EACH MONTHLY REPORT, AS DESCRIBED IN SUBDIVISION FIVE OF THIS SECTION.

(B) THE COMMISSIONER SHALL MAKE TRAINING AVAILABLE TO DESIGNATED LEGISLATIVE STAFF WITH REGARD TO THE SKILLS AND TECHNIQUES NEEDED TO EFFECTIVELY ACCESS AND REVIEW RELEVANT MEDICAL ASSISTANCE DATA BASES UNDER THE CONTROL OF THE DEPARTMENT, UPON THEIR REQUEST AND WITH REASONABLE NOTICE.

S 9. Section 280 of the public health law is REPEALED.

S 10. Subdivision 2 of section 2807-d-1 of the public health law, as added by section 52-c of part H of chapter 59 of the laws of 2011, is amended to read as follows:

2. The annual quality contribution amount referenced in subdivision one of this section shall be thirty million dollars for the state fiscal year beginning April first, two thousand eleven, and for each subsequent state fiscal year thereafter it shall be the amount of the preceding year as increased by the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years. FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, AND FOR EACH STATE FISCAL YEAR, THE CONTRIBUTION DESCRIBED HEREIN SHALL BE REDUCED BY FIFTEEN MILLION DOLLARS.

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

14. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER IS AUTHORIZED TO ESTABLISH, PURSUANT TO REGULATIONS, A 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.

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.

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 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.

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.

S 15. Intentionally omitted.

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 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 SIXTEEN AND NINETEEN OF A CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN.

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 SIXTEEN AND NINETEEN OF A CHAPTER OF THE LAWS OF TWO THOUSAND FIFTEEN.

S 24. Subdivisions 7, 7-a and 7-b of section 2807 of the public health law, subdivision 7 as amended by section 195 of part A of chapter 389 of the laws of 1997, subdivision 7-a as amended by chapter 938 of the laws of 1990, subdivision 7-b as added by chapter 731 of the laws of 1993, paragraph (b) of subdivision 7-b as amended by chapter 175 of the laws of 1997, are 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. 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.

[7-a. Notwithstanding any inconsistent provision of law, with regard to a general hospital the provisions of subdivisions four and seven of this section and the provisions of section eighteen of chapter two of the laws of nineteen hundred eighty-eight relating to the requirement of prior notice and the time frames for notice, approval or certification of rates of payment, maximum rates of payment or maximum charges where not otherwise waived pursuant to law shall be applicable only to such rates of payment or maximum charges prospectively established for an annual rate period and such provisions shall not be applicable to a general hospital with regard to prospective adjustments or retrospective adjustments of established rates of payment or maximum charges for or during an annual rate period based on correction of errors or omissions of data or in computation, rate appeals, audits or other rate adjustments authorized by law or regulations adopted pursuant to section twenty-eight hundred three of this article.

7-b. Notification of diagnostic and treatment center approved rates. (a) For rate periods or portions of rate periods beginning on or after October first, nineteen hundred ninety-four, the commissioner shall notify each diagnostic and treatment center of its approved rates of payment, which shall be used in the reimbursement for services provided to persons eligible for payments made by state governmental agencies at least thirty days prior to the beginning of the period for which such rates are to become effective.

(b)] (A) Notwithstanding any contrary provision of law, all diagnostic and treatment centers certified on or before September second, nineteen hundred ninety-seven shall, not later than September second, nineteen hundred ninety-seven, notify the commissioner whether they intend to maintain all books and records utilized by the diagnostic and treatment center for cost reporting and reimbursement purposes on a calendar year basis or, commencing on July first, nineteen hundred ninety-six, on a July first through June thirtieth basis, and shall thereafter maintain all books and records on such basis. All diagnostic and treatment centers certified after September second, nineteen hundred ninety-seven shall notify the commissioner at the time of certification whether they intend to maintain all books and records on a calendar year basis or on [or] a July first through June thirtieth basis, and shall thereafter maintain all books and records on such a basis.

[(c)] (B) The books and records maintained pursuant to paragraph [(b)] (A) of this subdivision shall be utilized and made available to the commissioner in promulgating rates of payment for annual rate periods beginning on or after October first, nineteen hundred ninety-seven.

[(d)] (C) Notwithstanding any provision of the law to the contrary, rates of payment established in accordance with paragraph [(b)] (A) as amended, and paragraph (f) of subdivision two of this section for the rate period beginning April first, nineteen hundred ninety-three shall continue in effect through September thirtieth, nineteen hundred ninety-four, and applicable trend factors shall be applied to that portion of such rates of payment for the rate period which begins April first, nineteen hundred ninety-four.

S 25. Section 365-l of the social services law is amended by adding a new subdivision 2-b 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 HEALTH HOMES AND THE CRIMINAL JUSTICE SYSTEM AND FOR THE INTEGRATION OF INFOR-

MATION OF HEALTH HOMES WITH STATE AND LOCAL CORRECTIONAL FACILITIES, TO THE EXTENT PERMITTED BY LAW. HEALTH HOMES RECEIVING SUCH FUNDS SHALL BE REQUIRED TO DOCUMENT AND DEMONSTRATE THE EFFECTIVE USE OF FUNDS DISTRIBUTED HEREIN.

S 26. Paragraph (e) of subdivision 2-a of section 2807 of the public health law is amended by adding a new subparagraph (iv) to read as follows:

(IV) NOTWITHSTANDING ANY LAW TO THE CONTRARY AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, FAMILY PLANNING OR FAMILY PLANNING RELATED SERVICES THAT ARE ELIGIBLE FOR ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES, SHALL NOT BE REIMBURSED PURSUANT TO THE METHODOLOGY ESTABLISHED IN THIS SUBDIVISION.

S 27. Subdivision 35 of section 2807-c of the public health law is amended by adding a new paragraph (k) to read as follows:

(K) NOTWITHSTANDING ANY LAW TO THE CONTRARY AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, FAMILY PLANNING OR FAMILY PLANNING RELATED SERVICES THAT ARE ELIGIBLE FOR ENHANCED FEDERAL MEDICAL ASSISTANCE PERCENTAGES SHALL BE EXCLUDED FROM REIMBURSEMENT UNDER THIS SUBDIVISION.

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.

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

(IV) IF A HEALTH PLAN PARTICIPATING IN PART C OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT PAYS FOR ITEMS AND SERVICES PROVIDED TO ELIGIBLE PERSONS WHO ARE ALSO BENEFICIARIES UNDER PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT OR TO QUALIFIED MEDICARE BENEFICIARIES, THE AMOUNT PAYABLE FOR SERVICES UNDER THIS TITLE SHALL BE THE AMOUNT OF ANY CO-INSURANCE LIABILITY OF SUCH ELIGIBLE PERSONS PURSUANT TO FEDERAL LAW IF THEY WERE NOT ELIGIBLE FOR MEDICAL ASSISTANCE OR WERE NOT QUALIFIED MEDICARE BENEFICIARIES WITH RESPECT TO SUCH BENEFITS UNDER PART B, BUT SHALL NOT EXCEED THE AMOUNT THAT OTHERWISE WOULD BE MADE UNDER THIS TITLE IF PROVIDED TO AN ELIGIBLE PERSON WHO IS NOT A BENEFICIARY UNDER PART B OR A QUALIFIED MEDICARE BENEFICIARY, LESS THE AMOUNT PAYABLE BY THE PART C HEALTH PLAN.

S 33. Paragraph (a) of subdivision 3 of section 366 of the social services law, as amended by chapter 110 of the laws of 1971, is amended to read as follows:

(a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative [or] AND the refusal or failure of such ABSENT relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three OF THIS CHAPTER and other applicable provisions of law.

S 34. The commissioner of health is authorized to contract with one or more entities to conduct an assessment of the mobility and transportation needs of persons with disabilities and other special needs populations. The assessment shall include identification of any legal, statutory or regulatory, and funding barriers. After consultation with the department of transportation, office for people with developmental disabilities, office for the aging, office of mental health, and office of alcoholism and substance abuse services, the contractor shall make recommendations for the development of a pilot demonstration project to coordinate medical and non-medical transportation services, maximize funding sources, enhance community integration and any other related tasks.

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 A MONETARY OR OTHER GRANT PURSUANT TO THIS SECTION FOR THE PURPOSE OF OBTAINING MEDICAL CARE, HOME CARE, OR RELATED SERVICES.

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 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]. NO MEDICAL ASSISTANCE UNDER THIS TITLE, REGARDLESS OF FUNDING SOURCE, SHALL BE AVAILABLE TO MEET THE IMMEDIATE NEEDS OF INDIVIDUALS PRIOR TO A DETERMINATION THAT THEY MEET THE ELIGIBILITY REQUIREMENTS OF THIS TITLE, EXCEPT DURING A PERIOD OF PRESUMPTIVE ELIGIBILITY AS PROVIDED IN THIS SUBDIVISION.

S 37. Notwithstanding any provision of law to the contrary, 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 shall be used to implement the state's comprehensive plan for serving New Yorkers with disabilities in the most integrated setting, also known as the state's Olmstead plan. Such monies shall be expended for the purposes consistent with the Olmstead plan. The Department of Health shall consult with stakeholders, relevant state agencies, the Division of Budget and the Olmstead cabinet in determining the level of investment for each of the programs under the Olmstead plan.

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

27. FOR PERIODS ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, THE COMMISSIONER SHALL AUTHORIZE AN ENERGY EFFICIENCY AND/OR DISASTER PREPAREDNESS DEMONSTRATION PROGRAM FOR RESIDENTIAL HEALTH CARE FACILITIES. SUCH PROGRAM SHALL BE LIMITED TO REAL PROPERTY CAPITAL COSTS. THE COMMISSIONER MAY PROMULGATE REGULATIONS IN ORDER TO IMPLEMENT THE PROVISIONS OF THIS SUBDIVISION.

S 39. The opening paragraph of subdivision 9 of section 3614 of the public health law, as amended by section 56 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

Notwithstanding any law to the contrary, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment for certified home health agencies for such services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department, long term home health care programs, AIDS home care programs established pursuant to this article, AND hospice programs established under article forty of this chapter [and for managed long term care plans and approved managed long term care operating demonstrations as defined in section forty-four hundred three-f of this chapter]. Such adjustments shall be for purposes of improving recruitment, training and retention of home health aides or other personnel with direct patient care responsibility in the following aggregate amounts for the following periods:

S 40. Paragraph (a) of subdivision 10 of section 3614 of the public health law, as amended by section 57 of part A of chapter 56 of the laws of 2013, is amended to read as follows:

(a) Such adjustments to rates of payments shall be allocated proportionally based on each certified home health agency, long term home health care program, AIDS home care and hospice program's home health aide or other direct care services total annual hours of service provided to medicaid patients, as reported in each such agency's most recently available cost report as submitted to the department [or for the purpose of the managed long term care program a suitable proxy developed by the department in consultation with the interested parties]. Payments made pursuant to this section shall not be subject to subsequent adjustment or reconciliation; provided that such adjustments to rates of payments to certified home health agencies shall only be for that portion of services provided to children under eighteen years of age and for services provided to a special needs population of medically complex and fragile children, adolescents and young disabled adults by a CHHA operating under a pilot program approved by the department.

S 41. The civil service law is amended by adding a new section 66 to read as follows:

S 66. TERM APPOINTMENTS IN HEALTH INSURANCE PROGRAM-RELATED POSITIONS. 1. THE DEPARTMENT OF HEALTH'S OFFICE OF HEALTH INSURANCE PROGRAMS IS TASKED WITH IMPLEMENTING SIGNIFICANT HEALTH INSURANCE PROGRAM REFORMS, INITIATIVES AND MANDATES. AS THE STATE CONTINUES TO IMPLEMENT THESE CHANGES, THE OFFICE OF HEALTH INSURANCE PROGRAMS MAY NEED TO RELY UPON THE EXPERTISE OF INDIVIDUALS FROM EITHER INSIDE OR OUTSIDE THE EXISTING STATE WORKFORCE THAT POSSESS HIGHLY SPECIALIZED EXPERTISE IN ASSESSING AND LEVERAGING EMERGING HEALTH INSURANCE PROGRAMS AND RELATED ISSUES.

TO THIS END, NOTWITHSTANDING ANY OTHER PROVISION IN THIS CHAPTER, THE DEPARTMENT MAY AUTHORIZE TERM APPOINTMENTS WITHOUT EXAMINATION TO TEMPORARY POSITIONS REQUIRING SPECIAL EXPERTISE OR QUALIFICATIONS IN HEALTH INSURANCE PROGRAMS. SUCH APPOINTMENTS MAY BE AUTHORIZED ONLY IN SUCH CASES WHERE THE OFFICE OF HEALTH INSURANCE PROGRAMS CERTIFIES TO THE DEPARTMENT THAT BECAUSE OF THE TYPE OF SERVICES TO BE RENDERED OR THE TEMPORARY OR OCCASIONAL CHARACTER OF SUCH SERVICES, IT WOULD NOT BE PRACTICABLE TO HOLD AN EXAMINATION OF ANY KIND. SUCH CERTIFICATION SHALL BE A PUBLIC DOCUMENT PURSUANT TO THE PUBLIC OFFICERS LAW AND SHALL IDENTIFY THE SPECIAL EXPERTISE OR QUALIFICATIONS THAT ARE REQUIRED AND WHY

THEY CANNOT BE OBTAINED THROUGH AN APPOINTMENT FROM AN ELIGIBLE LIST. THE MAXIMUM PERIOD FOR A TERM APPOINTMENT ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL NOT EXCEED SIXTY MONTHS AND SHALL NOT BE EXTENDED, AND THE MAXIMUM NUMBER OF SUCH APPOINTMENTS SHALL NOT EXCEED THREE HUNDRED. AT LEAST FIFTEEN DAYS PRIOR TO MAKING A TERM APPOINTMENT PURSUANT TO THIS SECTION THE APPOINTING AUTHORITY SHALL PUBLICLY AND CONSPICUOUSLY POST IN ITS OFFICES INFORMATION ABOUT THE TEMPORARY POSITION AND THE REQUIRED QUALIFICATIONS AND SHALL ALLOW ANY QUALIFIED EMPLOYEE TO APPLY FOR SAID POSITION. AN EMPLOYEE APPOINTED PURSUANT TO THIS PROVISION WHO HAS COMPLETED TWO YEARS OF CONTINUOUS SERVICE UNDER THIS PROVISION SHALL BE ABLE TO COMPETE IN ONE PROMOTIONAL EXAMINATION THAT IS ALSO OPEN TO EMPLOYEES WHO HAVE PERMANENT CIVIL SERVICE APPOINTMENTS AND APPROPRIATE QUALIFICATIONS.

2. A TEMPORARY POSITION ESTABLISHED PURSUANT TO SUBDIVISION ONE OF THIS SECTION MAY BE ABOLISHED FOR REASONS OF ECONOMY, CONSOLIDATION OR ABOLITION OF FUNCTIONS, CURTAILMENT OF ACTIVITIES OR OTHERWISE. UPON SUCH ABOLITION OR AT THE END OF THE TERM OF THE APPOINTMENT, THE PROVISIONS OF SECTIONS SEVENTY-EIGHT, SEVENTY-NINE, EIGHTY AND EIGHTY-ONE OF THIS CHAPTER SHALL NOT APPLY. IN THE EVENT OF A REDUCTION OF WORKFORCE PURSUANT TO SECTION EIGHTY OF THIS CHAPTER AFFECTING HEALTH INSURANCE PROGRAM-RELATED POSITIONS, THE TERM APPOINTMENTS PURSUANT TO THIS SECTION AT THE DEPARTMENT OF HEALTH'S OFFICE OF HEALTH INSURANCE PROGRAMS SHALL BE ABOLISHED PRIOR TO THE ABOLITION OF PERMANENT COMPETITIVE CLASS HEALTH INSURANCE PROGRAM-RELATED POSITIONS AT THE OFFICE OF HEALTH INSURANCE PROGRAMS INVOLVING COMPARABLE SKILLS AND RESPONSIBILITIES.

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 service law, as added by section 51 of part C of chapter 60 of the laws of 2014 and as renumbered by section thirty 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 47. 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 48. 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 49. 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 50. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015, section eight of this act shall expire and be deemed repealed March 31, 2017 and section thirty-eight of this act shall expire and be deemed repealed March 31, 2018 provided that:

1. sections two and three of this act shall take effect May 1, 2015;

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

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

4. the amendments to subdivision 9 of section 367-a of the social services law made by sections two and three of this act shall not affect the expiration and reversion of such subdivision and shall be deemed expired therewith;

5. 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;

6. 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;

7. the amendments to section 364-j of the social services law made by section seven of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith;

8. 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;

9. 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;

10. 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;

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

12. 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 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, 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, 2016 FOR PATIENTS IN THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH JUNE 30, 2017 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, 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.

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 article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through December 31, 2016 for patients in the city of New York, for all rate periods on and after the effective date of [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through June 30, 2017 for patients outside the city of New York, and for all rate periods on and after the effective date of [the] 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, 2016 FOR PATIENTS IN THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH JUNE 30, 2017 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, 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.

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, 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];

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 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 FOR EACH STATE FISCAL YEAR THEREAFTER 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] 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 AND PRIOR TO EACH FEBRUARY FIRST THEREAFTER 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 AND FOR EACH SUBSEQUENT YEAR SUCH PERCENTAGE SHALL BE CALLED THE statewide target percentage [respectively] OF THE RESPECTIVE YEAR.

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 OR SUBSEQUENT YEARS' 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 AND FOR EACH SUBSEQUENT YEAR SUCH PERCENTAGE SHALL BE CALLED THE statewide reduction percentage [respectively] OF THE RESPECTIVE YEAR. If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006,

2007, 2008, 2009, 2010, 2011, 2012, 2013[;], 2014 [and], 2015 OR SUBSEQUENT YEARS' 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 OR SUBSEQUENT YEARS' 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 OR RESPECTIVE SUBSEQUENT YEARS' 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 OR RESPECTIVE SUBSEQUENT YEARS' 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 OR RESPECTIVE SUBSEQUENT YEARS' 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 EACH JANUARY 1 THROUGH EACH NOVEMBER 30 OF A CALENDAR YEAR THEREAFTER SHALL MEAN SUCH YEARS' RESPECTIVE TARGET PERIOD.

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 FIRST EACH YEAR THEREAFTER, 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, AND EACH YEAR THEREAFTER, 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, AND EACH YEAR THEREAFTER, 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, AND FOR EACH YEAR THEREAFTER, 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, AND FOR EACH YEAR THEREAFTER, 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, AND FOR EACH YEAR THEREAFTER, 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, AND FOR EACH YEAR THEREAFTER, 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];

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 FOR EACH YEAR THEREAFTER.

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];

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 FOR EACH YEAR THEREAFTER, 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; 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, 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 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 legis-

lation necessary to implement the health and mental hygiene budget for the 2011-2012 state fiscal plan, is REPEALED.

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 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], 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 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 require-

ments 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 25. Section 5 of chapter 21 of the laws of 2011, amending the education law relating to authorizing pharmacists to perform collaborative drug therapy management with physicians in certain settings, as amended by chapter 125 of the laws of 2014, is amended to read as follows:

S 5. This act shall take effect on the one hundred twentieth day after it shall have become a law and shall expire [4] 7 years after such effective date when upon such date the provisions of this act shall be deemed repealed; provided, however, that the amendments to subdivision 1 of section 6801 of the education law made by section one of this act shall be subject to the expiration and reversion of such subdivision pursuant to section 8 of chapter 563 of the laws of 2008, when upon such date the provisions of section one-a of this act shall take effect; provided, further, that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date is authorized and directed to be made and completed on or before such effective date.

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] 2018.

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 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 REPEALED.

S 29. 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 30. 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 31. 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 32. 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. section eighteen of this act shall take effect on the same date as the reversion of subdivision 3 of section 1680-j of the public authorities law as provided in subdivision (a) of section 70 of part HH of chapter 57 of the laws of 2013, as amended;

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

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

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

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

6. 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 thou-

sand 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.

(D) NOTWITHSTANDING ANY PROVISION OF THIS SECTION TO THE CONTRARY, IN THE EVENT THE AGGREGATE LEVEL OF MEDICAID DSH PAYMENTS IS REDUCED DURING THE PERIODS DESCRIBED IN CLAUSE (C) OF THIS SUBPARAGRAPH, THE COMMISSIONER MAY ADJUST, BY REGULATION: THE AGGREGATE LEVEL OF PAYMENTS MADE PURSUANT TO CLAUSES (A) AND (B) OF SUBPARAGRAPH (II) OF PARAGRAPH (B) OF THIS SUBDIVISION, THE PERCENTAGE OF REDUCTIONS IN PAYMENTS REQUIRED BY CLAUSE (C) OF THIS SUBPARAGRAPH, AND THE METHODOLOGY BY WHICH SUCH DSH PAYMENTS ARE DISTRIBUTED. SUCH ADJUSTMENTS SHALL TAKE EFFECT AT THE BEGINNING OF THE CALENDAR YEAR FOLLOWING THE YEAR IN WHICH SUCH REDUCTIONS IN MEDICAID DSH PAYMENTS TAKE EFFECT AND PROVIDED, FURTHER, ANY SUCH REGULATIONS UNDER THIS SECTION MAY APPLY RETROACTIVELY TO SUCH DATE.

(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. Subdivision 17 of section 2807-k of the public health law, as added by section 3-b of part B of chapter 109 of the laws of 2010, is amended to read as follows:

17. Indigent care reductions. (A) For each hospital receiving payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, the commissioner shall reduce the sum of any amounts paid pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article, as computed based on projected facility specific disproportionate share hospital ceilings, by an amount equal to the lower of such sum or each such hospital's payments pursuant to paragraph (i) of subdivision thirty-five of section twenty-eight hundred seven-c of this article, provided, however, that any additional aggregate reductions enacted in a chapter of the laws of two thousand ten to the aggregate amounts payable pursuant to this section and pursuant to section twenty-eight hundred seven-w of this article shall be applied subsequent to the adjustments otherwise provided for in this subdivision.

(B) FOR ANY REDUCTIONS IN PAYMENTS UNDER PARAGRAPH (I) OF SUBDIVISION THIRTY-FIVE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-C OF THIS ARTICLE RESULTING FROM AGGREGATE UPPER PAYMENT LIMIT CALCULATIONS, THE COMMISSIONER MAY REDUCE OR REDISTRIBUTE PAYMENTS UNDER THIS SECTION OR SECTION TWENTY-EIGHT HUNDRED SEVEN-W OF THIS ARTICLE IN A MANNER TO BE DETERMINED IN HIS OR HER DISCRETION.

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;

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

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

PART F

Section 1. The public health law is amended by adding a new section 4415 to read as follows:

S 4415. VALUE BASED PAYMENTS. 1. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW IN THIS ARTICLE OR SECTION THREE HUNDRED SIXTY-FOUR-J OF THE SOCIAL SERVICES LAW, THE COMMISSIONER MAY AUTHORIZE MANAGED CARE ORGANIZATIONS LICENSED UNDER THIS ARTICLE TO CONTRACT FOR VALUE BASED PAYMENTS AND FURTHER, MAY AUTHORIZE THE DEPARTMENT TO UTILIZE METHODOLOGIES OF REIMBURSEMENT THAT ARE VALUE BASED.

2. NOTHING IN SUBDIVISION ONE OF THIS SECTION SHALL LIMIT THE AUTHORITY OF THE COMMISSIONER TO AUTHORIZE VALUE BASED PAYMENTS FOR PERFORMING PROVIDER SYSTEMS PARTICIPATING IN THE DELIVERY SYSTEM REFORM INCENTIVE PROGRAM ("DSRIP"), OR TO AUTHORIZE VALUE BASED PAYMENTS FOR ANY SUCH SUBSET OF PROVIDERS.

3. FOR THE PURPOSES OF THIS SECTION AND NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, A PERFORMING PROVIDER SYSTEM PARTICIPATING IN DSRIP, OR ANY SUCH SUBSET OF PROVIDERS, IS AUTHORIZED TO ARRANGE BY CONTRACT FOR THE DELIVERY AND PROVISION OF HEALTH SERVICES AS CONTEMPLATED BY THIS CHAPTER OR THE SOCIAL SERVICES LAW.

4. THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, MAY PROMULGATE REGULATIONS TO EFFECTUATE THE PROVISIONS OF THIS SECTION; PROVIDED, HOWEVER, THAT THE FAILURE TO ADOPT REGULATIONS SHALL NOT INVALIDATE ANY EXERCISE OF AUTHORITY UNDER THIS SECTION. SUCH REGULATIONS MAY, AND SHALL AS NECESSARY FOR THE PURPOSES OF THIS SECTION, ADDRESS MATTERS INCLUDING, BUT NOT LIMITED TO:

(A) AUTHORIZING DISCRETE LEVELS OF VALUE BASED PAYMENTS THAT ACCOUNT FOR LEVEL OF RISK;

(B) PLACING CONDITIONS UPON ANY SUCH LEVEL OF VALUE BASED PAYMENT;

(C) REQUIRING OR ADJUSTING RESERVES, AS APPLICABLE, FOR MANAGED CARE ORGANIZATIONS LICENSED UNDER THIS ARTICLE AND ENTITIES PARTICIPATING IN VALUE BASED PAYMENT ARRANGEMENTS;

(D) AUTHORIZING THE COMMISSIONER TO ESTABLISH A REINSURANCE POOL;

(E) MAKING ANY CHANGES TO VALUE BASED PAYMENTS OR METHODOLOGIES OF REIMBURSEMENT THAT ARE VALUE BASED AS NECESSARY TO CONFORM TO THE TERMS AND CONDITIONS OF THE DSRIP WAIVER.

5. NOTHING CONTAINED IN THIS SECTION SHALL LIMIT THE AUTHORITY OF THE COMMISSIONER TO MAINTAIN A SYSTEM OF VALUE BASED PAYMENTS SUBSEQUENT TO THE CONCLUSION OR EXPIRATION OF THE DSRIP WAIVER, NOR SHALL ANY REFERENCE TO THE DSRIP PROGRAM WITHIN THIS SECTION LIMIT THE AUTHORITY OF THE COMMISSIONER, IN CONSULTATION WITH THE SUPERINTENDENT OF FINANCIAL SERVICES, TO OTHERWISE APPLY SUCH PRINCIPLES TO ORGANIZATIONS LICENSED UNDER THIS ARTICLE OR TO IMPLEMENT METHODOLOGIES THAT UTILIZE VALUE BASED PAYMENTS FOR ANY PROVIDER REIMBURSED UNDER THIS CHAPTER.

S 2. 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 3. 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 4. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its

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

S 5. This act shall take effect 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 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 financial services and any appropriate council are authorized to adopt or amend or promulgate on an emergency basis any regulation he or she or such council determines necessary to implement any provision of this act on its effective date; and

5. 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 G

Section 1. The financial services law is amended by adding a new section 208 to read as follows:

S 208. ASSESSMENT FOR THE OPERATING EXPENSES OF THE NEW YORK HEALTH BENEFIT EXCHANGE. (A) FOR EACH FISCAL YEAR COMMENCING ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, ASSESSMENTS FOR THE OPERATING EXPENSES ATTRIBUTABLE TO QUALIFIED HEALTH PLAN COVERAGE OF THE NEW YORK HEALTH BENEFIT EXCHANGE, ESTABLISHED WITHIN THE DEPARTMENT OF HEALTH BY EXECUTIVE ORDER 42 SIGNED BY GOVERNOR ANDREW M. CUOMO ON APRIL 12, 2012 IN CONFORMITY WITH THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, PUBLIC LAW 111-14 AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT, PUBLIC LAW 111-152, AND DOING BUSINESS AS THE NY STATE OF HEALTH, THE OFFICIAL HEALTH PLAN MARKETPLACE (NY STATE OF HEALTH) SHALL BE ASSESSED BY THE SUPERINTENDENT IN ACCORDANCE WITH THIS SECTION. A DOMESTIC ACCIDENT AND HEALTH INSURER SHALL BE ASSESSED BY THE SUPERINTENDENT PURSUANT TO THIS SECTION FOR THE OPERATING EXPENSES OF THE NY STATE OF HEALTH ATTRIBUTABLE TO QUALIFIED HEALTH PLANS' COVERAGE, WHICH SHALL INCLUDE DIRECT AND INDIRECT EXPENSES RELATED TO THE OPERATION OF THE NEW YORK STATE OF HEALTH ATTRIBUTABLE TO SUCH QUALIFIED HEALTH PLAN COVERAGE WITH THE ASSESSMENTS ALLOCATED PRO RATA UPON ALL DOMESTIC ACCIDENT AND HEALTH INSURERS IN THE INDIVIDUAL, SMALL GROUP AND LARGE GROUP MARKETS, IN PROPORTION TO THE GROSS DIRECT PREMIUMS, EXCLUSIVE OF FEDERAL TAX CREDITS AND OTHER CONSIDERATIONS, WRITTEN OR RECEIVED BY THEM IN THIS STATE DURING THE CALENDAR YEAR ENDING DECEMBER THIRTY-FIRST IMMEDIATELY PRECEDING THE END OF THE FISCAL YEAR FOR WHICH THE ASSESSMENT IS MADE

(LESS RETURN PREMIUMS AND CONSIDERATIONS THEREON) FOR INSURANCE POLICIES OR CONTRACTS OF MAJOR MEDICAL OR SIMILAR COMPREHENSIVE TYPE MEDICAL COVERAGE OR DENTAL COVERAGE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE; BUT EXCLUDING INSURANCE POLICIES OR CONTRACTS FOR MAJOR MEDICAL OR SIMILAR COMPREHENSIVE TYPE MEDICAL OR DENTAL COVERAGE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT (MEDICARE), MEDICAL ASSISTANCE UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, CHILD HEALTH PLUS INSURANCE PLAN UNDER SECTION TWENTY-FIVE HUNDRED OF THE PUBLIC HEALTH LAW AND/OR THE BASIC HEALTH INSURANCE PLAN PURSUANT TO PARAGRAPH (E) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-NINE-GG OF THE SOCIAL SERVICES LAW.

(B) THE ASSESSMENT UPON DOMESTIC ACCIDENT AND HEALTH INSURERS DESCRIBED IN SUBSECTION (A) OF THIS SECTION SHALL BE MADE BY THE SUPERINTENDENT COMMENCING APRIL FIRST, TWO THOUSAND FIFTEEN, IN A SUM AS PRESCRIBED BY THE SUPERINTENDENT FOR SUCH INSURERS' PRO RATA SHARE OF THE ANNUAL EXPENSES OF THE NY STATE OF HEALTH ATTRIBUTABLE TO QUALIFIED HEALTH PLAN COVERAGE FOR THE TWO THOUSAND FIFTEEN-TWO THOUSAND SIXTEEN FISCAL YEAR, AS ESTIMATED BY THE SUPERINTENDENT. SUCH PAYMENT SHALL BE MADE ON OR BEFORE FEBRUARY FIFTEENTH, TWO THOUSAND SIXTEEN, OR ON OR BEFORE SUCH OTHER DATES AS THE SUPERINTENDENT MAY PRESCRIBE. FOLLOWING THE DETERMINATION OF THE AMOUNT COLLECTED BASED ON THE ACTUAL ENROLLMENT IN QUALIFIED HEALTH PLAN COVERAGE THROUGH THE NY STATE OF HEALTH AND FULLY INSURED INDIVIDUAL, SMALL GROUP, AND LARGE GROUP COVERAGE OUTSIDE THE NY STATE OF HEALTH FOR THE TWO THOUSAND FIFTEEN-TWO THOUSAND SIXTEEN FISCAL YEAR, ANY OVERPAYMENT OF SUCH ASSESSMENT SHALL BE APPLIED AGAINST THE NEXT ESTIMATED QUARTERLY ASSESSMENT FOR SUCH EXPENSES AS SET FORTH IN THIS SECTION, IF LESS THAN OR EQUAL TO SUCH AMOUNT, UNTIL FULLY RECONCILED. HOWEVER, IF THE ASSESSMENT COLLECTED IS LESS THAN THE EXPENSES OF THE NY STATE OF HEALTH ATTRIBUTABLE TO QUALIFIED HEALTH PLAN COVERAGE FOR THE TWO THOUSAND FIFTEEN-TWO THOUSAND SIXTEEN FISCAL YEAR, THE SUPERINTENDENT MAY REQUIRE FULL PAYMENT TO BE MADE ON SUCH DATE OF THE FISCAL YEAR AS THE SUPERINTENDENT MAY DETERMINE.

(C) FOR EACH FISCAL YEAR COMMENCING ON OR AFTER APRIL FIRST, TWO THOUSAND SIXTEEN, A PARTIAL PAYMENT SHALL BE MADE BY A DOMESTIC ACCIDENT AND HEALTH INSURER IN A SUM EQUAL TO TWENTY-FIVE PER CENTUM, OR SUCH OTHER PER CENTUM OR PER CENTUMS AS THE SUPERINTENDENT MAY PRESCRIBE, OF ITS PRO RATA SHARE OF THE ANNUAL EXPENSES OF THE NY STATE OF HEALTH ATTRIBUTABLE TO QUALIFIED HEALTH PLAN COVERAGE ASSESSED UPON IT FOR THE FISCAL YEAR AS ESTIMATED BY THE SUPERINTENDENT. SUCH PAYMENT SHALL BE MADE ON MARCH FIFTEENTH OF THE PRECEDING FISCAL YEAR AND ON JUNE FIFTEENTH, SEPTEMBER FIFTEENTH AND DECEMBER FIFTEENTH OF EACH YEAR, OR AT SUCH OTHER DATES AS THE SUPERINTENDENT MAY PRESCRIBE. THE SUPERINTENDENT SHALL ANNUALLY RECONCILE THE ASSESSMENT PERCENTAGE BASED UPON ACTUAL PREMIUM DATA SUBMITTED TO THE SUPERINTENDENT OR COMMISSIONER OF HEALTH, AS APPLICABLE. THE BALANCE OF ASSESSMENTS FOR THE FISCAL YEAR SHALL BE PAID UPON DETERMINATION OF THE AMOUNT COLLECTED FOR POLICIES OR CONTRACTS OF MAJOR MEDICAL OR SIMILAR COMPREHENSIVE TYPE MEDICAL COVERAGE OR DENTAL COVERAGE DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE AS SET FORTH IN SUBSECTION (A) OF THIS SECTION. ANY OVERPAYMENT OF ANNUAL ASSESSMENT RESULTING FROM COMPLYING WITH THE REQUIREMENTS OF THIS SECTION SHALL BE APPLIED AGAINST THE NEXT ESTIMATED QUARTERLY ASSESSMENT, IF LESS THAN OR EQUAL TO SUCH AMOUNT, UNTIL FULLY RECONCILED.

(D)(1) PAYMENTS AND REPORTS SUBMITTED OR REQUIRED TO BE SUBMITTED TO THE COMMISSIONER OF HEALTH PURSUANT TO THIS SECTION BY A DOMESTIC ACCIDENT AND HEALTH INSURER SHALL BE SUBJECT TO AUDIT BY THE COMMISSIONER OF HEALTH FOR A PERIOD OF SIX YEARS FOLLOWING THE CLOSE OF THE CALENDAR

YEAR IN WHICH SUCH PAYMENTS AND REPORTS ARE DUE, AFTER WHICH SUCH PAYMENTS SHALL BE DEEMED FINAL AND NOT SUBJECT TO FURTHER ADJUSTMENT OR RECONCILIATION, INCLUDING THROUGH OFFSET ADJUSTMENTS OR RECONCILIATIONS MADE BY THE DOMESTIC ACCIDENT AND HEALTH INSURER WITH REGARD TO SUBSEQUENT PAYMENTS, PROVIDED, HOWEVER, THAT NOTHING HEREIN SHALL BE CONSTRUED AS PRECLUDING THE COMMISSIONER OF HEALTH FROM PURSUING COLLECTION OF ANY SUCH PAYMENTS WHICH ARE IDENTIFIED AS DELINQUENT WITHIN SUCH SIX YEAR PERIOD, OR WHICH ARE IDENTIFIED AS DELINQUENT AS A RESULT OF AN AUDIT COMMENCED WITHIN SUCH SIX YEAR PERIOD, OR FROM CONDUCTING AN AUDIT OF ANY ADJUSTMENTS AND RECONCILIATION WITHIN SUCH SIX YEAR PERIOD, OR FROM CONDUCTING AN AUDIT OF PAYMENTS MADE PRIOR TO SUCH SIX YEAR PERIOD WHICH ARE FOUND TO BE COMMINGLED WITH PAYMENTS WHICH ARE OTHERWISE SUBJECT TO TIMELY AUDIT PURSUANT TO THIS SECTION.

(2) THE SUPERINTENDENT MAY ASSESS A DOMESTIC ACCIDENT AND HEALTH INSURER WHICH, IN THE COURSE OF AN AUDIT PURSUANT TO THIS SECTION, FAILS TO PRODUCE DATA OR DOCUMENTATION REQUESTED IN FURTHERANCE OF SUCH AN AUDIT, WITHIN THIRTY DAYS OF SUCH REQUEST, A CIVIL PENALTY OF UP TO TEN THOUSAND DOLLARS FOR EACH SUCH FAILURE, PROVIDED, HOWEVER, THAT SUCH CIVIL PENALTY SHALL NOT BE IMPOSED IF THE DOMESTIC ACCIDENT AND HEALTH INSURER DEMONSTRATES GOOD CAUSE FOR SUCH FAILURE.

(3) RECORDS REQUIRED TO BE RETAINED FOR AUDIT VERIFICATION PURPOSES BY A DOMESTIC ACCIDENT AND HEALTH INSURER IN ACCORDANCE WITH THIS SECTION SHALL INCLUDE, ON A MONTHLY BASIS, THE SOURCE RECORDS GENERATED BY SUPPORTING INFORMATION SYSTEMS, FINANCIAL ACCOUNTING RECORDS, AND SUCH OTHER RECORDS AS MAY BE REQUIRED TO PROVE COMPLIANCE WITH, AND TO SUPPORT REPORTS SUBMITTED IN ACCORDANCE WITH, THIS SECTION.

(4) IF A DOMESTIC ACCIDENT AND HEALTH INSURER FAILS TO PRODUCE DATA OR DOCUMENTATION REQUESTED IN FURTHERANCE OF AN AUDIT PURSUANT TO THIS SECTION FOR A QUARTER TO WHICH THE ASSESSMENT APPLIES, THE SUPERINTENDENT MAY ESTIMATE, BASED ON AVAILABLE FINANCIAL AND STATISTICAL DATA AS DETERMINED BY THE SUPERINTENDENT, THE AMOUNT DUE FOR SUCH QUARTER. INTEREST AND PENALTIES SHALL BE APPLIED TO SUCH AMOUNTS DUE IN ACCORDANCE WITH THE PROVISIONS OF SUBSECTION (B) OF SECTION NINE THOUSAND ONE HUNDRED NINE OF THE INSURANCE LAW.

(5) THE SUPERINTENDENT MAY, AS PART OF A FINAL RESOLUTION OF AN AUDIT CONDUCTED BY THE COMMISSIONER OF HEALTH PURSUANT TO THIS SUBSECTION, WAIVE PAYMENT OF INTEREST AND PENALTIES OTHERWISE APPLICABLE PURSUANT TO SUBSECTION (B) OF SECTION NINE THOUSAND ONE HUNDRED NINE OF THE INSURANCE LAW, WHEN AMOUNTS DUE AS A RESULT OF SUCH AUDIT, OTHER THAN SUCH WAIVED PENALTIES AND INTEREST, ARE PAID IN FULL TO THE COMMISSIONER OF HEALTH WITHIN SIXTY DAYS OF THE ISSUANCE OF A FINAL AUDIT REPORT THAT IS MUTUALLY AGREED TO BY THE COMMISSIONER OF HEALTH AND DOMESTIC ACCIDENT AND HEALTH INSURER, PROVIDED, HOWEVER, THAT IF SUCH FINAL AUDIT REPORT IS NOT SO MUTUALLY AGREED UPON, THEN THE SUPERINTENDENT SHALL HAVE NO OBLIGATIONS PURSUANT TO THIS PARAGRAPH.

(6) THE COMMISSIONER OF HEALTH MAY ENTER INTO AN AGREEMENT WITH A DOMESTIC ACCIDENT AND HEALTH INSURER IN REGARD TO WHICH AUDIT FINDINGS OR PRIOR SETTLEMENTS HAVE BEEN MADE PURSUANT TO THIS SECTION, EXTENDING AND APPLYING SUCH AUDIT FINDINGS OR PRIOR SETTLEMENTS, OR A PORTION THEREOF, IN SETTLEMENT AND SATISFACTION OF POTENTIAL AUDIT LIABILITIES FOR SUBSEQUENT UNAUDITED PERIODS. THE SUPERINTENDENT MAY REDUCE OR WAIVE PAYMENT OF INTEREST AND PENALTIES OTHERWISE APPLICABLE TO SUCH SUBSEQUENT UNAUDITED PERIODS WHEN SUCH AMOUNTS DUE AS A RESULT OF SUCH AGREEMENT, OTHER THAN REDUCED OR WAIVED INTEREST AND PENALTIES, ARE PAID IN FULL TO THE COMMISSIONER OF HEALTH WITHIN SIXTY DAYS OF EXECUTION OF SUCH AGREEMENT BY ALL PARTIES TO THE AGREEMENT. ANY PAYMENTS MADE PURSU-

ANT TO AN AGREEMENT ENTERED INTO IN ACCORDANCE WITH THIS PARAGRAPH SHALL BE DEEMED TO BE IN FULL SATISFACTION OF ANY LIABILITY ARISING UNDER THIS SECTION, AS REFERENCED IN SUCH AGREEMENT AND FOR THE TIME PERIODS COVERED BY SUCH AGREEMENT, PROVIDED, HOWEVER, THAT THE COMMISSIONER OF HEALTH MAY AUDIT FUTURE RETROACTIVE ADJUSTMENTS TO PAYMENTS MADE FOR SUCH PERIODS BASED ON REPORTS FILED BY A DOMESTIC ACCIDENT AND HEALTH INSURER SUBSEQUENT TO SUCH AGREEMENT.

(E) THE COMMISSIONER OF HEALTH SHALL HAVE THE AUTHORITY UNDER SECTION TWENTY-EIGHT HUNDRED SEVEN-Y OF THE PUBLIC HEALTH LAW TO CONTRACT WITH THE ARTICLE FORTY-THREE INSURANCE LAW PLANS, OR SUCH OTHER CONTRACTORS AS THE COMMISSIONER OF HEALTH SHALL DESIGNATE, TO ISSUE INVOICES, RECEIVE PAYMENT, AND DISTRIBUTE FUNDS FROM THE ASSESSMENT AUTHORIZED BY THIS SECTION AND TO DEPOSIT IT INTO THE SPECIAL REVENUE FUNDS-OTHER, HCRA RESOURCES FUND.

(F) FOR THE PURPOSE OF THIS SECTION, "ACCIDENT AND HEALTH INSURER" SHALL MEAN AN INSURER AUTHORIZED UNDER THE INSURANCE LAW TO WRITE ACCIDENT AND HEALTH INSURANCE IN THIS STATE, A CORPORATION ORGANIZED PURSUANT TO ARTICLE FORTY-THREE OF THE INSURANCE LAW, OR A HEALTH MAINTENANCE ORGANIZATION HOLDING OR REQUIRED TO HOLD A CERTIFICATE OF AUTHORITY PURSUANT TO ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, THAT WRITES MAJOR MEDICAL OR SIMILAR COMPREHENSIVE TYPE MEDICAL COVERAGE OR WRITES DENTAL COVERAGE.

(G) FOR THE PURPOSE OF THIS SECTION, "DOMESTIC ACCIDENT AND HEALTH INSURER" SHALL MEAN AN ACCIDENT AND HEALTH INSURER INCORPORATED OR ORGANIZED UNDER ANY LAW OF THIS STATE.

S 2. Paragraph (g) and (h) of subdivision 1 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, are amended and a new paragraph (i) is added to read as follows:

(g) section thirty-six hundred fourteen-a of this chapter; [and]

(h) section three hundred sixty-seven-i of the social services law[.]; AND

(I) SECTION TWO HUNDRED EIGHT OF THE FINANCIAL SERVICES LAW.

S 3. Subdivision 3 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:

3. The reasonable costs and expenses of an administrator as approved by the commissioner, not to exceed for personnel services on an annual basis [four] SIX million [five hundred] fifty thousand dollars, increased annually by the lower of the consumer price index or five percent, for collection and distribution of allowances and assessments set forth in subdivision one of this section, shall be paid from the allowance and assessment funds.

S 4. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

S 5. 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:

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 financial services 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 financial services are authorized to adopt or amend or promulgate on an emergency basis any regulation they determine necessary to implement any provision of this act on its effective date; and

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

PART H

Section 1. Section 2801-a of the public health law is amended by adding a new subdivision 17 to read as follows:

17. (A) DIAGNOSTIC OR TREATMENT CENTERS ESTABLISHED TO PROVIDE HEALTH CARE SERVICES WITHIN THE SPACE OF A RETAIL BUSINESS OPERATION, SUCH AS A PHARMACY OR A STORE OPEN TO THE GENERAL PUBLIC, OR WITHIN SPACE USED BY AN EMPLOYER FOR PROVIDING HEALTH CARE SERVICES TO ITS EMPLOYEES, MAY BE OPERATED BY LEGAL ENTITIES FORMED UNDER THE LAWS OF THE STATE OF NEW YORK: (I) WHOSE STOCKHOLDERS OR MEMBERS, AS APPLICABLE, ARE NOT NATURAL PERSONS; (II) WHOSE PRINCIPAL STOCKHOLDERS AND MEMBERS, AS APPLICABLE, AND CONTROLLING PERSONS COMPLY WITH ALL APPLICABLE REQUIREMENTS OF THIS SECTION; AND (III) THAT DEMONSTRATE, TO THE SATISFACTION OF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, SUFFICIENT EXPERIENCE AND EXPERTISE IN DELIVERING HIGH QUALITY HEALTH CARE SERVICES. SUCH DIAGNOSTIC AND TREATMENT CENTERS SHALL BE REFERRED TO IN THIS SECTION AS "LIMITED SERVICES CLINICS".

(B) FOR PURPOSES OF PARAGRAPH (A) OF THIS SUBDIVISION, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL ADOPT AND AMEND RULES AND REGULATIONS, NOTWITHSTANDING ANY INCONSISTENT PROVISION OF THIS SECTION, TO ADDRESS ANY MATTER IT DEEMS PERTINENT TO THE ESTABLISHMENT OF LIMITED SERVICES CLINICS. SUCH RULES AND REGULATIONS SHALL INCLUDE, BUT NOT BE LIMITED TO, PROVISIONS GOVERNING OR RELATING TO: (I) ANY DIRECT OR INDIRECT CHANGES OR TRANSFERS OF OWNERSHIP INTERESTS OR VOTING RIGHTS IN SUCH ENTITIES OR THEIR STOCKHOLDERS OR MEMBERS, AS APPLICABLE; (II) PUBLIC HEALTH AND HEALTH PLANNING COUNCIL APPROVAL OF ANY CHANGE IN CONTROLLING INTERESTS, PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, PARENT COMPANY OR SPONSORS; (III) OVERSIGHT OF THE OPERATOR AND ITS SHAREHOLDERS OR MEMBERS, AS APPLICABLE, INCLUDING LOCAL GOVERNANCE OF THE LIMITED SERVICES CLINICS; AND (IV) THE CHARACTER AND COMPETENCE AND

QUALIFICATIONS OF, AND CHANGES RELATING TO, THE DIRECTORS AND OFFICERS OF THE OPERATOR AND ITS PRINCIPAL STOCKHOLDERS, CONTROLLING PERSONS, PARENT COMPANY OR SPONSORS.

(C) THE FOLLOWING PROVISIONS OF THIS SECTION SHALL NOT APPLY TO LIMITED SERVICES CLINICS: (I) PARAGRAPH (A) OF SUBDIVISION THREE OF THIS SECTION; (II) PARAGRAPH (B) OF SUBDIVISION THREE OF THIS SECTION, RELATING TO STOCKHOLDERS AND MEMBERS OTHER THAN PRINCIPAL STOCKHOLDERS AND PRINCIPAL MEMBERS; (III) PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE DISPOSITION OF STOCK OR VOTING RIGHTS; AND (IV) PARAGRAPH (E) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE OWNERSHIP OF STOCK OR MEMBERSHIP.

(D) A LIMITED SERVICES CLINIC SHALL BE DEEMED TO BE A "HEALTH CARE PROVIDER" FOR THE PURPOSES OF TITLE TWO-D OF ARTICLE TWO OF THIS CHAPTER. A PRESCRIBER PRACTICING IN A LIMITED SERVICE CLINIC SHALL NOT BE DEEMED TO BE IN THE EMPLOY OF A PHARMACY OR PRACTICING IN A HOSPITAL FOR PURPOSES OF SUBDIVISION TWO OF SECTION SIXTY-EIGHT HUNDRED SEVEN OF THE EDUCATION LAW.

(E) THE COMMISSIONER SHALL PROMULGATE REGULATIONS SETTING FORTH OPERATIONAL AND PHYSICAL PLANT STANDARDS FOR LIMITED SERVICES CLINICS, WHICH MAY BE DIFFERENT FROM THE REGULATIONS OTHERWISE APPLICABLE TO DIAGNOSTIC OR TREATMENT CENTERS, INCLUDING, BUT NOT LIMITED TO:

(I) REQUIRING THAT LIMITED SERVICES CLINICS ATTAIN AND MAINTAIN ACCREDITATION AND REQUIRING TIMELY REPORTING TO THE DEPARTMENT IF A LIMITED SERVICE CLINIC LOSES ITS ACCREDITATION;

(II) DESIGNATING OR LIMITING THE TREATMENTS AND SERVICES THAT MAY BE PROVIDED, INCLUDING:

(1) PROHIBITING THE PROVISION OF SERVICES TO PATIENTS TWENTY-FOUR MONTHS OF AGE OR YOUNGER;

(2) THE PROVISION OF SPECIFIC IMMUNIZATIONS TO PATIENTS YOUNGER THAN EIGHTEEN YEARS OF AGE;

(III) REQUIRING LIMITED SERVICE CLINICS TO ACCEPT WALK-INS AND OFFER EXTENDED BUSINESS HOURS;

(IV) SETTING FORTH GUIDELINES FOR ADVERTISING AND SIGNAGE, DISCLOSURE OF OWNERSHIP INTERESTS, INFORMED CONSENT, RECORD KEEPING, REFERRAL FOR TREATMENT AND CONTINUITY OF CARE, CASE REPORTING TO THE PATIENT'S PRIMARY CARE OR OTHER HEALTH CARE PROVIDERS, DESIGN, CONSTRUCTION, FIXTURES, AND EQUIPMENT. SIGNAGE SHALL ALSO BE REQUIRED TO INDICATE THAT PRESCRIPTIONS AND OVER-THE-COUNTER SUPPLIES MAY BE PURCHASED BY A PATIENT FROM ANY BUSINESS AND DO NOT NEED TO BE PURCHASED ON-SITE; AND

(V) REQUIRING THE OPERATOR TO DIRECTLY EMPLOY A MEDICAL DIRECTOR WHO IS LICENSED AND CURRENTLY REGISTERED TO PRACTICE MEDICINE IN THE STATE OF NEW YORK.

(F) SUCH REGULATIONS ALSO SHALL PROMOTE AND STRENGTHEN PRIMARY CARE THROUGH: (I) THE INTEGRATION OF SERVICES PROVIDED BY LIMITED SERVICES CLINICS WITH THE SERVICES PROVIDED BY THE PATIENT'S OTHER HEALTH CARE PROVIDERS; AND (II) THE REFERRAL OF PATIENTS TO APPROPRIATE HEALTH CARE PROVIDERS, INCLUDING APPROPRIATE TRANSMISSION OF PATIENT HEALTH RECORDS.

S 2. The public health law is amended by adding a new section 230-e to read as follows:

S 230-E. URGENT CARE. 1. DEFINITIONS. AS USED IN THIS SECTION:

(A) "ACCREDITED STATUS" SHALL MEAN THE FULL ACCREDITATION BY SUCH NATIONALLY-RECOGNIZED ACCREDITING AGENCIES AS DETERMINED BY THE COMMISSIONER.

(B) "EMERGENCY MEDICAL CARE" SHALL MEAN THE PROVISION OF TREATMENT FOR LIFE-THREATENING OR POTENTIALLY DISABLING TRAUMA, BURNS, RESPIRATORY, CIRCULATORY OR OBSTETRICAL CONDITIONS.

(C) "LICENSEE" SHALL MEAN AN INDIVIDUAL LICENSED OR OTHERWISE AUTHORIZED UNDER ARTICLE ONE HUNDRED THIRTY-ONE OR ONE HUNDRED THIRTY-ONE-B OF THE EDUCATION LAW.

(D) "URGENT CARE" SHALL MEAN THE PROVISION OF TREATMENT ON AN UNSCHEDULED BASIS TO PATIENTS FOR ACUTE EPISODIC ILLNESS, MINOR TRAUMAS THAT ARE NOT LIFE-THREATENING, OR POTENTIALLY DISABLING, OR FOR MONITORING OR TREATMENT OVER PROLONGED PERIODS.

(E) "URGENT CARE PROVIDER" SHALL MEAN A LICENSEE PRACTICE THAT ADVERTISES OR HOLDS ITSELF OUT AS A PROVIDER OF URGENT CARE.

2. NO LICENSEE PRACTICE SHALL, WITHIN THIS STATE, DISPLAY SIGNAGE, ADVERTISE OR HOLD ITSELF OUT AS A PROVIDER OF URGENT CARE THROUGH THE USE OF THE TERM URGENT CARE, OR THROUGH ANY OTHER TERM OR SYMBOL THAT IMPLIES THAT IT IS A PROVIDER OF URGENT CARE, UNLESS IT OBTAINS AND MAINTAINS ACCREDITED STATUS, OBTAINS THE APPROVAL OF THE DEPARTMENT AND OTHERWISE COMPLIES WITH THE PROVISIONS OF THIS SECTION AND REGULATIONS PROMULGATED HEREUNDER. ANY PROVIDER THAT LOSES ITS ACCREDITED STATUS SHALL PROMPTLY NOTIFY THE DEPARTMENT THEREOF.

3. NO LICENSEE PRACTICE SHALL, WITHIN THIS STATE, DISPLAY SIGNAGE, ADVERTISE OR HOLD ITSELF OUT AS A PROVIDER OF EMERGENCY MEDICAL CARE THROUGH THE USE OF THE TERM EMERGENCY, OR THROUGH ANY OTHER TERM OR SYMBOL THAT IMPLIES THAT IT IS A PROVIDER OF EMERGENCY MEDICAL CARE, REGARDLESS OF WHETHER IT IS AN URGENT CARE PROVIDER ACCREDITED UNDER THIS SECTION.

4. NOTHING IN THIS SECTION SHALL BE CONSTRUED TO PROHIBIT A HOSPITAL ESTABLISHED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER FROM PROVIDING URGENT CARE OR EMERGENCY MEDICAL CARE, OR FROM DISPLAYING SIGNAGE, ADVERTISING OR HOLDING ITSELF OUT AS A PROVIDER OF URGENT OR EMERGENCY CARE PURSUANT TO REGULATIONS PROMULGATED UNDER THAT ARTICLE.

5. THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, BY A MAJORITY VOTE OF ITS MEMBERS, SHALL ADOPT AND AMEND RULES AND REGULATIONS, SUBJECT TO THE APPROVAL OF THE COMMISSIONER, TO EFFECTUATE THE PURPOSES AND PROVISIONS OF THIS SECTION, INCLUDING, BUT NOT LIMITED TO DEFINING THE SCOPE OF SERVICES THAT MAY BE PROVIDED BY URGENT CARE PROVIDERS AND THE MINIMUM SERVICES THAT SHALL BE PROVIDED; REQUIRING URGENT CARE PROVIDERS TO DISCLOSE TO PATIENTS THE SCOPE OF SERVICES PROVIDED; AND ESTABLISHING STANDARDS FOR APPROPRIATE REFERRAL AND CONTINUITY OF CARE, STAFFING, EQUIPMENT, AND MAINTENANCE AND TRANSMISSION OF PATIENT RECORDS. SUCH REGULATIONS SHALL ALSO PROMOTE AND STRENGTHEN PRIMARY CARE THROUGH: (I) THE INTEGRATION OF SERVICES PROVIDED BY URGENT CARE PROVIDERS WITH THE SERVICES PROVIDED BY THE PATIENT'S OTHER HEALTH CARE PROVIDERS; AND (II) THE REFERRAL OF PATIENTS TO APPROPRIATE HEALTH CARE PROVIDERS, INCLUDING APPROPRIATE TRANSMISSION OF PATIENT HEALTH RECORDS.

S 3. Subdivision 4 of section 2951 of the public health law is REPEALED.

S 4. Section 2956 of the public health law is REPEALED.

S 5. Section 225 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MAY REVIEW THE TYPE OF PROCEDURES PERFORMED IN OUTPATIENT SETTINGS, INCLUDING PRACTICES REQUIRED TO REPORT ADVERSE EVENTS UNDER SECTION TWO HUNDRED THIRTY-D OF THIS ARTICLE AND HEALTH CARE FACILITIES LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER THAT PROVIDE AMBULATORY SURGERY SERVICES, FOR PURPOSES OF:

(A) IDENTIFYING THE TYPES OF PROCEDURES PERFORMED AND TYPES OF ANESTHESIA/SEDATION ADMINISTERED IN SUCH SETTINGS;

(B) CONSIDERING WHETHER IT IS APPROPRIATE FOR SUCH PROCEDURES OR ANESTHESIA/SEDATION TO BE PERFORMED IN SUCH SETTINGS;

(C) CONSIDERING WHETHER SETTINGS PERFORMING SUCH PROCEDURES OR ADMINISTERING SUCH ANESTHESIA/SEDATION ARE SUBJECT TO SUFFICIENT OVERSIGHT;

(D) CONSIDERING WHETHER SETTINGS PERFORMING SUCH PROCEDURES OR ADMINISTERING SUCH ANESTHESIA/SEDATION ARE SUBJECT TO AN EQUIVALENT LEVEL OF OVERSIGHT REGARDLESS OF SETTING; AND

(E) MAKING RECOMMENDATIONS TO THE DEPARTMENT REGARDING THE FOREGOING.

S 6. This act shall take effect immediately, provided, however, that subdivision 2 of section 230-e of the public health law, as added by section two of this act, shall take effect January 1, 2017; subdivision 3 of section 230-e of the public health law, as added by section two of this act, shall take effect January 1, 2016; and regulations shall be adopted or amended pursuant to subdivision 5 of section 230-e of the public health law, as added by section two of this act, on or before January 1, 2016, and shall not take effect until January 1, 2017.

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. Paragraph (g) of subdivision 2 of section 850 of the general business law, as amended by chapter 812 of the laws of 1980, is amended to read as follows:

(g) Hypodermic syringes, needles and other objects, used or designed for the purpose of parenterally injecting controlled substances into the human body; PROVIDED, HOWEVER, HYPODERMIC SYRINGES AND NEEDLES OBTAINED AND POSSESSED FROM THE STATE'S SYRINGE EXCHANGE AND PHARMACY AND MEDICAL PROVIDER-BASED EXPANDED SYRINGE ACCESS PROGRAMS SHALL NOT BE CONSIDERED DRUG-RELATED PARAPHERNALIA;

S 6. Paragraph (c) of subdivision 1 of section 3381 of the public health law, as amended by chapter 178 of the laws of 2010, is amended to read as follows:

(c) by a pharmacy licensed under article one hundred thirty-seven of the education law, health care facility licensed under article twenty-eight of this chapter or a health care practitioner who is otherwise authorized to prescribe the use of hypodermic needles or syringes within his or her scope of practice; provided, however, that such sale or furnishing: (i) shall only be to a person eighteen years of age or older; AND (ii) [shall be limited to a quantity of ten or less hypodermic needles or syringes; and (iii)] shall be in accordance with subdivision five of this section.

S 7. Paragraph (d) of subdivision 5 of section 3381 of the public health law, as amended by section 9-a of part B of chapter 58 of the laws of 2007, is amended to read as follows:

(d) In addition to the requirements of paragraph (c) of subdivision one of this section, a pharmacy licensed under article one hundred thirty-seven of the education law may sell or furnish hypodermic needles or syringes only if such pharmacy[: (i) does not advertise to the public the availability for retail sale or furnishing of hypodermic needles or syringes without a prescription; and (ii) at any location where hypodermic needles or syringes are kept for retail sale or furnishing,] stores such needles and syringes in a manner that makes them available only to authorized personnel and not openly available to customers.

S 8. This act shall take effect immediately.

PART J

Section 1. Subparagraph (v) of paragraph a of subdivision 1 of section 6908 of the education law is relettered subparagraph (vi) and a new subparagraph (v) is added to read as follows:

(V) TASKS PROVIDED BY AN ADVANCED HOME HEALTH AIDE IN ACCORDANCE WITH REGULATIONS DEVELOPED IN CONSULTATION WITH THE COMMISSIONER OF HEALTH WHICH, AT A MINIMUM, SHALL: (1) SPECIFY THE TYPES OF TASKS THAT MAY BE PERFORMED BY ADVANCED HOME HEALTH AIDES PURSUANT TO THIS SUBPARAGRAPH ("ADVANCED TASKS"), WHICH SHALL INCLUDE THE ADMINISTRATION OF MEDICATIONS WHICH ARE ROUTINE AND PREFILLED OR OTHERWISE PACKAGED IN A MANNER THAT PROMOTES RELATIVE EASE OF ADMINISTRATION; (2) PROVIDE THAT ADVANCED TASKS PERFORMED BY ADVANCED HOME HEALTH AIDES MAY BE PERFORMED ONLY

UNDER THE DIRECT SUPERVISION OF A REGISTERED PROFESSIONAL NURSE LICENSED IN NEW YORK STATE AND EMPLOYED BY A HOME CARE SERVICES AGENCY LICENSED OR CERTIFIED PURSUANT TO ARTICLE THIRTY-SIX OF THE PUBLIC HEALTH LAW OR HOSPICE PROGRAM CERTIFIED PURSUANT TO ARTICLE FORTY OF THE PUBLIC HEALTH LAW, WHERE SUCH NURSING SUPERVISION (A) INCLUDES TRAINING AND PERIODIC ASSESSMENT OF THE PERFORMANCE OF ADVANCED TASKS, (B) SHALL BE DETERMINED BY THE REGISTERED PROFESSIONAL NURSE RESPONSIBLE FOR SUPERVISING SUCH ADVANCED TASKS BASED UPON THE COMPLEXITY OF SUCH ADVANCED TASKS, THE SKILL AND EXPERIENCE OF THE ADVANCED HOME HEALTH AIDE, AND THE HEALTH STATUS OF THE INDIVIDUAL FOR WHOM SUCH ADVANCED TASKS ARE BEING PERFORMED, AND (C) INCLUDES A COMPREHENSIVE ASSESSMENT OF THE INDIVIDUAL'S NEEDS; (3) PROVIDE THAT ADVANCED TASKS MAY BE PERFORMED ONLY IN ACCORDANCE WITH AND PURSUANT TO AN AUTHORIZED PRACTITIONER'S ORDERED CARE; (4) PROVIDE THAT ONLY A HOME HEALTH AIDE WHO HAS AT LEAST ONE YEAR OF EXPERIENCE AS A CERTIFIED HOME HEALTH AIDE, HAS COMPLETED THE REQUISITE TRAINING AND DEMONSTRATED COMPETENCIES OF AN ADVANCED HOME HEALTH AIDE, HAS SUCCESSFULLY COMPLETED COMPETENCY EXAMINATIONS SATISFACTORY TO THE COMMISSIONER AND MEETS OTHER APPROPRIATE QUALIFICATIONS MAY PERFORM ADVANCED TASKS AS AN ADVANCED HOME HEALTH AIDE; (5) PROVIDE THAT ONLY AN INDIVIDUAL WHO IS LISTED IN THE HOME CARE SERVICES REGISTRY MAINTAINED BY THE DEPARTMENT OF HEALTH PURSUANT TO SUBDIVISION NINE OF SECTION THIRTY-SIX HUNDRED THIRTEEN OF THE PUBLIC HEALTH LAW AS HAVING SATISFIED ALL APPLICABLE TRAINING REQUIREMENTS AND HAVING PASSED THE APPLICABLE COMPETENCY EXAMINATIONS AND WHO MEETS OTHER REQUIREMENTS AS SET FORTH IN REGULATIONS ISSUED BY THE COMMISSIONER OF HEALTH PURSUANT TO SUBDIVISION SEVENTEEN OF SECTION THIRTY-SIX HUNDRED TWO OF THE PUBLIC HEALTH LAW MAY PERFORM ADVANCED TASKS PURSUANT TO THIS SUBPARAGRAPH AND MAY HOLD HIMSELF OR HERSELF OUT AS AN ADVANCED HOME HEALTH AIDE; (6) ESTABLISH MINIMUM STANDARDS OF TRAINING FOR THE PERFORMANCE OF ADVANCED TASKS BY ADVANCED HOME HEALTH AIDES, INCLUDING (A) DIDACTIC TRAINING, (B) CLINICAL TRAINING, AND (C) A SUPERVISED CLINICAL PRACTICUM WITH STANDARDS SET FORTH BY THE COMMISSIONER; (7) PROVIDE THAT ADVANCED HOME HEALTH AIDES SHALL RECEIVE CASE-SPECIFIC TRAINING ON THE ADVANCED TASKS TO BE ASSIGNED BY THE SUPERVISING NURSE, PROVIDED THAT ADDITIONAL TRAINING SHALL TAKE PLACE WHENEVER ADDITIONAL ADVANCED TASKS ARE ASSIGNED; (8) PROHIBIT AN ADVANCED HOME HEALTH AIDE FROM HOLDING HIMSELF OR HERSELF OUT, OR ACCEPTING EMPLOYMENT AS, A PERSON LICENSED TO PRACTICE NURSING UNDER THE PROVISIONS OF THIS ARTICLE; (9) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE IS NOT REQUIRED NOR PERMITTED TO ASSESS THE MEDICATION NEEDS OF AN INDIVIDUAL; (10) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE SHALL NOT BE AUTHORIZED TO PERFORM ANY TASKS OR ACTIVITIES PURSUANT TO THIS SUBPARAGRAPH THAT ARE OUTSIDE THE SCOPE OF PRACTICE OF A LICENSED PRACTICAL NURSE; (11) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE SHALL DOCUMENT MEDICATION ADMINISTRATION TO EACH INDIVIDUAL THROUGH THE USE OF A MEDICATION ADMINISTRATION RECORD; AND (12) PROVIDE THAT THE SUPERVISING REGISTERED PROFESSIONAL NURSE SHALL RETAIN THE DISCRETION TO DECIDE WHETHER TO ASSIGN ADVANCED TASKS TO HOME HEALTH AIDES UNDER THIS PROGRAM AND SHALL NOT BE SUBJECT TO COERCION OR THE THREAT OF RETALIATION; IN DEVELOPING SUCH REGULATIONS, THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE RECOMMENDATIONS OF THE WORKGROUP OF STAKEHOLDERS CONVENED BY THE COMMISSIONER OF HEALTH FOR THE PURPOSE OF PROVIDING GUIDANCE ON THE FOREGOING; OR

S 2. Section 3602 of the public health law is amended by adding a new subdivision 17 to read as follows:

17. "ADVANCED HOME HEALTH AIDES" MEANS HOME HEALTH AIDES WHO ARE AUTHORIZED TO PERFORM ADVANCED TASKS AS DELINEATED IN SUBPARAGRAPH (V)

OF PARAGRAPH A OF SUBDIVISION ONE OF SECTION SIX THOUSAND NINE HUNDRED EIGHT OF THE EDUCATION LAW AND REGULATIONS ISSUED BY THE COMMISSIONER OF EDUCATION, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH, RELATING THERETO. THE COMMISSIONER SHALL PROMULGATE REGULATIONS REGARDING SUCH AIDES, WHICH SHALL INCLUDE A PROCESS FOR THE LIMITATION OR REVOCATION OF THE ADVANCED HOME HEALTH AIDE'S AUTHORIZATION TO PERFORM ADVANCED TASKS IN APPROPRIATE CASES.

S 3. Subdivision 9 of section 3613 of the public health law is renumbered subdivision 10 and a new subdivision 9 is added to read as follows:

9. THE DEPARTMENT SHALL INDICATE WITHIN THE HOME CARE SERVICES WORKER REGISTRY WHEN A HOME HEALTH AIDE HAS SATISFIED ALL APPLICABLE TRAINING AND RECERTIFICATION REQUIREMENTS AND HAS PASSED THE APPLICABLE COMPETENCY EXAMINATIONS NECESSARY TO PERFORM ADVANCED TASKS PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH A OF SUBDIVISION ONE OF SECTION SIX THOUSAND NINE HUNDRED EIGHT OF THE EDUCATION LAW AND REGULATIONS ISSUED THERETO. ANY LIMITATION OR REVOCATION OF THE ADVANCED HOME HEALTH AIDE'S AUTHORIZATION ALSO SHALL BE INDICATED ON THE REGISTRY.

S 4. In developing regulations required under subparagraph (v) of paragraph a of subdivision 1 of section 6908 of the education law, as added by section one of this act, the commissioner of education shall consider the recommendations of the workgroup of stakeholders convened by the commissioner of health, to provide guidance on the tasks which may be performed by advanced home health aides pursuant to such section including but not limited to recommendations encompassing the following matters:

(a) the tasks that appropriately could be performed by advanced home health aides with appropriate training and supervision ("advanced tasks");

(b) the types of medications that advanced home health aides should be authorized to administer, including whether subcutaneous injectables and controlled substances should be authorized;

(c) qualifications that must be satisfied by advanced home health aides to perform advanced tasks, including those related to experience, training, moral character, and examination requirements;

(d) minimum training and education standards; and

(e) adequate levels of supervision to be provided by nurses, including adherence to existing requirements for comprehensive assessment and any additional assessment that should be required, including when the individual receiving advanced tasks performed by an advanced home health aide experiences a significant change in condition.

S 5. This act shall take effect October 1, 2015; provided, however, that the commissioner of education shall adopt or amend regulations necessary to implement the provisions of subparagraph (v) of paragraph a of subdivision 1 of section 6908 of the education law, as added by section one of this act, by such effective date; provided, further, that no advanced tasks may be performed pursuant to such provision until such regulations are adopted and except in conformance with such regulations.

PART K

Section 1. Subdivisions 1, 2 and 3 of section 2802 of the public health law, subdivisions 1 and 2 as amended by section 58 of part A of chapter 58 of the laws of 2010, subdivision 3 as amended by chapter 609 of the laws of 1982 and paragraph (e) of subdivision 3 as amended by chapter 731 of the laws of 1993, are amended to read as follows:

1. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents to the public health and health planning council, and the health systems agency, if any, having geographical jurisdiction of the area where the hospital is located.

2. The commissioner shall not act upon an application for construction of a hospital until the public health and health planning council and the health systems agency have had a reasonable time to submit their recommendations, and unless (a) the applicant has obtained all approvals and consents required by law for its incorporation or establishment (including the approval of the public health and health planning council pursuant to the provisions of this article) provided, however, that the commissioner may act upon an application for construction by an applicant possessing a valid operating certificate when the application qualifies for review without the recommendation of the council pursuant to regulations adopted by the council and approved by the commissioner; and (b) the commissioner is satisfied as to the public need for the construction, at the time and place and under the circumstances proposed, provided however that[,] in the case of an application by a hospital established or operated by an organization defined in subdivision one of section four hundred eighty-two-b of the social services law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need[.]; AND FURTHER PROVIDED THAT: (I) AN APPLICATION BY A GENERAL HOSPITAL OR DIAGNOSTIC AND TREATMENT CENTER, ESTABLISHED UNDER THIS ARTICLE, TO CONSTRUCT A FACILITY TO PROVIDE PRIMARY CARE SERVICES, AS DEFINED IN REGULATION, MAY BE APPROVED WITHOUT REGARD FOR PUBLIC NEED; OR (II) AN APPLICATION BY A GENERAL HOSPITAL OR A DIAGNOSTIC AND TREATMENT CENTER, ESTABLISHED UNDER THIS ARTICLE, TO UNDERTAKE CONSTRUCTION THAT DOES NOT INVOLVE A CHANGE IN CAPACITY, THE TYPES OF SERVICES PROVIDED, MAJOR MEDICAL EQUIPMENT, FACILITY REPLACEMENT, OR THE GEOGRAPHIC LOCATION OF SERVICES, MAY BE APPROVED WITHOUT REGARD FOR PUBLIC NEED.

3. Subject to the provisions of paragraph (b) of subdivision two OF THIS SECTION, the commissioner in approving the construction of a hospital shall take into consideration and be empowered to request information and advice as to (a) the availability of facilities or services such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for the whole or any part of the proposed hospital construction;

(b) the need for special equipment in view of existing utilization of comparable equipment at the time and place and under the circumstances proposed;

(c) the possible economies and improvements in service to be anticipated from the operation of joint central services including, but not limited to laboratory, research, radiology, pharmacy, laundry and purchasing;

(d) the adequacy of financial resources and sources of future revenue, PROVIDED THAT THE COMMISSIONER MAY, BUT IS NOT REQUIRED TO, CONSIDER THE ADEQUACY OF FINANCIAL RESOURCES AND SOURCES OF FUTURE REVENUE IN RELATION TO APPLICATIONS UNDER SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (B) OF SUBDIVISION TWO OF THIS SECTION; and

(e) whether the facility is currently in substantial compliance with all applicable codes, rules and regulations, provided, however, that the

commissioner shall not disapprove an application solely on the basis that the facility is not currently in substantial compliance, if the application is specifically:

(i) to correct life safety code or patient care deficiencies;

(ii) to correct deficiencies which are necessary to protect the life, health, safety and welfare of facility patients, residents or staff;

(iii) for replacement of equipment that no longer meets the generally accepted operational standards existing for such equipment at the time it was acquired; and

(iv) for decertification of beds and services.

S 2. Subdivisions 1, 2 and 3 of section 2807-z of the public health law, as amended by chapter 400 of the laws of 2012, are amended to read as follows:

1. Notwithstanding any provision of this chapter or regulations or any other state law or regulation, for any eligible capital project as defined in subdivision six of this section, the department shall have thirty days [of] AFTER receipt of the certificate of need OR CONSTRUCTION application, PURSUANT TO SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, for a limited or administrative review to deem such application complete. If the department determines the application is incomplete or that more information is required, the department shall notify the applicant in writing within thirty days of the date of the application's submission, and the applicant shall have twenty business days to provide additional information or otherwise correct the deficiency in the application.

2. For an eligible capital project requiring a limited or administrative review, within ninety days of the department deeming the application complete, the department shall make a decision to approve or disapprove the certificate of need OR CONSTRUCTION application for such project. If the department determines to disapprove the project, the basis for such disapproval shall be provided in writing; however, disapproval shall not be based on the incompleteness of the application. If the department fails to take action to approve or disapprove the application within ninety days of the certificate of need application being deemed complete, the application will be deemed approved.

3. For an eligible capital project requiring full review by the council, the certificate of need OR CONSTRUCTION application shall be placed on the next council agenda following the department deeming the application complete.

S 3. Section 2801-a of the public health law is amended by adding a new subdivision 3-b to read as follows:

3-B. NOTWITHSTANDING ANY OTHER PROVISIONS OF THIS CHAPTER TO THE CONTRARY, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MAY APPROVE THE ESTABLISHMENT OF DIAGNOSTIC OR TREATMENT CENTERS TO BE ISSUED OPERATING CERTIFICATES FOR THE PURPOSE OF PROVIDING PRIMARY CARE, AS DEFINED BY THE COMMISSIONER IN REGULATIONS, WITHOUT REGARD TO THE REQUIREMENTS OF PUBLIC NEED AND FINANCIAL RESOURCES AS SET FORTH IN SUBDIVISION THREE OF THIS SECTION.

S 4. Subdivision 3 of section 2801-a of the public health law, as amended by section 57 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

3. The public health and health planning council shall not approve a certificate of incorporation, articles of organization or application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the institution at the time and place and under the circumstances proposed, provided, however, that in

the case of an institution proposed to be established or operated by an organization defined in subdivision one of section one hundred seventy-two-a of the executive law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their religious or ethical convictions, shall be deemed to be public need; (b) the character, competence, and standing in the community, of the proposed incorporators, directors, sponsors, MEMBERS, PRINCIPAL MEMBERS, stockholders, [members] PRINCIPAL STOCKHOLDERS or operators; with respect to any proposed incorporator, director, sponsor, MEMBER, PRINCIPAL MEMBER, stockholder, [member] PRINCIPAL STOCKHOLDER or operator who is already or within the past [ten] SEVEN years has been an incorporator, director, sponsor, member, principal stockholder, principal member, or operator of any hospital, private proprietary home for adults, residence for adults, or non-profit home for the aged or blind which has been issued an operating certificate by the state department of social services, or a halfway house, hostel or other residential facility or institution for the care, custody or treatment of the mentally disabled which is subject to approval by the department of mental hygiene, no approval shall be granted unless the public health and health planning council, having afforded an adequate opportunity to members of health systems agencies, if any, having geographical jurisdiction of the area where the institution is to be located to be heard, shall affirmatively find by substantial evidence as to each such incorporator, director, sponsor, MEMBER, PRINCIPAL MEMBER, principal stockholder or operator that a substantially consistent high level of care is being or was being rendered in each such hospital, home, residence, halfway house, hostel, or other residential facility or institution with which such person is or was affiliated; for the purposes of this paragraph, the public health and health planning council shall adopt rules and regulations, subject to the approval of the commissioner, to establish the criteria to be used to determine whether a substantially consistent high level of care has been rendered, provided, however, that there shall not be a finding that a substantially consistent high level of care has been rendered where there have been violations of the state hospital code, or other applicable rules and regulations, that (i) threatened to directly affect the health, safety or welfare of any patient or resident, and (ii) were recurrent or were not promptly corrected, UNLESS THE PROPOSED INCORPORATOR, DIRECTOR, SPONSOR, MEMBER, PRINCIPAL MEMBER, STOCKHOLDER, PRINCIPAL STOCKHOLDER, OR OPERATOR DEMONSTRATES, AND THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL FINDS, THAT THE VIOLATIONS CANNOT BE ATTRIBUTED TO THE ACTION OR INACTION OF SUCH PROPOSED INCORPORATOR, DIRECTOR, SPONSOR, MEMBER, PRINCIPAL MEMBER, STOCKHOLDER, PRINCIPAL STOCKHOLDER, OR OPERATOR DUE TO THE TIMING, EXTENT OR MANNER OF THE AFFILIATION; (c) the financial resources of the proposed institution and its sources of future revenues; and (d) such other matters as it shall deem pertinent.

S 5. Paragraphs (b) and (c) of subdivision 4 of section 2801-a of the public health law, as amended by section 57 of part A of chapter 58 of the laws of 2010, are amended to read as follows:

(b) [(i)] Any transfer, assignment or other disposition of ten percent or more of [an] DIRECT OR INDIRECT interest or voting rights in [a partnership or limited liability company, which is the] AN operator of a hospital to a new STOCKHOLDER, partner or member, OR ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF A DIRECT OR INDIRECT INTEREST OR VOTING RIGHTS OF SUCH AN OPERATOR WHICH RESULTS IN THE OWNERSHIP OR CONTROL OF MORE THAN TEN PERCENT OF THE INTEREST OR VOTING RIGHTS OF SUCH OPERATOR BY ANY PERSON NOT PREVIOUSLY APPROVED BY THE PUBLIC HEALTH

AND HEALTH PLANNING COUNCIL, OR ITS PREDECESSOR, FOR THAT OPERATOR shall be approved by the public health and health planning council, in accordance with the provisions of subdivisions two and three of this section, except that: (A) any such change shall be subject to the approval by the public health and health planning council in accordance with paragraph (b) of subdivision three of this section only with respect to the new STOCKHOLDER, partner or member, and any remaining STOCKHOLDERS, partners or members who have not been previously approved for that facility in accordance with such paragraph, and (B) such change shall not be subject to paragraph (a) of subdivision three of this section. IN THE ABSENCE OF SUCH APPROVAL, THE OPERATING CERTIFICATE OF SUCH HOSPITAL SHALL BE SUBJECT TO REVOCATION OR SUSPENSION.

[(ii)] (C) (I) With respect to a transfer, assignment or disposition involving less than ten percent of [an] A DIRECT OR INDIRECT interest or voting rights in [such partnership or limited liability company] AN OPERATOR OF A HOSPITAL to a new STOCKHOLDER, partner or member, no prior approval of the public health and health planning council shall be required EXCEPT WHERE REQUIRED BY PARAGRAPH (B) OF THIS SUBDIVISION. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the [partnership or limited liability company] OPERATOR fully completes and files with the public health and health planning council notice on a form, to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction for any of the reasons set forth in item (A), (B), (C) or (D) below. Within ninety days from the date of receipt of such notice, the public health and health planning council may bar any transaction under this subparagraph: (A) if the equity position of the [partnership or limited liability company,] OPERATOR, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition; (B) if the transaction would result in the ownership of a [partnership or membership] DIRECT OR INDIRECT interest OR VOTING RIGHTS by any persons who have been convicted of a felony described in subdivision five of section twenty-eight hundred six of this article; (C) if there are reasonable grounds to believe that the proposed transaction does not satisfy the character and competence criteria set forth in subdivision three of this section; or (D) UPON THE RECOMMENDATION OF THE DEPARTMENT, if the transaction, together with all transactions under this subparagraph for the [partnership] OPERATOR, or successor, during any five year period would, in the aggregate, involve twenty-five percent or more of the interest in the [partnership] OPERATOR. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

[(iii) With respect to a transfer, assignment or disposition of an interest or voting rights in such partnership or limited liability company to any remaining partner or member, which transaction involves the withdrawal of the transferor from the partnership or limited liability company, no prior approval of the public health and health planning council shall be required. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the partnership or limited liability company fully completes and files with the public health and health planning council notice on a form, to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for

the public health and health planning council to determine whether it should bar the transaction for the reason set forth below. Within ninety days from the date of receipt of such notice, the public health and health planning council may bar any transaction under this subparagraph if the equity position of the partnership or limited liability company, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

(c) Any transfer, assignment or other disposition of ten percent or more of the stock or voting rights thereunder of a corporation which is the operator of a hospital or which is a member of a limited liability company which is the operator of a hospital to a new stockholder, or any transfer, assignment or other disposition of the stock or voting rights thereunder of such a corporation which results in the ownership or control of more than ten percent of the stock or voting rights thereunder of such corporation by any person not previously approved by the public health and health planning council, or its predecessor, for that corporation shall be subject to approval by the public health and health planning council, in accordance with the provisions of subdivisions two and three of this section and rules and regulations pursuant thereto; except that: any such transaction shall be subject to the approval by the public health and health planning council in accordance with paragraph (b) of subdivision three of this section only with respect to a new stockholder or a new principal stockholder; and shall not be subject to paragraph (a) of subdivision three of this section. In the absence of such approval, the operating certificate of such hospital shall be subject to revocation or suspension.]

(II) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition of ten percent or more of [the stock] A DIRECT OR INDIRECT INTEREST or voting rights [thereunder of a corporation which is the] IN AN operator of a hospital [or which is a member of a limited liability company which is the owner of a hospital] to any person previously approved by the public health and health planning council, or its predecessor, for that [corporation] OPERATOR. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the [stockholder] OPERATOR FULLY completes and files with the public health and health planning council notice on forms to be developed by the public health and health planning council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction. Nothing in this paragraph shall be construed as permitting a person not previously approved by the public health and health planning council for that [corporation] OPERATOR to become the owner of ten percent or more of the [stock of a corporation which is] INTEREST OR VOTING RIGHTS, DIRECTLY OR INDIRECTLY, IN the operator of a hospital [or which is a member of a limited liability company which is the owner of a hospital] without first obtaining the approval of the public health and health planning council.

S 6. Subdivision 1 of section 3611-a of the public health law, as amended by section 67 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

1. Any change in the person who, or any transfer, assignment, or other disposition of an interest or voting rights of ten percent or more, or any transfer, assignment or other disposition which results in the ownership or control of an interest or voting rights of ten percent or more, in a limited liability company or a partnership which is the operator of a licensed home care services agency or a certified home health agency shall be approved by the public health and health planning council, in accordance with the provisions of subdivision four of section thirty-six hundred five of this article relative to licensure or subdivision two of section thirty-six hundred six of this article relative to certificate of approval, except that:

(a) Public health and health planning council approval shall be required only with respect to the person, or the member or partner that is acquiring the interest or voting rights; and

(b) With respect to certified home health agencies, such change shall not be subject to the public need assessment described in paragraph (a) of subdivision two of section thirty-six hundred six of this article.

(c) IN THE ABSENCE OF SUCH APPROVAL, THE LICENSE OR CERTIFICATE OF APPROVAL SHALL BE SUBJECT TO REVOCATION OR SUSPENSION.

(D) (I) No prior approval of the public health and health planning council shall be required with respect to a transfer, assignment or disposition of:

[(i)] (A) an interest or voting rights to any person previously approved by the public health and health planning council, or its predecessor, for that operator; or

[(ii)] (B) an interest or voting rights of less than ten percent in the operator. [However, no]

(II) NO such transaction UNDER SUBPARAGRAPH (I) OF THIS PARAGRAPH shall be effective unless at least ninety days prior to the intended effective date thereof, the [partner or member] OPERATOR completes and files with the public health and health planning council notice on forms to be developed by the public health council, which shall disclose such information as may reasonably be necessary for the public health and health planning council to determine whether it should bar the transaction. Such transaction will be final as of the intended effective date unless, prior thereto, the public health and health planning council shall state specific reasons for barring such transactions under this paragraph and shall notify each party to the proposed transaction.

S 7. This act shall take effect immediately.

PART L

Section 1. Section 230-d of the public health law, as added by chapter 365 of the laws of 2007, paragraph (i) of subdivision 1 as amended by chapter 438 of the laws of 2012, and subdivision 4 as amended by chapter 477 of the laws of 2008, is amended to read as follows:

S 230-d. Office-based surgery AND OFFICE-BASED ANESTHESIA. 1. The following words or phrases, as used in this section shall have the following meanings:

(a) "Accredited status" means the full accreditation by nationally-recognized accrediting agency(ies) determined by the commissioner.

(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; (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.

(c) "Deep sedation" means a drug-induced depression of consciousness during which (i) the patient cannot be easily aroused but responds purposefully following repeated painful stimulation; (ii) the patient's ability to maintain independent ventilatory function may be impaired; (iii) the patient may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

(d) "General anesthesia" means a drug-induced depression of consciousness during which (i) the patient is not arousable, even by painful stimulation; (ii) the patient's ability to maintain independent ventilatory function is often impaired; (iii) the patient, in many cases, often requires assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function; and (iv) the patient's cardiovascular function may be impaired.

(e) "Moderate sedation" means a drug-induced depression of consciousness during which (i) the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation; (ii) no interventions are required to maintain a patent airway; (iii) spontaneous ventilation is adequate; and (iv) the patient's cardiovascular function is usually maintained without assistance.

(f) "Minimal sedation" means a drug-induced state during which (i) patients respond normally to verbal commands; (ii) cognitive function and coordination may be impaired; and (iii) ventilatory and cardiovascular functions are unaffected.

(g) "Minor procedures" means (i) procedures that can be performed safely with a minimum of discomfort where the likelihood of complications requiring hospitalization is minimal; (ii) procedures performed with local or topical anesthesia; or (iii) liposuction with removal of less than 500 cc of fat under unsupplemented local anesthesia.

(h) "Office-based surgery" means any surgical or other invasive procedure, requiring general anesthesia, NEURAXIAL ANESTHESIA, MAJOR UPPER OR LOWER EXTREMITY REGIONAL NERVE BLOCKS, moderate sedation, or deep sedation, and any liposuction procedure, where such surgical or other invasive procedure or liposuction is performed by a licensee in a location other than a hospital, as such term is defined in article twenty-eight of this chapter, excluding minor procedures and procedures requiring minimal sedation.

(i) "Licensee" shall mean an individual licensed or otherwise authorized under article one hundred thirty-one, one hundred thirty-one-B, [individuals who have obtained an issuance of a privilege to perform podiatric standard or advanced ankle surgery pursuant to subdivisions one and two of section seven thousand nine] ONE HUNDRED THIRTY-TWO, OR ONE HUNDRED FORTY-ONE of the education law.

(J) "MAJOR UPPER OR LOWER EXTREMITY REGIONAL NERVE BLOCKS" MEANS TYPES OF REGIONAL ANESTHESIA IN WHICH PAIN SENSATION IS MODIFIED OR BLOCKED TO A LARGE AREA OF THE EXTREMITY BY ADMINISTRATION OF MEDICATION AROUND THE NERVES SUPPLYING THAT REGION OF THE EXTREMITY.

(K) "NEURAXIAL ANESTHESIA" MEANS A FORM OF REGIONAL ANESTHESIA IN WHICH PAIN SENSATION IS MODIFIED OR BLOCKED BY ADMINISTRATION OF MEDICATION INTO THE EPIDURAL SPACE OR SPINAL CANAL.

(L) "OFFICE-BASED ANESTHESIA" MEANS GENERAL ANESTHESIA, NEURAXIAL ANESTHESIA, MAJOR UPPER OR LOWER EXTREMITY REGIONAL NERVE BLOCKS, MODERATE SEDATION OR DEEP SEDATION WHERE SUCH ANESTHESIA IS ADMINISTERED BY A LICENSEE IN A LOCATION OTHER THAN A HOSPITAL, AS SUCH TERM IS DEFINED IN ARTICLE TWENTY-EIGHT OF THIS CHAPTER.

2. Licensee practices in which office-based surgery OR OFFICE-BASED ANESTHESIA is performed shall obtain and maintain full accredited status AND REGISTER WITH THE DEPARTMENT.

3. A licensee may only perform office-based surgery OR OFFICE-BASED ANESTHESIA in a setting that has obtained and maintains full accredited status AND IS REGISTERED WITH THE DEPARTMENT.

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 AND EVALUATION OF PATIENT CARE AND QUALITY IMPROVEMENT AND ASSURANCE ACTIVITIES.

(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.

4-A. OFFICE-BASED SURGERY OR OFFICE-BASED ANESTHESIA SHALL BE LIMITED TO OPERATIONS AND PROCEDURES WITH AN EXPECTED DURATION OF NO MORE THAN SIX HOURS AND EXPECTED APPROPRIATE AND SAFE DISCHARGE WITHIN SIX HOURS.

5. The commissioner shall make, adopt, promulgate and enforce such rules and regulations, as he or she may deem appropriate, to effectuate the purposes of this section. Where any rule or regulation under this section would affect the scope of practice of a health care practitioner licensed, registered or certified under title eight of the education law other than those licensed under articles one hundred thirty-one or one hundred thirty-one-B of the education law, the rule or regulation shall be made with the concurrence of the commissioner of education.

S 2. 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 AND ANESTHESIA.

1. The commissioner shall enter into agreements with accrediting agencies pursuant to which the accrediting agencies shall REQUIRE ALL OFFICE-BASED SURGICAL AND OFFICE-BASED ANESTHESIA PRACTICES TO CONDUCT QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES AND UTILIZE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) OR EQUIVALENT CERTIFICATION, HOSPITAL PRIVILEGING OR OTHER EQUIVALENT METHODS TO DETERMINE COMPETENCY OF PRACTITIONERS TO PERFORM OFFICE-BASED SURGERY AND OFFICE-BASED ANESTHESIA, CARRY OUT SURVEYS OR COMPLAINT/INCIDENT INVESTIGATIONS UPON DEPARTMENT REQUEST 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 AND OFFICE-BASED ANESTHESIA practices accredited by the accrediting agencies to the depart-

ment. 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 MAINTAINED BY OFFICE-BASED SURGERY AND OFFICE-BASED ANESTHESIA PRACTICES UNDER 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 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 3. 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 DETER-

MINATION 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. 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.

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 discussion regarding the potential impact and the feasibility of the expansion of the agency's community living integration services beginning April 1, 2016.

S 4. This act shall take effect immediately.

PART O

Section 1. Section 1 of part D of chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs as amended by section 1 of part C of chapter 58 of the laws of 2014, is amended to read as follows:

Section 1. The office of mental health is authorized to recover funding from community residences and family-based treatment providers licensed by the office of mental health, consistent with contractual obligations of such providers, and notwithstanding any other inconsistent provision of law to the contrary, in an amount equal to 50 percent of the income received by such providers which exceeds the fixed amount of annual Medicaid revenue limitations, as established by the commissioner of mental health. Recovery of such excess income shall be for the following fiscal periods: for programs in counties located outside of the city of New York, the applicable fiscal periods shall be January 1, 2003 through December 31, 2009 and January 1, 2011 through December 31, [2015] 2016; and for programs located within the city of New York, the applicable fiscal periods shall be July 1, 2003 through June 30, 2010 and July 1, 2011 through June 30, [2015] 2016.

S 2. This act shall take effect immediately.

PART P

Section 1. Subparagraph 9 of paragraph h of subdivision 4 of section 1950 of the education law, as added by section 1 of part M of chapter 56 of the laws of 2012, is amended to read as follows:

(9) To enter into contracts with the commissioner of the office of mental health, to provide special education [and], related services AND ANY ALTERNATIVE EDUCATION PROGRAMS PROVIDED BY THE BOARD OF COOPERATIVE EDUCATIONAL SERVICES TO COMPONENT SCHOOL DISTRICTS, in accordance with subdivision six-b of section thirty-two hundred two of this chapter to patients hospitalized in hospitals operated by the office of mental health who are between the ages of five and twenty-one who have not received a high school diploma. Any such proposed contract shall be subject to the review by the commissioner and his [and] OR her determination that it is an approved cooperative educational service. Services provided pursuant to such contracts shall be provided at cost and approved by the commissioner of the office of mental health and the director of the division of the budget, and the board of cooperative educational services shall not be authorized to charge any costs incurred in providing such services to its component school districts.

S 2. The opening paragraph of subdivision 6-b of section 3202 of the education law, as added by section 2 of part M of chapter 56 of the laws of 2012, is amended to read as follows:

The commissioner of mental health may meet his or her obligations under section 33.11 of the mental hygiene law by contracting pursuant to this subdivision for educational services for children between the ages of five and twenty-one who do not hold a high school diploma and who are hospitalized in hospitals operated by the office of mental health with the trustees or board of education of any school district for educational services or with a board of cooperative educational services for the provision of special education [and], related services AND ANY ALTERNATIVE EDUCATION PROGRAMS PROVIDED BY THE BOARD OF COOPERATIVE EDUCATIONAL SERVICES TO COMPONENT SCHOOL DISTRICTS to such children in

accordance with their individualized education programs. The costs of such education shall not be a charge upon a school district pursuant to section 33.11 of the mental hygiene law.

S 3. Section 4 of part M of chapter 56 of the laws of 2012 amending the education law, relating to authorizing contracts for the provision of special education and related services for certain patients hospitalized in hospitals operated by the office of mental health, is amended to read as follows:

S 4. This act shall take effect July 1, 2012 and shall expire June 30, [2015] 2018, when upon such date the provisions of this act shall be deemed repealed.

S 4. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015, provided, however, that:

a. The amendments to subparagraph 9 of paragraph h of subdivision 4 of section 1950 of the education law made by section one of this act shall not affect the repeal of such subparagraph and shall be deemed repealed therewith; and

b. The amendments to the opening paragraph of subdivision 6-b of section 3202 of the education law made by section two of this act shall not affect the repeal of such subdivision and shall be deemed repealed therewith.

PART Q

Section 1. Section 2801-a of the public health law is amended by adding a new subdivision 17 to read as follows:

17. (A) THE COMMISSIONER IS AUTHORIZED TO ESTABLISH A PILOT PROGRAM TO ASSIST IN RESTRUCTURING HEALTH CARE DELIVERY SYSTEMS BY ALLOWING FOR INCREASED CAPITAL INVESTMENT. PURSUANT TO THE PILOT PROGRAM, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL SHALL APPROVE THE ESTABLISHMENT, IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPHS (F), (G) AND (H) OF THIS SUBDIVISION AND SUBDIVISION THREE OF THIS SECTION, OF NO MORE THAN FIVE BUSINESS CORPORATIONS FORMED UNDER THE BUSINESS CORPORATION LAW. SUCH BUSINESS CORPORATIONS SHALL AFFILIATE, THE EXTENT OF THE AFFILIATION TO BE DETERMINED BY THE COMMISSIONER, WITH AT LEAST ONE ACADEMIC MEDICAL INSTITUTION OR TEACHING HOSPITAL APPROVED BY THE COMMISSIONER. A BUSINESS CORPORATION SHALL NOT BE ELIGIBLE TO PARTICIPATE IN THIS PROGRAM IF ANY OF ITS STOCK, OR THAT OF ANY OF ITS DIRECT OR INDIRECT OWNERS, IS OR WILL BE TRADED ON A PUBLIC STOCK EXCHANGE OR ON AN OVER-THE-COUNTER MARKET.

(B) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, BUSINESS CORPORATIONS ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE DEEMED ELIGIBLE TO PARTICIPATE IN DEBT FINANCING PROVIDED BY THE DORMITORY AUTHORITY OF THE STATE OF NEW YORK, LOCAL DEVELOPMENT CORPORATIONS AND ECONOMIC DEVELOPMENT CORPORATIONS.

(C) THE FOLLOWING PROVISIONS OF THIS CHAPTER SHALL NOT APPLY TO BUSINESS CORPORATIONS ESTABLISHED PURSUANT TO THIS SUBDIVISION: (I) PARAGRAPH (B) OF SUBDIVISION THREE OF THIS SECTION, RELATING TO STOCKHOLDERS, OTHER THAN PRINCIPAL STOCKHOLDERS; (II) PARAGRAPH (C) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE DISPOSITION OF STOCK OR VOTING RIGHTS; (III) PARAGRAPHS (D) AND (E) OF SUBDIVISION FOUR OF THIS SECTION, RELATING TO THE OWNERSHIP OF STOCK; AND (IV) PARAGRAPH (A) OF SUBDIVISION THREE OF SECTION FOUR THOUSAND FOUR OF THIS CHAPTER, RELATING TO THE OWNERSHIP OF STOCK. NOTWITHSTANDING THE FOREGOING, THE

PUBLIC HEALTH AND HEALTH PLANNING COUNCIL MAY REQUIRE THE DISCLOSURE OF THE IDENTITY OF STOCKHOLDERS.

(D) THE CORPORATE POWERS AND PURPOSES OF A BUSINESS CORPORATION ESTABLISHED AS AN OPERATOR PURSUANT TO THIS SUBDIVISION SHALL BE LIMITED TO THE OWNERSHIP AND OPERATION, OR OPERATION, OF A HOSPITAL OR HOSPITALS SPECIFICALLY NAMED AND THE LOCATION OR LOCATIONS OF WHICH ARE SPECIFICALLY DESIGNATED BY STREET ADDRESS, CITY, TOWN, VILLAGE OR LOCALITY AND COUNTY; PROVIDED, HOWEVER, THAT THE CORPORATE POWERS AND PURPOSES MAY ALSO INCLUDE THE OWNERSHIP AND OPERATION, OR OPERATION, OF A CERTIFIED HOME HEALTH AGENCY OR LICENSED HOME CARE SERVICES AGENCY OR AGENCIES AS DEFINED IN ARTICLE THIRTY-SIX OF THIS CHAPTER OR A HOSPICE OR HOSPICES AS DEFINED IN ARTICLE FORTY OF THIS CHAPTER, IF THE CORPORATION HAS RECEIVED ALL APPROVALS REQUIRED UNDER SUCH LAW TO OWN AND OPERATE, OR OPERATE, SUCH HOME CARE SERVICES AGENCY OR AGENCIES OR HOSPICE OR HOSPICES. SUCH CORPORATE POWERS AND PURPOSES SHALL NOT BE MODIFIED, AMENDED OR DELETED WITHOUT THE PRIOR APPROVAL OF THE COMMISSIONER.

(E)(1) IN DISCHARGING THE DUTIES OF THEIR RESPECTIVE POSITIONS, THE BOARD OF DIRECTORS, COMMITTEES OF THE BOARD AND INDIVIDUAL DIRECTORS AND OFFICERS OF A BUSINESS CORPORATION ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL CONSIDER THE EFFECTS OF ANY ACTION UPON:

(A) THE ABILITY OF THE BUSINESS CORPORATION TO ACCOMPLISH ITS PURPOSE;

(B) THE SHAREHOLDERS OF THE BUSINESS CORPORATION;

(C) THE EMPLOYEES AND WORKFORCE OF THE HOSPITAL OR HOSPITALS;

(D) THE INTERESTS OF PATIENTS OF THE HOSPITAL OR HOSPITALS;

(E) COMMUNITY AND SOCIETAL CONSIDERATIONS, INCLUDING THOSE OF ANY COMMUNITY IN WHICH FACILITIES OF THE HOSPITAL OR HOSPITALS ARE LOCATED; AND

(F) THE SHORT-TERM AND LONG-TERM INTERESTS OF THE BUSINESS CORPORATION, INCLUDING BENEFITS THAT MAY ACCRUE TO THE BUSINESS CORPORATION FROM ITS LONG-TERM PLANS.

(2) THE CONSIDERATION OF INTERESTS AND FACTORS IN THE MANNER REQUIRED BY SUBPARAGRAPH ONE OF THIS PARAGRAPH:

(A) SHALL NOT CONSTITUTE A VIOLATION OF THE PROVISIONS OF SECTION SEVEN HUNDRED FIFTEEN OR SEVEN HUNDRED SEVENTEEN OF THE BUSINESS CORPORATION LAW; AND

(B) IS IN ADDITION TO THE ABILITY OF DIRECTORS TO CONSIDER INTERESTS AND FACTORS AS PROVIDED IN SECTION SEVEN HUNDRED SEVENTEEN OF THE BUSINESS CORPORATION LAW.

(F) WHILE ANY DECISION TO APPROVE A BUSINESS CORPORATION UNDER THIS SECTION MUST WEIGH AND BALANCE A NUMBER OF FACTORS, IN DETERMINING WHETHER TO APPROVE A BUSINESS CORPORATION UNDER THIS SECTION, THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, IN CONSULTATION WITH THE COMMISSIONER, SHALL CONSIDER THE EXTENT TO WHICH THE BUSINESS CORPORATION:

(1) PROVIDES FOR EITHER EQUAL OR MAJORITY GOVERNANCE RIGHTS OF THE NOT-FOR-PROFIT HOSPITAL PARTNER, REGARDLESS OF EQUITY STAKES, THROUGH WEIGHTED CLASS VOTING STRUCTURE OR OTHERWISE;

(2) INCORPORATES A REPRESENTATIVE GOVERNANCE MODEL THAT:

(A) CLEARLY DELINEATES AUTHORITY AND RESPONSIBILITY FOR THE HOSPITAL'S OPERATIONS;

(B) DEFINES MECHANISMS FOR APPROVAL OF DESIGNATED SHAREHOLDERS OR INVESTORS; AND

(C) RESERVES POWERS GRANTED TO A LOCAL GOVERNING AUTHORITY TO ASSURE ACCESS AND QUALITY;

(3) IS INCORPORATED AS A BENEFIT CORPORATION UNDER THE BUSINESS CORPORATION LAW;

(4) COMMITS TO MAINTAINING OR ENHANCING EXISTING LEVELS OF SERVICES, CHARITY CARE AND CORE COMMUNITY BENEFITS;
(5) IDENTIFIES AN ACTIONABLE STRATEGY TO MONITOR AND MAINTAIN OR IMPROVE QUALITY OF CARE;
(6) EXPLAINS THE LEVEL OF CAPITAL COMMITMENT AND THE MECHANISM OR MECHANISMS FOR INFUSING CAPITAL INTO THE NOT-FOR-PROFIT HOSPITAL PARTNER;
(7) EXPLAINS HOW IT WILL RETAIN THE WORKFORCE, EITHER IN EXISTING JOBS OR THROUGH RETRAINING, AND ADDRESSES OBLIGATIONS OWED TO EMPLOYEE BENEFIT PLANS AND PENSIONS;
(8) WILL CREATE A FOUNDATION TO ADDRESS THE PUBLIC HEALTH NEEDS OF THE COMMUNITY; AND
(9) IDENTIFIES HOW PROFIT DISTRIBUTIONS SHALL BE MADE IN A WAY TO ENSURE THAT THE COMMUNITY'S ACCESS TO QUALITY CARE AND CORE COMMUNITY BENEFITS ARE NOT COMPROMISED AND ACCESS TO CAPITAL IS NOT COMPROMISED.
NONE OF THE FOREGOING FACTORS SHALL BE DISPOSITIVE IN THE APPROVAL OR DISAPPROVAL OF THE BUSINESS CORPORATION.
(G) NO BUSINESS CORPORATION SHALL BE APPROVED UNDER THIS SECTION THAT FAILS TO:
(1) ATTEST THAT IT WILL PROVIDE THE NOT-FOR-PROFIT HOSPITAL PARTNER WITH THE EXCLUSIVE AUTHORITY OVER FUNCTIONS RELATING TO ITS EXEMPT STATUS;
(2) COMMIT TO ONGOING MONITORING AND REPORTING TO THE DEPARTMENT ON QUALITY OF CARE, ACCESS TO SERVICES, LOCAL INVESTMENT, AND WORKFORCE ISSUES, TO BE DEFINED BY THE COMMISSIONER; AND
(3) PROVIDE FOR A LOCAL ADVISORY BOARD CONSISTING OF COMMUNITY REPRESENTATIVES, WHICH SHALL MAKE RECOMMENDATIONS ON MATTERS INCLUDING:
(A) ADOPTING A MISSION, VISION AND VALUES STATEMENT;
(B) MONITORING OPERATING PERFORMANCE;
(C) ASSURING QUALITY OF CARE;
(D) ENSURING MEDICAL STAFF COMPLY WITH JOINT COMMISSION REQUIREMENTS;
(E) GRANTING MEDICAL STAFF PRIVILEGES;
(F) FORMULATING STRATEGIC, OPERATIONAL AND CAPITAL PLANS;
(G) NOMINATING ADVISORY BOARD MEMBERS;
(H) APPROVING THE CHIEF EXECUTIVE OFFICER AND EVALUATING HIS OR HER PERFORMANCE; AND
(I) IDENTIFYING AND APPROVING POLICIES RELATING TO CORE COMMUNITY SERVICES AND BENEFITS AND CHARITY CARE POLICIES.
(H) ANY BUSINESS CORPORATION APPROVED UNDER THIS SECTION MUST ARTICULATE:
(1) THE TIME PERIOD IT EXPECTS TO KEEP ITS INVESTMENT IN THE HOSPITAL OR HOSPITALS;
(2) WHETHER IT WILL ALLOW A "BUY-BACK" OPTION TO ITS NOT-FOR-PROFIT HOSPITAL PARTNER OR BY AN EMPLOYEE OWNERSHIP PLAN;
(3) WHAT SAFEGUARDS IT PLANS TO PUT IN PLACE TO PROTECT ACCESS TO SERVICES WHEN IT BEGINS TO NEGOTIATE WITH A SUBSEQUENT INVESTOR; AND
(4) THE ROLE OF THE NOT-FOR-PROFIT HOSPITAL PARTNER IN THOSE DISCUSSIONS WITH A SUBSEQUENT INVESTOR.
(I) THE BOARD OF DIRECTORS OF A BUSINESS CORPORATION ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE DEEMED A "GOVERNING BODY" FOR THE PURPOSES OF SECTION TWENTY-EIGHT HUNDRED THREE-L OF THIS ARTICLE AND SHALL COMPLY WITH THE PROVISIONS OF SUCH SECTION, REGARDLESS OF THE CORPORATION'S PROFIT-MAKING STATUS.
(J) A SALE, LEASE, CONVEYANCE, EXCHANGE, TRANSFER, OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF THE BUSINESS CORPO-

RATION SHALL NOT BE EFFECTIVE UNLESS THE TRANSACTION IS APPROVED BY THE COMMISSIONER.

NO SUCH TRANSACTION MAY OCCUR WITHIN THREE YEARS OF THE COMMISSIONER'S APPROVAL OF THE BUSINESS CORPORATION'S PARTICIPATION IN THE DEMONSTRATION PROJECT. IN APPROVING SUCH A TRANSACTION, THE COMMISSIONER SHALL CONSIDER, AMONG OTHER THINGS, WHETHER THE TRANSACTION:

(1) IMPOSES SAFEGUARDS TO PROTECT QUALITY AND ACCESS TO CORE COMMUNITY SERVICES DURING THE TRANSITION TO THE NEW INVESTOR;

(2) REQUIRES THE SUBSEQUENT INVESTOR TO GUARANTEE ALL OBLIGATIONS, INCLUDING THOSE DESCRIBED IN SUBPARAGRAPH SEVEN OF PARAGRAPH (F) OF THIS SUBDIVISION;

(3) WILL MAINTAIN THE HOSPITAL GOVERNANCE STRUCTURE AND LOCAL GOVERNING BOARD'S POWERS; AND

(4) IMPOSES MINIMUM CAPITALIZATION CRITERIA POST-TRANSACTION.

(K) NO LATER THAN THREE YEARS AFTER THE ESTABLISHMENT OF A BUSINESS CORPORATION UNDER THIS SUBDIVISION, THE COMMISSIONER SHALL PROVIDE THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY WITH A WRITTEN EVALUATION OF THE PILOT PROGRAM. SUCH EVALUATION SHALL ADDRESS THE OVERALL EFFECTIVENESS OF THE PROGRAM IN ALLOWING FOR ACCESS TO CAPITAL INVESTMENT AND THE IMPACT SUCH ACCESS MAY HAVE ON THE QUALITY OF CARE PROVIDED BY HOSPITALS OPERATED BY BUSINESS CORPORATIONS ESTABLISHED UNDER THIS SUBDIVISION.

S 2. Paragraph (b) of subdivision 2 of section 1676 of the public authorities law is amended by adding a new undesignated paragraph to read as follows:

SUCH BUSINESS CORPORATIONS AS ARE ESTABLISHED PURSUANT TO SUBDIVISION SEVENTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THE PUBLIC HEALTH LAW FOR THE ACQUISITION, CONSTRUCTION, RECONSTRUCTION, REHABILITATION AND IMPROVEMENT, OR OTHERWISE PROVIDING, FURNISHING AND EQUIPPING OF A HOSPITAL OR HOSPITALS.

S 3. Subdivision 1 of section 1680 of the public authorities law is amended by adding a new undesignated paragraph to read as follows:

SUCH BUSINESS CORPORATIONS AS ARE ESTABLISHED PURSUANT TO SUBDIVISION SEVENTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THE PUBLIC HEALTH LAW FOR THE ACQUISITION, CONSTRUCTION, RECONSTRUCTION, REHABILITATION AND IMPROVEMENT, OR OTHERWISE PROVIDING, FURNISHING AND EQUIPPING OF A HOSPITAL OR HOSPITALS.

S 4. This act shall take effect immediately.

PART R

Section 1. Section 3 of part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, as amended by section 1 of part B of chapter 58 of the laws of 2014, is amended to read as follows:

S 3. This act shall take effect immediately; and shall expire and be deemed repealed June 30, [2015] 2018.

S 2. This act shall take effect immediately.

PART S

Section 1. Section 366 of the social services law is amended by adding a new subdivision 7-a to read as follows:

7-A. A. THE COMMISSIONER OF HEALTH IN CONSULTATION WITH THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL APPLY FOR A HOME AND COMMUNITY-BASED WAIVER, PURSUANT TO SUBDIVISION (C) OF SECTION NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT, IN ORDER TO PROVIDE HOME AND COMMUNITY-BASED SERVICES FOR A POPULATION OF PERSONS WITH DEVELOPMENTAL DISABILITIES, AS SUCH TERM IS DEFINED IN SECTION 1.03 OF THE MENTAL HYGIENE LAW.

B. PERSONS ELIGIBLE FOR PARTICIPATION IN THE WAIVER PROGRAM SHALL:

(I) HAVE A DEVELOPMENTAL DISABILITY AS SUCH TERM IS DEFINED IN SUBDIVISION TWENTY-TWO OF SECTION 1.03 OF THE MENTAL HYGIENE LAW;

(II) MEET THE LEVEL OF CARE CRITERIA PROVIDED BY AN INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED;

(III) BE ELIGIBLE FOR MEDICAID;

(IV) LIVE AT HOME OR IN AN INDIVIDUALIZED RESIDENTIAL ALTERNATIVE, COMMUNITY RESIDENCE OR FAMILY CARE HOME, OPERATED, FUNDED OR LICENSED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES OR OTHER APPROPRIATE COMMUNITY SETTING AS DEFINED IN REGULATION BY THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES;

(V) BE CAPABLE OF BEING CARED FOR IN THE COMMUNITY IF PROVIDED WITH SUCH SERVICES AS RESPITE, HOME ADAPTATION, OR OTHER HOME AND COMMUNITY-BASED SERVICES, OTHER THAN ROOM AND BOARD, AS MAY BE APPROVED BY THE SECRETARY OF THE FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN ADDITION TO OTHER SERVICES PROVIDED UNDER THIS TITLE, AS DETERMINED BY THE ASSESSMENT REQUIRED BY PARAGRAPH C OF THIS SUBDIVISION;

(VI) HAVE A DEMONSTRATED NEED FOR HOME AND COMMUNITY BASED WAIVER SERVICES; AND

(VII) MEET SUCH OTHER CRITERIA AS MAY BE ESTABLISHED BY THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES, AS MAY BE NECESSARY TO ADMINISTER THE PROVISIONS OF THIS SUBDIVISION.

C. THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES SHALL ASSESS THE ELIGIBILITY OF PERSONS ENROLLED, OR SEEKING TO ENROLL, IN THE WAIVER PROGRAM. THE ASSESSMENT SHALL INCLUDE, BUT NEED NOT BE LIMITED TO, AN EVALUATION OF THE HEALTH, PSYCHO-SOCIAL, DEVELOPMENTAL, HABILITATION AND ENVIRONMENTAL NEEDS OF THE PERSON AND SHALL SERVE AS THE BASIS FOR THE DEVELOPMENT AND PROVISION OF AN APPROPRIATE PLAN OF CARE FOR SUCH PERSON.

D. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL UNDERTAKE OR ARRANGE FOR THE DEVELOPMENT OF A WRITTEN PLAN OF CARE FOR EACH PERSON ENROLLED IN THE WAIVER. SUCH PLAN OF CARE SHALL DESCRIBE THE PROVISION OF HOME AND COMMUNITY BASED WAIVER SERVICES CONSISTENT WITH THE ASSESSMENT FOR EACH PERSON.

E. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL REVIEW THE PLAN OF CARE AND AUTHORIZE THOSE HOME AND COMMUNITY BASED SERVICES TO BE INCLUDED IN THE PLAN OF CARE, TAKING INTO ACCOUNT THE PERSON'S ASSESSED NEEDS, VALUED OUTCOMES AND AVAILABLE RESOURCES.

F. THE COMMISSIONERS OF DEVELOPMENTAL DISABILITIES AND HEALTH SHALL DETERMINE QUALITY STANDARDS FOR ORGANIZATIONS PROVIDING SERVICES UNDER SUCH WAIVER AND SHALL AUTHORIZE ORGANIZATIONS THAT MEET SUCH STANDARDS TO PROVIDE SUCH SERVICES.

G. THE COMMISSIONER OF DEVELOPMENTAL DISABILITIES OR HEALTH MAY PROMULGATE RULES AND REGULATIONS AS NECESSARY TO EFFECTUATE THE PROVISIONS OF THIS SECTION.

H. THIS SUBDIVISION SHALL BE EFFECTIVE ONLY IF, AND AS LONG AS, FEDERAL FINANCIAL PARTICIPATION IS AVAILABLE FOR EXPENDITURES INCURRED UNDER THIS SUBDIVISION.

S 2. Paragraph (a) of subdivision 4 of section 488 of the social services law, as added by section 1 of part B of chapter 501 of the laws of 2012, is amended to read as follows:

(a) a facility or program in which services are provided and which is operated, licensed or certified by the office of mental health, the office for people with developmental disabilities or the office of alcoholism and substance abuse services, including but not limited to psychiatric centers, inpatient psychiatric units of a general hospital, developmental centers, intermediate care facilities, community residences, group homes and family care homes, provided, however, that such term shall not include a secure treatment facility as defined in section 10.03 of the mental hygiene law, SERVICES DEFINED IN SUBPARAGRAPH FOUR OF SUBDIVISION (A) OF SECTION 16.03 OF THE MENTAL HYGIENE LAW, or services provided in programs or facilities that are operated by the office of mental health and located in state correctional facilities under the jurisdiction of the department of corrections and community supervision;

S 3. Subdivision 2 of section 550 of the executive law, as added by section 3 of part A of chapter 501 of the laws of 2012, is amended to read as follows:

2. "Mental hygiene facility" shall mean a facility as defined in subdivision six of section 1.03 of the mental hygiene law and facilities for the operation of which an operating certificate is required pursuant to article sixteen or thirty-one of the mental hygiene law and including family care homes. "Mental hygiene facility" also means a secure treatment facility as defined by article ten of the mental hygiene law. THIS TERM SHALL NOT INCLUDE SERVICES DEFINED IN SUBPARAGRAPH FOUR OF SUBDIVISION (A) OF SECTION 16.03 OF THE MENTAL HYGIENE LAW.

S 4. Subdivisions 3, 4, 5 and 22 of section 1.03 of the mental hygiene law, subdivision 3 as amended by chapter 223 of the laws of 1992, subdivision 4 as added by chapter 978 of the laws of 1977, subdivision 5 as amended by chapter 75 of the laws of 2006, and subdivision 22 as amended by chapter 255 of the laws of 2002, are amended to read as follows:

3. "Mental disability" means mental illness, [mental retardation] INTELLECTUAL DISABILITY, developmental disability, alcoholism, substance dependence, or chemical dependence. [A mentally disabled person is one who has a mental disability.]

4. "Services for [the mentally disabled] PERSONS WITH A MENTAL DISABILITY" means examination, diagnosis, care, treatment, rehabilitation, SUPPORTS, HABILITATION or training of the mentally disabled.

5. "Provider of services" means an individual, association, corporation, partnership, limited liability company, or public or private agency, other than an agency or department of the state, which provides services for [the mentally disabled] PERSONS WITH A MENTAL DISABILITY. It shall not include any part of a hospital as defined in article twenty-eight of the public health law which is not being operated for the purpose of providing services for the mentally disabled. No provider of services shall be subject to the regulation or control of the department or one of its offices except as such regulation or control is provided for by other provisions of this chapter.

22. "Developmental disability" means a disability of a person which:

(a) (1) is attributable to [mental retardation] INTELLECTUAL DISABILITY, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;

(2) is attributable to any other condition of a person found to be closely related to [mental retardation] INTELLECTUAL DISABILITY because

such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of [mentally retarded] INTELLECTUALLY DISABLED persons or requires treatment and services similar to those required for such person; or

(3) is attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph;

(b) originates before such person attains age twenty-two;

(c) has continued or can be expected to continue indefinitely; and

(d) constitutes a substantial handicap to such person's ability to function normally in society.

S 5. Paragraph 3 of subdivision (a) of section 16.03 of the mental hygiene law, as amended by chapter 37 of the laws of 2011, is amended to read as follows:

(3) Operation of a facility established or maintained by a public agency, board, or commission, or by a corporation or voluntary association for the rendition of out-patient or non-residential services for persons with developmental disabilities; provided, however, that such operation shall not be deemed to include (i) professional practice, within the scope of a professional license or certificate issued by an agency of the state, by an individual practitioner or by a partnership of such individuals or by a professional service corporation duly incorporated pursuant to the business corporation law or by a university faculty practice corporation duly incorporated pursuant to the not-for-profit corporation law or (ii) non-residential services which are licensed, supervised, or operated by another agency of the state and non-residential services which are chartered or issued a certificate of incorporation pursuant to the education law or (iii) pastoral counseling by a clergyman or minister, including those defined as clergyman or minister by section two of the religious corporations law.

S 6. Subdivision (a) of section 16.03 of the mental hygiene law is amended by adding a new paragraph 4 to read as follows:

(4) THE PROVISION OF HOME AND COMMUNITY BASED SERVICES APPROVED UNDER A WAIVER PROGRAM AUTHORIZED PURSUANT TO SUBDIVISION (C) OF SECTION NINETEEN HUNDRED FIFTEEN OF THE FEDERAL SOCIAL SECURITY ACT AND SUBDIVISIONS SEVEN AND SEVEN-A OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW.

S 7. Section 16.03 of the mental hygiene law is amended by adding a new subdivision (f) to read as follows:

(F) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, THE PROVISION OF LICENSED PROFESSIONAL SERVICES, INCLUDING, BUT NOT LIMITED TO, PSYCHOLOGY, NURSING, SOCIAL WORK, SPEECH-LANGUAGE PATHOLOGY, OCCUPATIONAL THERAPY, PHYSICAL THERAPY AND APPLIED BEHAVIORAL ANALYSIS, SHALL BE AUTHORIZED AS PART OF THE PROGRAMS CERTIFIED PURSUANT TO THIS ARTICLE.

S 8. Subdivision (a), paragraphs 2, 3, and 6 of subdivision (c), paragraphs 1 and 4 of subdivision (d), subdivision (e), and subdivision (i) of section 16.05 of the mental hygiene law, subdivision (a), paragraphs 2, 3, and 6 of subdivision (c), paragraphs 1 and 4 of subdivision (d) and subdivision (e) as added by chapter 786 of the laws of 1983, paragraph 6 of subdivision (c) and paragraph 4 of subdivision (d) as renumbered by chapter 618 of the laws of 1990, and subdivision (i) as amended by chapter 37 of the laws of 2011, are amended to read as follows:

(a)(1) Application for an operating certificate shall be made upon forms prescribed by the commissioner.

(2) Application shall be made by the person or entity responsible for operation of the facility OR PROVISION OF SERVICES AS DESCRIBED IN

SUBDIVISION FOUR OF SECTION 16.03 OF THIS ARTICLE. Applications shall be in writing, shall be verified and shall contain such information as required by the commissioner.

(2) The character, competence and standing in the community of the person or entity responsible for operating the facility OR PROVIDING SERVICES;

(3) The financial resources of the proposed facility OR PROVIDER OF SERVICES and its sources of future revenues;

(6) In the case of residential facilities, that arrangements have been made with other providers of services for the provision of health, habilitation, day treatment, education, sheltered workshop, transportation or other services as may be necessary to meet the needs of [clients] INDIVIDUALS who will reside in the facility; and

(1) the financial resources of the proposed facility OR PROVIDER OF SERVICES and its sources of future revenues;

(4) in the case of residential facilities, that arrangements have been made with other providers of services for the provision of health, habilitation, day treatment, education, sheltered workshop, transportation or other services as may be necessary to meet the needs of [clients] INDIVIDUALS who will reside in the facility; and

(e) The commissioner may disapprove an application for an operating certificate, may authorize fewer services than applied for, and may place limitations or conditions on the operating certificate including, but not limited to compliance with a time limited plan of correction of any deficiency which does not threaten the health or well-being of any [client] INDIVIDUALS. In such cases the applicant shall be given an opportunity to be heard, at a public hearing if requested by the applicant.

(i) In the event that the holder of an operating certificate for a residential facility issued by the commissioner pursuant to this article wishes to cease the operation or conduct of any of the activities, as defined in paragraph one OR FOUR of subdivision (a) of section 16.03 of this article, for which such certificate has been issued or to cease operation of any one or more of facilities for which such certificate has been issued; wishes to transfer ownership, possession or operation of the premises and facilities upon which such activities are being conducted or to transfer ownership, possession or operation of any one or more of the premises or facilities for which such certificate has been issued; or elects not to apply to the commissioner for re-certification upon the expiration of any current period of certification, it shall be the duty of such certificate holder to give to the commissioner written notice of such intention not less than sixty days prior to the intended effective date of such transaction. Such notice shall set forth a detailed plan which makes provision for the safe and orderly transfer of each person with a developmental disability served by such certificate holder pursuant to such certificate into a program of services appropriate to such person's on-going needs and/or for the continuous provision of a lawfully operated program of such activities and services at the premises and facilities to be conveyed by the certificate holder. Such certificate holder shall not cease to provide any such services to any such person with a developmental disability under any of the circumstances described in this section until the notice and plan required hereby are received, reviewed and approved by the commissioner. For the purposes of this paragraph, the requirement of prior notice and continuous provision of programs and services by the certificate holder shall not apply to those situations and changes in circumstances directly

affecting the certificate holder that are not reasonably foreseeable at the time of occurrence, including, but not limited to, death or other sudden incapacitating disability or infirmity. Written notice shall be given to the commissioner as soon as reasonably possible thereafter in the manner set forth within this subdivision.

S 9. Paragraph 1 of subdivision (a) of section 16.09 of the mental hygiene law, as added by chapter 786 of the laws of 1983, is amended to read as follows:

(1) "Facility" is limited to a facility in which services are offered for which an operating certificate is required by this article. For the purposes of this section facility shall include family care homes BUT SHALL NOT INCLUDE THE PROVISION OF SERVICES, AS DEFINED IN PARAGRAPH FOUR OF SUBDIVISION (A) OF SECTION 16.03 OF THIS ARTICLE, OUTSIDE OF A FACILITY.

S 10. The section heading and subdivision (a) of section 16.11 of the mental hygiene law are REPEALED and a new section heading and subdivision (a) are added to read as follows:

OVERSIGHT OF FACILITIES AND SERVICES. (A) THE COMMISSIONER SHALL PROVIDE FOR THE OVERSIGHT OF FACILITIES AND PROVIDERS OF SERVICES HOLDING OPERATING CERTIFICATES PURSUANT TO SECTION 16.03 OF THIS ARTICLE AND SHALL PROVIDE FOR THE ANNUAL REVIEW OF SUCH FACILITIES AND PROVIDERS IN IMPLEMENTING THE REQUIREMENTS OF THE OFFICE AND IN PROVIDING QUALITY CARE AND PERSON CENTERED AND COMMUNITY BASED SERVICES.

(1) THE REVIEW OF FACILITIES ISSUED AN OPERATING CERTIFICATE PURSUANT TO THIS ARTICLE SHALL INCLUDE A SITE VISIT TO OCCUR AT LEAST ONCE DURING EACH CALENDAR YEAR AND SHALL BE WITHOUT PRIOR NOTICE. AREAS OF REVIEW SHALL INCLUDE, BUT NOT BE LIMITED TO, A REVIEW OF A FACILITY'S: PHYSICAL PLANT, FIRE SAFETY PROCEDURES, HEALTH CARE, PROTECTIVE OVERSIGHT, ABUSE AND NEGLECT PREVENTION, AND REPORTING PROCEDURES.

(2) THE REVIEW OF PROVIDERS OF SERVICES, AS DEFINED IN PARAGRAPH FOUR OF SUBDIVISION (A) OF SECTION 16.03 OF THIS ARTICLE, SHALL ENSURE THAT THE PROVIDER OF SERVICES COMPLIES WITH ALL THE REQUIREMENTS OF THE APPLICABLE FEDERAL HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM AND APPLICABLE FEDERAL REGULATION, SUBDIVISIONS SEVEN AND SEVEN-A OF SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW AND RULES AND REGULATIONS ADOPTED BY THE COMMISSIONER.

S 11. Subdivisions (b), (c), (d), and (e) of section 16.11 of the mental hygiene law, subdivision (b) as amended by chapter 37 of the laws of 2011, and subdivisions (c), (d) and (e) as added by chapter 786 of the laws of 1983, are amended to read as follows:

(b) The commissioner shall have the power to conduct investigations into the operations of any PROVIDER OF SERVICE, person or entity which holds an operating certificate issued by the office, into the operation of any facility, SERVICE or program issued an operating certificate by the office and into the operations, related to the provision of services regulated by this chapter, of any person or entity providing a residence for one or more unrelated persons with developmental disabilities.

(c) In conducting an inspection or investigation, the commissioner or his OR HER authorized representative shall have the power to inspect facilities, conduct interviews of clients, interview personnel, examine and copy all records, including financial and medical records of the facility OR PROVIDER OF SERVICES, and obtain such other information as may be required in order to carry out his OR HER responsibilities under this chapter.

(d) In conducting any inspection or investigation under this chapter, the commissioner or his OR HER authorized representative is empowered to

subpoena witnesses, compel their attendance, administer oaths to witnesses, examine witnesses under oath, and require the production of any books or papers deemed relevant to the investigation, inspection, or hearing. A subpoena issued under this section shall be regulated by the civil practice law and rules.

(e) The supreme court may enjoin persons or entities subject to inspection or investigation pursuant to this article to cooperate with the commissioner and to allow the commissioner access to PROVIDERS OF SERVICES, facilities, records, clients and personnel as necessary to enable the commissioner to conduct the inspection or investigation.

S 12. Section 16.17 of the mental hygiene law, as added by chapter 786 of the laws of 1983, subdivision (a) and paragraph 2 and subparagraph b of paragraph 1 of subdivision (b) as amended and subparagraph d of paragraph 1 of subdivision (b) as relettered by chapter 169 of the laws of 1992, subdivision (b) as amended by chapter 856 of the laws of 1985, the opening paragraph and subparagraph c of paragraph 1 of subdivision (b) as amended by chapter 37 of the laws of 2011, subparagraph d of paragraph 1 of subdivision (b) as added by chapter 618 of the laws of 1990, paragraph 4 of subdivision (b) as amended by chapter 168 of the laws of 2010, paragraph 1 of subdivision (f) as amended by chapter 601 of the laws of 2007, subdivision (g) as amended by chapter 24 of the laws of 2007, and subdivision (h) as amended by chapter 306 of the laws of 1995, is amended to read as follows:

S 16.17 Suspension, revocation, or limitation of an operating certificate.

(a) The commissioner may revoke, suspend, or limit an operating certificate or impose the penalties described in subparagraph a, b, c or d of paragraph one of subdivision (b) or in subdivision (g) of this section upon a determination that the holder of the certificate has failed to comply with the terms of its operating certificate or with the provisions of any applicable statute, rule or regulation. The holder of the certificate shall be given notice and an opportunity to be heard prior to any such determination except that no such notice and opportunity to be heard shall be necessary prior to an emergency suspension or limitation of the facility's OR PROVIDER OF SERVICES' operating certificate imposed pursuant to paragraph one of subdivision (b) of this section, nor shall such notice and opportunity to be heard be necessary should the commissioner, in his OR HER discretion, decide to issue separate operating certificates to each facility OR PROVIDER OF SERVICES formerly included under the services authorized by one operating certificate to the provider of services.

(b) (1) An operating certificate may be temporarily suspended or limited without a prior hearing for a period not in excess of sixty days upon written notice to the facility OR PROVIDER OF SERVICES following a finding by the office for people with developmental disabilities that a [client's] INDIVIDUAL'S health or safety is in imminent danger. Upon such finding and notice, the power of the commissioner temporarily to suspend or limit an operating certificate shall include, but shall not be limited to, the power to:

a. Prohibit or limit the placement of new [clients] INDIVIDUALS in the facility OR SERVICES;

b. Remove or cause to be removed some or all of the [clients] INDIVIDUALS in the facility OR SERVICES;

c. Suspend or limit or cause to be suspended or limited the payment of any governmental funds to the facility OR PROVIDER OF SERVICES provided that such action shall not in any way jeopardize the health, safety and

welfare of any person with a developmental disability in such program or facility OR SERVICES;

d. Prohibit or limit the placement of new [clients] INDIVIDUALS, remove or cause to be removed some or all [clients] INDIVIDUALS, or suspend or limit or cause to be suspended or limited the payment of any governmental funds, in or to any one or more of the facilities OR PROVIDER OF SERVICES authorized pursuant to an operating certificate [issued to a provider of services].

(2) At any time subsequent to the suspension or limitation of any operating certificate pursuant to paragraph one of this subdivision where said suspension or limitation is the result of correctable physical plant, staffing or program deficiencies, the facility OR PROVIDER OF SERVICES may request the office to [reinspect] REVIEW the facility OR PROVIDER OF SERVICES to redetermine whether a physical plant, staffing or program deficiency continues to exist. After the receipt of such a request, the office shall [reinspect] REVIEW the facility OR PROVIDER OF SERVICES within ten days and in the event that the previously found physical plant, staffing or program deficiency has been corrected, the suspension or limitation shall be withdrawn. If the physical plant, staffing or program deficiency has not been corrected, the commissioner shall not thereafter be required to [reinspect] REVIEW the facility OR PROVIDER OF SERVICES during the emergency period of suspension or limitation.

(3) During the sixty day suspension or limitation period provided for in paragraph one of this subdivision the commissioner shall determine whether to reinstate or remove the limitations on the facility's OR PROVIDER OF SERVICES' operating certificate or to revoke, suspend or limit the operating certificate pursuant to subdivision (a) of this section. Should the commissioner choose to revoke, suspend or limit the operating certificate, then the emergency suspension or limitation provided for in this subdivision shall remain in effect pending the outcome of an administrative hearing on the revocation, suspension or limitation.

(4) The facility operator OR PROVIDER OF SERVICES, within ten days of the date when the emergency suspension or limitation pursuant to paragraph one of this subdivision is first imposed, may request an evidentiary hearing to contest the validity of the emergency suspension or limitation. Such an evidentiary hearing shall commence within ten days of the facility operator's OR PROVIDER'S request and no request for an adjournment shall be granted without the concurrence of the facility operator OR PROVIDER OF SERVICE, office for people with developmental disabilities, and the hearing officer. The evidentiary hearing shall be limited to those violations of federal and state law and regulations that existed at the time of the emergency suspension or limitation and which gave rise to the emergency suspension or limitation. The emergency suspension or limitation shall be upheld upon a determination that the office for people with developmental disabilities had reasonable cause to believe that a [client's] INDIVIDUAL'S health or safety was in imminent danger. A record of such hearing shall be made available to the facility operator OR PROVIDER OF SERVICE upon request. Should the commissioner determine to revoke, suspend or limit [the facility's] AN operating certificate pursuant to subdivision (a) of this section, no administrative hearing on that action shall commence prior to the conclusion of the evidentiary hearing. The commissioner shall issue a ruling within ten days after the receipt of the hearing officer's report.

(c) When the holder of an operating certificate shall request an opportunity to be heard, the commissioner shall fix a time and place for the hearing. A copy of the charges, together with the notice of the time and place of the hearing, shall be served in person or mailed by registered or certified mail to the facility OR PROVIDER OF SERVICES at least ten days before the date fixed for the hearing. The facility OR PROVIDER OF SERVICES shall file with the office, not less than three days prior to the hearing, a written answer to the charges.

(d) (1) When a hearing must be afforded pursuant to this section or other provisions of this article, the commissioner, acting as hearing officer, or any person designated by him OR HER as hearing officer, shall have power to:

a. administer oaths and affirmations;

b. issue subpoenas, which shall be regulated by the civil practice law and rules;

c. take testimony; or

d. control the conduct of the hearing.

(2) The rules of evidence observed by courts need not be observed except that the rules of privilege recognized by law shall be respected. Irrelevant or unduly repetitious evidence may be excluded.

(3) All parties shall have the right of counsel and be afforded an opportunity to present evidence and cross-examine witnesses.

(4) If evidence at the hearing relates to the identity, condition, or clinical record of [a client] AN INDIVIDUAL, the hearing officer may exclude all persons from the room except parties to the proceeding, their counsel and the witness. The record of such proceeding shall not be available to anyone outside the office, other than a party to the proceeding or his counsel, except by order of a court of record.

(5) The commissioner may establish regulations to govern the hearing procedure and the process of determination of the proceeding.

(6) The commissioner shall issue a ruling within ten days after the termination of the hearing or, if a hearing officer has been designated, within ten days from the hearing officer's report.

(e) All orders or determinations hereunder shall be subject to review as provided in article seventy-eight of the civil practice law and rules.

(f) (1) Except as provided in paragraph two of this subdivision, anything contained in this section to the contrary notwithstanding, an operating certificate of a facility OR PROVIDER OF SERVICE shall be revoked upon a finding by the office that any individual, member of a partnership or shareholder of a corporation to whom or to which an operating certificate has been issued, has been convicted of a class A, B or C felony or a felony related in any way to any activity or program subject to the regulations, supervision, or administration of the office or of the office of temporary and disability assistance, the department of health, or another office of the department of mental hygiene, or in violation of the public officers law in a court of competent jurisdiction of the state, or in a court in another jurisdiction for an act which would have been a class A, B or C felony in this state or a felony in any way related to any activity or program which would be subject to the regulations, supervision, or administration of the office or of the office of temporary and disability assistance, the department of health, or another office of the department of mental hygiene, or for an act which would be in violation of the public officers law. The commissioner shall not revoke or limit the operating certificate of any facility OR PROVIDER OF SERVICE, solely because of the conviction, whether in the

courts of this state or in the courts of another jurisdiction, more than ten years prior to the effective date of such revocation or limitation, of any person of a felony, or what would amount to a felony if committed within the state, unless the commissioner makes a determination that such conviction was related to an activity or program subject to the regulations, supervision, and administration of the office or of the office of temporary and disability assistance, the department of health, or another office of the department of mental hygiene, or in violation of the public officers law.

(2) In the event one or more members of a partnership or shareholders of a corporation shall have been convicted of a felony as described in paragraph one of this subdivision, the commissioner shall, in addition to his OR HER other powers, limit the existing operating certificate of such partnership or corporation so that it shall apply only to the remaining partner or shareholders, as the case may be, provided that every such convicted person immediately and completely ceases and withdraws from participation in the management and operation of the facility OR PROVIDER OF SERVICES and further provided that a change of ownership or transfer of stock is completed without delay, and provided that such partnership or corporation shall immediately reapply for a certificate of operation pursuant to subdivision (a) of section 16.05 of this article.

(g) The commissioner may impose a fine upon a finding that the holder of the certificate has failed to comply with the terms of the operating certificate or with the provisions of any applicable statute, rule or regulation. The maximum amount of such fine shall be one thousand dollars per day or fifteen thousand dollars per violation.

Such penalty may be recovered by an action brought by the commissioner in any court of competent jurisdiction OR BY OFFSETTING SUCH PENALTY AGAINST A FUTURE MEDICAID OR OFFICE PAYMENT TO SUCH PROVIDER.

Such penalty may be released or compromised by the commissioner before the matter has been referred to the attorney general. Any such penalty may be released or compromised and any action commenced to recover the same may be settled or discontinued by the attorney general with the consent of the commissioner.

(h) Where a proceeding has been brought pursuant to section 16.27 of this article, and a receiver appointed pursuant thereto, the commissioner may assume operation of the facility subject to such receivership, upon termination of such receivership, and upon showing to the court having jurisdiction over such receivership that no voluntary association, not-for-profit corporation or other appropriate provider is willing to assume operation of the facility subject to receivership and is capable of meeting the requirements of this article; provided that the commissioner notifies the chairman of the assembly ways and means committee, the chairman of the senate finance committee and the director of the budget of his intention to assume operation of such facility upon service of the order to show cause upon the owner or operator of the facility, pursuant to subdivision (b) of section 16.27 of this article.

S 13. Paragraph 5 of subdivision (a) of section 16.29 of the mental hygiene law, as amended by section 9 of part C of chapter 501 of the laws of 2012, is amended to read as follows:

(5) removing a service recipient when it is determined that there is a risk to such person if he or she continues to remain in a facility OR SERVICE PROGRAM; and

S 14. Paragraph (ii) of subdivision (c) of section 16.29 of the mental hygiene law, as amended by section 9 of part C of chapter 501 of the laws of 2012, is amended to read as follows:

(ii) development and implementation of a plan of prevention and remediation, in the event an investigation of a report of an alleged reportable incident exists and such reportable incident may be attributed in whole or in part to noncompliance by the facility OR PROVIDER OF SERVICES with the provisions of this chapter or regulations of the office applicable to the operation of such facility OR PROVIDER OF SERVICES. Any plan of prevention and remediation required to be developed pursuant to this subdivision by a facility supervised by the office shall be submitted to and approved by such office in accordance with time limits established by regulations of such office. Implementation of the plan shall be monitored by such office. In reviewing the continued qualifications of a residential facility OR PROVIDER OF SERVICES or program for an operating certificate, the office shall evaluate such facility's OR PROVIDER OF SERVICE'S compliance with plans of prevention and remediation developed and implemented pursuant to this subdivision.

S 15. 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 a court of component 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 in the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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