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

6007

2015-2016 Regular Sessions

I N A S S E M B L Y

March 9, 2015

Introduced by COMMITTEE ON RULES -- read once and referred to the Committee on Ways and Means

AN ACT to amend section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, in relation to extending the provisions thereof; and to amend the social services law, in relation 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 part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medical expenditures, in relation to extending the provisions thereof; 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 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 covered lives assessments in the Rochester region; to amend the public health law, in relation to noticing of hospitals; to amend the public health law, in relation to community service plans and performing provider systems community advisory boards; to amend the social services law, in relation to health homes; 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 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 school-based health centers; to amend the social services law, in relation to payments for Medicare beneficiaries; to authorize a mobility management contractor; to amend the public health law, in relation to energy efficiency; to amend the

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

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public health law, in relation to payment rates for managed long term care enrollees and long term care health programs; 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 amend the social services law, in relation to establishing a health technology assessment committee within the medical assistance program; to repeal subdivision 25-a of section 364-j of the social services law, relating to managed care provided coverage for certain drugs; to repeal subdivision 7 of section 364-i of the social services law, relating to presumptive eligibility for medical assistance; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to rates of payment paid to certain providers by the Child Health Plus Program; and to amend chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to rates of payment paid to certain providers by the Child Health Plus Program (Part C); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to reimbursements; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to the effectiveness thereof; to amend the public health law, in relation to rates of payment for long term home health care programs and making such provisions permanent; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the public health law and other laws

relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend the public authorities law, in relation to the transfer of certain funds; to amend part H of chapter 59 of the laws of 2011, relating to enacting into law major components of legislation necessary to implement the health and mental hygiene budget for the 2011-2012 state fiscal plan, in relation to the effectiveness of program oversight and administration of managed long term care plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to the effectiveness thereof; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs, in relation to the effectiveness thereof; 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 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; to amend 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, in relation to the effectiveness of certain provisions; to amend part A of chapter 56 of the laws of 2013, amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates, relating to the cap on local Medicaid expenditures, in relation to extending the provisions thereof; and to repeal section 2 of chapter 459 of the laws of 1996 amending the public health law relating to recertification of persons providing emergency medical care (Part D); to amend the public health law, in relation to the payment of certain funds for uncompensated care (Part E); intentionally omitted (Part F); 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 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 civil practice law and rules, the criminal procedure law and the executive law, in relation to the use in evidence of the fact of possession of a condom; to amend the penal law, in relation to criminal possession of a controlled substance in the seventh degree; to amend the general business law, in relation to drug-related paraphernalia; to amend the public health law, in relation to the sale and possession of hypodermic syringes and needles; to repeal subdivision 2-a of section 2781 of the public health law relating to certain consent for HIV related testing; and to repeal section 220.45 of the penal law relating to criminally possessing a hypodermic instrument (Part I); to amend the education law and the public health law, in relation to authorizing certain advanced home health aides to perform certain advanced tasks; and providing for the repeal of such provisions upon expiration thereof (Part J); to amend the public health law, in relation to streamlin-

ing 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, and in relation to hospital sponsored off-campus emergency departments (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; to require the commissioner of mental health to report on children 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); intentionally omitted (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); to amend the social services law, the education 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); intentionally omitted (Part T); intentionally omitted (Part U); to amend the mental hygiene law, in relation to commissioning a statewide evaluation regarding the extent of legal and illegal gambling by New York residents (Part V); to amend the mental hygiene law and the racing, pari-mutuel wagering and breeding law, in relation to compulsive gambling assistance (Part W); to amend chapter 495 of the laws of 2004 amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, in relation to the effectiveness thereof (Part X); to amend the insurance law, in relation to an exemption to certain provisions of law relating to risk-based capital for property/casualty insurance companies (Part Y); to amend chapter 266 of the laws of 1986 amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct; and to amend part J of chapter 63 of the laws of 2001 amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, in relation to extending certain provisions concerning the hospital excess liability pool and requiring a tax clearance for doctors and dentists to be eligible for such excess coverage (Part Z); to amend the insurance

law, in relation to the New York state health insurance modernization and quality care commission (Part AA); to amend the elder law, in relation to enriched social adult day services; and to amend chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, in relation to the effectiveness thereof (Part BB); to amend the mental hygiene law, in relation to providing state operated opportunities for people with developmental disabilities (Part CC); to amend the social services law, in relation to establishing presumptive eligibility for Medicaid for inmates (Part DD); to amend the mental hygiene law, in relation to establishing a crisis intervention team program (Part EE); to amend the mental hygiene law, in relation to requiring the commissioner of developmental disabilities to conduct a geographic analysis of supports and services in community settings for individuals with developmental disabilities (Part FF); and to amend the metal hygiene law, in relation to transformation workgroups (Part GG)

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 GG. 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. Intentionally omitted.

S 1-a. Section 4 of part X2 of chapter 62 of the laws of 2003, amending the public health law relating to allowing for the use of funds of the office of professional medical conduct for activities of the patient health information and quality improvement act of 2000, as amended by section 25 of part B of chapter 56 of the laws of 2013, is amended to read as follows:

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

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. Section 461-s of the social services law, as added by section 21 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

S 461-s. Enhancing the quality of adult living program for adult care facilities. 1. The commissioner of health shall establish the enhanced quality of adult living program (referred to in this section as the "EQUAL program" or the "program") for adult care facilities. The program shall be targeted at improving the quality of life for adult care facility residents by means of grants to facilities for specified purposes. The department of health, subject to the approval of the director of the budget, shall develop an allocation methodology taking into account the financial status and size of the facility as well as resident needs.

2. (A) No payment shall be made under the program to a facility that, IN THE PRECEDING YEAR:

(I) has received official written notice from the department of a proposed revocation, suspension, limitation or denial of the operator's operating certificate[.];

(II) HAS RECEIVED ISSUANCE OF A DEPARTMENT ORDER UNDER SUBDIVISION TWO OF SECTION FOUR HUNDRED SIXTY-D OF THIS ARTICLE; A PROPOSED ASSESSMENT OF CIVIL PENALTIES FOR A VIOLATION OF SUBPARAGRAPH TWO OF PARAGRAPH (B) OF SUBDIVISION SEVEN OF SECTION FOUR HUNDRED SIXTY-D OF THIS ARTICLE; THE GRANTING OF EQUITABLE RELIEF UNDER SUBDIVISION FIVE OF SECTION FOUR HUNDRED SIXTY-D OF THIS ARTICLE; OR THE ISSUANCE OF A COMMISSIONER'S ORDER UNDER SUBDIVISION EIGHT OF SECTION FOUR HUNDRED SIXTY-D OF THIS ARTICLE;

(III) IS SUBJECT TO AN ORDER BY A COURT OF COMPETENT JURISDICTION OR AN APPROVED SETTLEMENT AGREEMENT WHICH AFFIRMS THAT THE RIGHTS AFFORDED TO RESIDENTS OF ADULT CARE FACILITIES AS PROVIDED FOR BY SECTION FOUR HUNDRED SIXTY-ONE-D OF THIS ARTICLE HAVE BEEN VIOLATED; OR

(IV) HAS FAILED TO COMPLY WITH SUBDIVISION FIVE OF THIS SECTION.

(B) WHEN PAYMENT IS DENIED UNDER THIS SUBDIVISION, THE DEPARTMENT SHALL DETERMINE THE MEANS WHEREBY PAYMENT SHALL BE MADE TO THE RESIDENTS LIVING IN THE FACILITY IN ENFORCEMENT, PROVIDED THAT THE FUNDS WILL SUPPORT EXPENSES THAT DIRECTLY BENEFIT THE RESIDENTS.

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

4. EQUAL PROGRAM FUNDS SHALL NOT BE EXPENDED FOR A FACILITY'S DAILY OPERATING EXPENSES, INCLUDING EMPLOYEE SALARIES OR BENEFITS, FOR EXPENSES INCURRED RETROSPECTIVELY, OR FOR EXPENDITURES RELATED TO CORRECTIVE ACTION AS REQUIRED BY AN INSPECTION REPORT OR AUDIT UNDER SUBDIVISION FIVE OF THIS SECTION.

5. THE DEPARTMENT OF HEALTH SHALL CONDUCT AN ANNUAL AUDIT OF EACH FACILITY THAT HAS RECEIVED PAYMENT UNDER THIS SECTION TO ENSURE THAT PROGRAM FUNDS WERE SPENT AS INDICATED IN THE EXPENDITURE PLAN UPON WHICH THE RESPECTIVE PAYMENT WAS MADE. AT THE COMPLETION OF THE AUDIT, THE FACILITY SHALL PREPARE A CORRECTIVE ACTION PLAN TO ADDRESS OR DISPUTE EACH NEGATIVE AUDIT FINDING INCLUDED IN THE CURRENT YEAR AUDITOR'S REPORTS. THE CORRECTIVE ACTION PLAN SHALL PROVIDE THE NAMES OF THE

CONTACT PERSONS RESPONSIBLE FOR CORRECTIVE ACTION, THE CORRECTIVE ACTION PLANNED, AND THE ANTICIPATED COMPLETION DATE.

6. THE DEPARTMENT SHALL PROMULGATE REGULATIONS TO IMPLEMENT THIS SECTION.

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) 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 ANTIRETRO-VIRALS AND HEPATITIS C AGENTS 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. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. Intentionally omitted.

S 6-a. Subdivision 25 of section 364-j of the social services law, as added by section 55 of part D of chapter 56 of the laws of 2012, is amended to read as follows:

25. [Effective January first, two thousand thirteen, notwithstanding any provision of law to the contrary, managed care providers shall cover medically necessary prescription drugs in the atypical antipsychotic therapeutic class, including non-formulary drugs, upon demonstration by the prescriber, after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted.] NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, MANAGED CARE PROVIDERS SHALL COVER MEDICALLY NECESSARY PRESCRIPTION DRUGS IN ALL DRUG CLASSES, INCLUDING NON-FORMULARY DRUGS, UPON DEMONSTRATION BY THE PRESCRIBER, AFTER CONSULTING WITH THE MANAGED CARE PROVIDER, THAT SUCH DRUGS, IN THE PRESCRIBER'S REASONABLE PROFESSIONAL JUDGMENT, ARE MEDICALLY NECESSARY AND WARRANTED.

S 6-b. Subdivision 25-a of section 364-j of the social services law is REPEALED.

S 7. Intentionally omitted.

S 8. Subdivision 1 of section 92 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to known and projected department of health state fund medicaid expenditures, as amended by section 33 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

1. For state fiscal years 2011-12 through [2015-16] 2016-17, the director of the budget, in consultation with the commissioner of health referenced as "commissioner" for purposes of this section, shall assess on a monthly basis, as reflected in monthly reports pursuant to subdivision five of this section known and projected department of health state funds medicaid expenditures by category of service and by geographic regions, as defined by the commissioner, and if the director of the budget determines that such expenditures are expected to cause medicaid

disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established pursuant to the federal social security act, changes in provider revenues, reductions to local social services district medical assistance administration, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund. Such projections may be adjusted by the director of the budget to account for increased or expedited department of health state funds medicaid expenditures as a result of a natural or other type of disaster, including a governmental declaration of emergency.

S 9. Intentionally omitted.

S 10. Intentionally omitted.

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.

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

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

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

22. NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, GENERAL HOSPITALS DESIGNATED AS SOLE COMMUNITY HOSPITALS IN ACCORDANCE WITH TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT FOR INPATIENT AND/OR OUTPATIENT SERVICES OF UP TO TWELVE MILLION DOLLARS

UNDER A SUPPLEMENTAL OR REVISED RATE METHODOLOGY, ESTABLISHED BY THE COMMISSIONER IN REGULATION, FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING THE QUALITY OF CARE. IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE, THEN THE NON-FEDERAL SHARE OF SUCH PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

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

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

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

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

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

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

(F) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, NO LESS THAN TEN MILLION DOLLARS SHALL BE ALLOCATED TO PROVIDERS DESCRIBED IN THIS SUBDIVISION; PROVIDED, HOWEVER THAT IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE FOR ANY ELIGIBLE PROVIDER, OR FOR ANY POTENTIAL INVESTMENT UNDER THIS SUBDIVISION THEN THE NON-FEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

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

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

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

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

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

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

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

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

ALLOCATIONS, AND THE AVAILABILITY OF FEDERAL MATCHING FUNDS. THE COMMISSIONER SHALL PROVIDE QUARTERLY REPORTS TO THE CHAIR OF THE SENATE FINANCE COMMITTEE AND THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE ON THE DISTRIBUTION AND DISBURSEMENT OF SUCH FUNDS.

S 15. 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 deter-

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

S 23-a. Subdivision 6 of section 2807-s of the public health law is amended by adding a new paragraph (g) to read as follows:

(G) A FURTHER GROSS ANNUAL AMOUNT ALLOCATED TO THE ROCHESTER REGION BEGINNING JANUARY FIRST, TWO THOUSAND SIXTEEN SHALL BE ONE HUNDRED TEN MILLION DOLLARS. SUCH AMOUNT SHALL BE EXCLUDED FROM ALL COMPUTATIONS AND ADJUSTMENTS MADE PURSUANT TO PARAGRAPH (B) OF SUBDIVISION SIX OF SECTION TWO THOUSAND EIGHT HUNDRED SEVEN-T OF THIS ARTICLE.

S 23-b. Subdivision 7 of section 2807-s of the public health law is amended by adding a new paragraph (d) to read as follows:

(D)(I) FIVE MILLION DOLLARS OF THE FUNDS ALLOCATED PURSUANT TO PARAGRAPH (G) OF SUBDIVISION SIX OF THIS SECTION SHALL BE DISTRIBUTED TO A REGIONAL HEALTH PLANNING ORGANIZATION FOR USE IN FUNDING REGIONAL HEALTH CARE IMPROVEMENT PROJECTS. THE REGIONAL HEALTH PLANNING ORGANIZATION SHALL DISBURSE THOSE FUNDS IN ACCORDANCE WITH THIS PARAGRAPH, OR PURSUANT TO GRANTS MADE BY THE ORGANIZATION IN ACCORDANCE WITH THIS PARAGRAPH. DISTRIBUTION OF ANY GRANT FUNDS ADMINISTERED BY THE REGIONAL HEALTH PLANNING ORGANIZATION SHALL BE PURSUANT TO A MULTI-STAKEHOLDER PROCESS. THE REGIONAL HEALTH CARE IMPROVEMENT GRANT FUND PROJECTS SHALL INCLUDE THREE MILLION DOLLARS PER YEAR FOR A SHARED COMMUNITY HEALTH INFRASTRUCTURE DESIGNED ON THE BASIS OF COLLABORATIVE COMMUNITY EFFORTS,

INCLUDING COMMUNITY-WIDE PATIENT SAFETY AND QUALITY IMPROVEMENT PROGRAMS, ELIMINATION OF HEALTH DISPARITIES, HEALTH INFORMATION TECHNOLOGY, AND TWO MILLION DOLLARS TO FUND THE REGIONAL HEALTH PLANNING ORGANIZATION. THE HEALTH PLANNING ORGANIZATION SHALL USE REASONABLE EFFORTS TO GENERATE MATCHING FUND CONTRIBUTIONS IN THE FORM OF GRANTS, DONATIONS AND OTHER CONTRIBUTIONS.

(II) ONE HUNDRED FIVE MILLION DOLLARS OF THE FUNDS ALLOCATED PURSUANT TO PARAGRAPH (G) OF SUBDIVISION SIX OF THIS SECTION SHALL BE ALLOCATED TO A NOT-FOR-PROFIT ORGANIZATION OR ASSOCIATION THAT HAS BEEN DESIGNATED THROUGH A MULTI-STAKEHOLDER PROCESS, WHICH SHALL DISTRIBUTE THOSE FUNDS TO ALL OF THE HOSPITALS IN THE REGION ENGAGED IN GRADUATE MEDICAL EDUCATION IN ORDER TO FUND GRADUATE MEDICAL EDUCATION. ONE HUNDRED MILLION DOLLARS OF SUCH FUNDING SHALL BE DISTRIBUTED PROPORTIONALLY TO EACH OF THE HOSPITALS IN AMOUNTS WHICH REFLECT EACH HOSPITAL'S CURRENT COSTS FOR GRADUATE MEDICAL EDUCATION, AND FIVE MILLION DOLLARS OF UNREIMBURSED ADMINISTRATIVE AND OTHER GRADUATE MEDICAL EDUCATION RELATED COSTS SHALL BE ALLOCATED IN THE SAME PROPORTIONS. ONE HUNDRED MILLION DOLLARS OF THE DISTRIBUTED FUNDS SHALL BE IN LIEU OF CURRENT FUNDING OF SUCH COSTS AS CURRENTLY INCLUDED IN CLAIMS PAYMENTS BY SPECIFIED THIRD PARTY PAYORS IN THE REGION RESULTING IN A REDUCTION IN THE AMOUNT PAID BY SUCH THIRD PARTY PAYORS IN AN AMOUNT EQUAL TO THE ONE HUNDRED MILLION DOLLARS. PRIOR TO THE ALLOCATION OF FUNDS PURSUANT TO THIS SUBDIVISION, THE PARTICIPATING HOSPITALS AND SUCH THIRD PARTY PAYORS SHALL DEVELOP A PROCESS FOR THE DISTRIBUTION OF SUCH FUNDS AND A MECHANISM TO ENSURE THAT THE REQUIRED REDUCTION OF PAYMENTS BY SUCH THIRD PARTY PAYORS TO THE HOSPITALS OCCURS. THE AFFECTED HOSPITALS AND THE THIRD PARTY PAYORS IN THE REGION SHALL SELECT AN INDEPENDENT THIRD PARTY TO DETERMINE THE REDUCTIONS WHICH SHALL OCCUR FROM PREVIOUSLY NEGOTIATED RATES FOR CLAIMS PAYMENTS TO SUCH HOSPITALS BY SPECIFIED THIRD PARTY PAYORS IN ORDER TO AVOID DUPLICATE FUNDING PURSUANT TO THIS PARAGRAPH. PRIOR TO THE IMPLEMENTATION OF THESE PROVISIONS, A REPORT SHALL BE PREPARED BY SUCH INDEPENDENT THIRD PARTY TO ANALYZE THE ANTICIPATED IMPACT OF THESE PROVISIONS ON GRADUATE MEDICAL EDUCATION AND THE PROMOTION OF COMMUNITY HEALTH IN THE ROCHESTER REGION. THE REPORT WILL CONSIDER: THE IMPACT OF THE PROPOSAL ON THE DEVELOPMENT AND RETENTION OF THE PHYSICIAN WORKFORCE IN ROCHESTER AND THE SURROUNDING REGION AS A RESULT OF ITS EFFECTS ON THE SUPPORT OF GRADUATE MEDICAL EDUCATION; THE IMPACT OF THE PROPOSAL ON THE HEALTHCARE COMMUNITY (INCLUDING HOSPITALS AND OTHER HEALTHCARE PROVIDERS), THIRD PARTY PAYORS, THE BUSINESS COMMUNITY AND CONSUMERS; AND THE OVERALL IMPACT OF THE PROPOSAL ON THE HEALTHCARE DELIVERY SYSTEM IN THE ROCHESTER REGION, INCLUDING ITS SUPPORT FOR COMMUNITY HEALTH INITIATIVES AND HEALTHCARE PLANNING. THE REPORT WILL BE SUBMITTED TO THE SPEAKER OF THE ASSEMBLY, THE TEMPORARY PRESIDENT OF THE SENATE AND TO THE COMMISSIONER OF HEALTH NO LATER THAN OCTOBER 1, 2015.

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. Notifica-

tion 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 24-a. Section 2803-l of the public health law, as amended by chapter 639 of the laws of 1996, is amended to read as follows:

S 2803-l. Community service plans. 1. The governing body of a voluntary non-profit general hospital OR THE SPONSORING ENTITY OF A PERFORMING PROVIDER SYSTEM ("PPS") PARTICIPATING IN THE MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT ("DSRIP") PROGRAM must issue an organizational mission statement identifying at a minimum the populations and communities served by the hospital OR THE PPS and the hospital's OR PPS'S commitment to meeting the health care needs of the community.

2. The governing body OR PPS SPONSORING ENTITY must at least every three years IN THE CASE OF A HOSPITAL AND EVERY TWO YEARS IN THE CASE OF A PPS:

(i) review and amend as necessary the [hospital] mission statement;

(ii) solicit the views of the communities served by the hospital OR PPS on such issues as [the hospital's] performance and service priorities;

(iii) demonstrate the hospital's OR PPS'S operational and financial commitment to meeting community health care needs, to provide charity care services and to improve access to health care services by the underserved; and

(iv) prepare and make available to the public a statement showing on a combined basis a summary of the financial resources of the hospital OR PPS and related corporations and the allocation of available resources to hospital OR PPS purposes including the provision of free or reduced charge services.

3. The governing body OR SPONSORING ENTITY OF A PPS must at least annually prepare and make available to the public an implementation report regarding the hospital's OR PPS'S performance in meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.

4. The governing body OR SPONSORING ENTITY OF A PPS shall file with the commissioner its mission statement, its annual implementation report, and at least every three years a report detailing amendments to the statement and reflecting changes in the hospital's OR PPS'S operational and financial commitment to meeting the health care needs of the community, providing charity care services, and improving access to health care services by the underserved.

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

(C) (I) PERFORMING PROVIDER SYSTEMS COMMUNITY ADVISORY BOARDS. 1. THE SPONSORING ENTITY OF EACH PERFORMING PROVIDER SYSTEM ("PPS") PARTICIPATING IN THE MEDICAID DELIVERY SYSTEM REFORM INCENTIVE PAYMENT ("DSRIP") SHALL ESTABLISH A COMMUNITY ADVISORY BOARD, OR BOARDS BASED ON GEOGRAPHIC SERVICE AREAS. THE COMMUNITY ADVISORY BOARD OR BOARDS SHALL CONSIDER AND ADVISE THE PPS UPON THE PPS'S MISSION STATEMENT AND ANNUAL IMPLEMENTATION REPORT UNDER SECTION TWENTY-EIGHT HUNDRED THREE-L OF THIS ARTI-

CLE, MATTERS CONCERNING OPERATIONAL ASPECTS OF THE PPS, SERVICE DELIVERY ISSUES, ELIMINATION OF HEALTH CARE DISPARITIES, MEASUREMENT OF PROJECT OUTCOMES, THE DEGREE TO WHICH PROJECT GOALS ARE BEING REACHED AND THE DEVELOPMENT OF ANY PLANS OR PROGRAMS. THE PPS MAY ESTABLISH RULES WITH RESPECT TO ITS COMMUNITY ADVISORY BOARD OR BOARDS.

(II) THE MEMBERS OF THE COMMUNITY ADVISORY BOARD OR BOARDS SHALL BE REPRESENTATIVES OF THE COMMUNITY, OR GEOGRAPHIC SERVICE AREAS, SERVED BY THE PPS, INCLUDING MEDICAID CONSUMERS ATTRIBUTED TO THAT PPS. THE PPS SHALL FILE WITH THE COMMISSIONER, AND FROM TIME TO TIME UPDATE, AN UP-TO-DATE LIST OF THE MEMBERS OF THE PPS'S COMMUNITY ADVISORY BOARD OR BOARDS, WHICH SHALL BE MADE AVAILABLE TO THE PUBLIC BY THE PPS ON ITS WEBSITE AND SHALL BE MADE AVAILABLE TO THE PUBLIC BY THE DEPARTMENT ON ITS WEBSITE.

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

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

(i) analysis of progress made toward DSRIP goals;

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

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

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

(v) a status update on project milestone progress;

(vi) information on project spending and budget;

(vii) analysis of impact on Medicaid beneficiaries served;

(viii) a summary of public engagement and public comments received;

(ix) a description of DSRIP funding applications that were denied;

(x) a description of all regulation waivers issued pursuant to paragraph [(e)] (F) of this subdivision; and

(xi) a summary of the statewide geographic distribution of funds.

(e) For periods on and after April first, two thousand fourteen the commissioner shall promptly make all DSRIP governing documents, including 1115 waiver standard terms and conditions, supporting attachments and detailed project descriptions, and all materials made available to the legislature pursuant to paragraph [(c)] (D) of this subdivision, available on the department's website. The commissioner shall also provide a detailed overview on the department's website of the opportunities for public comment on the DSRIP program.

(f) Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any

regulatory requirements as are necessary, consistent with applicable law, to allow applicants under this subdivision and paragraph (a) of subdivision two of section twenty-eight hundred twenty-five of this article to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the authorizing commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be described, including each regulations waived and the project it relates to, in the report provided pursuant to paragraph [(c)] (D) of this subdivision.

S 25. Section 365-l of the social services law is amended by adding 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 INFORMATION 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. Intentionally omitted.

S 27. Intentionally omitted.

S 28. Subdivisions 6 and 7 of section 369-gg of the social services law are renumbered subdivisions 7 and 8 and a new subdivision 6 is added to read as follows:

6. RATES OF PAYMENT. (A) THE COMMISSIONER SHALL SELECT AND 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 RATES 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 30-a. Subdivision 1 of section 364-j of the social services law is amended by adding a new paragraph (w) to read as follows:

(W) "SCHOOL-BASED HEALTH CENTER." A CLINIC LICENSED OR SPONSORED BY A FACILITY LICENSED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW, WHICH PROVIDES PRIMARY HEALTH CARE SERVICES WHICH MAY INCLUDE URGENT CARE, WELL CHILD CARE, REPRODUCTIVE HEALTH CARE, DENTAL CARE, BEHAVIORAL HEALTH SERVICES, VISION CARE, AND MANAGEMENT OF CHRONIC DISEASES TO CHILDREN AND ADOLESCENTS WITHIN AN ELEMENTARY, SECONDARY OR PREKINDERGARTEN PUBLIC SCHOOL SETTING.

S 30-b. Subdivision 2 of section 364-j of the social services law is amended by adding a new paragraph (d) to read as follows:

(D)(I) THE COMMISSIONER OF HEALTH IS AUTHORIZED TO INCLUDE THE SERVICES OF SCHOOL-BASED HEALTH CENTERS DESIGNATED BY THE COMMISSIONER OF HEALTH, IN THE MANAGED CARE PROGRAM PURSUANT TO THIS SECTION ON AND AFTER JULY FIRST, TWO THOUSAND FIFTEEN, COMMENCING WITH NO FEWER THAN THREE SCHOOL-BASED HEALTH CENTERS, THAT VOLUNTEER TO BE PART OF A PILOT PROJECT FOR A PERIOD OF TWO YEARS. THE COMMISSIONER OF HEALTH SHALL PROVIDE AN INTERIM REPORT ON THE IMPLEMENTATION OF THE PILOT PROJECT TO

THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ON OR BEFORE JULY FIRST, TWO THOUSAND SIXTEEN. THE COMMISSIONER OF HEALTH SHALL PROVIDE A FINAL REPORT ON THE IMPLEMENTATION OF THE PILOT PROJECT TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ON OR BEFORE JANUARY FIRST, TWO THOUSAND SEVENTEEN. SUCH INTERIM AND FINAL REPORTS SHALL INCLUDE BUT NOT BE LIMITED TO INFORMATION CONCERNING ACCESS BY CHILDREN AND ADOLESCENTS TO PRIMARY HEALTH CARE SERVICES, URGENT CARE SERVICES, SERVICES FOR THE MANAGEMENT OF CHRONIC DISEASE, WELL CHILD CARE, AND DENTAL CARE, AND THE TIMELINESS AND ADEQUACY OF PAYMENT TO SCHOOL-BASED HEALTH CENTERS BY MANAGED CARE PROVIDERS.

(II) ON AND AFTER JULY FIRST, TWO THOUSAND SEVENTEEN, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO INCLUDE THE SERVICES OF SCHOOL-BASED HEALTH CENTERS IN THE MANAGED CARE PROGRAM ON A PHASED-IN SCHEDULE BASED ON GEOGRAPHY AND THE CAPABILITY OF THE SCHOOL-BASED HEALTH CENTER AND THE MANAGED CARE PROVIDER TO PARTICIPATE IN THE PROGRAM. SUCH ASSESSMENT OF CAPABILITY TO PARTICIPATE IN THE PROGRAM SHALL BE MADE BY THE COMMISSIONER OF HEALTH AFTER CONSULTATION WITH THE INVOLVED SCHOOL-BASED HEALTH CENTER, THE ORGANIZATION SPONSORING THE SCHOOL-BASED HEALTH CENTER, IF ANY, AND THE MANAGED CARE PROVIDER. THE COMMISSIONER OF HEALTH SHALL TAKE INTO CONSIDERATION ANY RELEVANT FINDINGS OF THE FINAL AND INTERIM REPORTS.

(III) THIS PARAGRAPH SHALL NOT APPLY TO BEHAVIORAL HEALTH AND REPRODUCTIVE HEALTH CARE SERVICES PROVIDED BY SCHOOL-BASED HEALTH CENTERS.

S 30-c. Subdivision 3 of section 364-j of the social services law is amended by adding a new paragraph (d-2) to read as follows:

(D-2)(I) HEALTH CARE SERVICES PROVIDED BY SCHOOL-BASED HEALTH CENTERS SHALL NOT BE PROVIDED TO MEDICAL ASSISTANCE RECIPIENTS THROUGH MANAGED CARE PROGRAMS ESTABLISHED UNDER THIS SECTION, EXCEPT AS AUTHORIZED UNDER PARAGRAPH (D) OF SUBDIVISION TWO OF THIS SECTION.

(II) BEHAVIORAL HEALTH AND REPRODUCTIVE HEALTH CARE SERVICES PROVIDED BY SCHOOL-BASED HEALTH CENTERS SHALL NOT BE PROVIDED TO MEDICAL ASSISTANCE RECIPIENTS THROUGH MANAGED CARE PROGRAMS ESTABLISHED UNDER THIS SECTION.

(III) WHERE HEALTH CARE SERVICES ARE PROVIDED BY SCHOOL-BASED HEALTH CENTERS TO MEDICAL ASSISTANCE OTHER THAN THROUGH THE MANAGED CARE PROGRAM, THE SERVICES SHALL BE PAID FOR IN ACCORDANCE WITH APPLICABLE REIMBURSEMENT METHODOLOGIES. APPLICABLE REIMBURSEMENT METHODOLOGIES SHALL MEAN:

(A) FOR SCHOOL-BASED HEALTH CENTERS SPONSORED BY A FEDERALLY QUALIFIED HEALTH CENTER, RATES OF REIMBURSEMENT AND REQUIREMENTS IN ACCORDANCE WITH THOSE MANDATED BY 42 U.S.C. SECS. 1396A(BB), 1396(M)(2)(A)(IX) AND 1936(A)(13)(C); AND

(B) FOR SCHOOL-BASED HEALTH CENTERS SPONSORED BY AN ENTITY LICENSED PURSUANT TO ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW THAT IS NOT A FEDERALLY QUALIFIED HEALTH CENTER, RATES OF REIMBURSEMENT AT THE OTHERWISE-APPLICABLE AMBULATORY PATIENT GROUP RATE FOR THE SERVICE.

(C) FOR THE PURPOSES OF THIS PARAGRAPH, THE TERM "BEHAVIORAL HEALTH SERVICES" SHALL MEAN BEHAVIORAL HEALTH SERVICES INCLUDING: PRIMARY PREVENTION, INDIVIDUAL MENTAL HEALTH ASSESSMENT, TREATMENT AND FOLLOW-UP, CRISIS INTERVENTION, GROUP AND FAMILY COUNSELING, AND SHORT AND LONG-TERM COUNSELING; BEHAVIORAL HEALTH SERVICES ARE HEALTH CARE SERVICES.

S 30-d. The social services law is amended by adding a new section 364-j-3 to read as follows:

S 364-J-3. INDEPENDENT CONSUMER ADVOCACY NETWORK. 1. THERE IS HEREBY ESTABLISHED IN THE DEPARTMENT OF HEALTH AN INDEPENDENT OMBUDSMAN PROGRAM

KNOWN AS THE INDEPENDENT CONSUMER ADVOCACY NETWORK (REFERRED TO IN THIS SECTION AS "ICAN") TO PROVIDE COMMUNITY CONTACT AND INVOLVEMENT WITH ENROLLEES IN MEDICAID MANAGED CARE PROGRAMS UNDER THIS ARTICLE AND ARTICLE FORTY-FOUR OF THE PUBLIC HEALTH LAW, AND ANY OTHER MEDICAID COORDINATED CARE PROGRAM; APPLICANTS AND RECIPIENTS WHO MAY BE ELIGIBLE FOR ENROLLMENT IN ANY OF THOSE MEDICAID PROGRAMS; AND REPRESENTATIVES, ADVOCATES, CAREGIVERS, AND FAMILY MEMBERS OF THOSE ENROLLEES, APPLICANTS, AND RECIPIENTS. THE COMMISSIONER OF HEALTH SHALL DESIGNATE (WHICH MAY BE DONE THROUGH A REQUEST FOR PROPOSALS PROCESS BEING UNDERTAKEN (UPON THE EFFECTIVE DATE OF THIS SECTION) AND CONTRACT WITH AN ENTITY TO FUNCTION AS THE ICAN. THE ENTITY SHALL BE A NOT-FOR-PROFIT CORPORATION WITH EXPERIENCE ADMINISTERING A STATEWIDE PROGRAM OF ASSISTING AND ADVOCATING FOR CONSUMERS IN MATTERS RELATING TO HEALTH COVERAGE AND A DEMONSTRATED ABILITY TO ASSEMBLE AND MANAGE A STATEWIDE NETWORK OF PARTICIPATING ORGANIZATIONS IN THAT PROGRAM. UNLESS THE CONTEXT CLEARLY REQUIRES OTHERWISE, AS USED IN THIS SECTION, "ICAN ENTITY" SHALL MEAN THE ENTITY DESIGNATED UNDER THIS SUBDIVISION AND ANY PARTICIPATING ORGANIZATION OF THE ENTITY. THE ICAN ENTITY SHALL BE AUTHORIZED TO CONDUCT ACTIVITIES INCLUDING, BUT NOT LIMITED TO:

(A) EDUCATING AND CONSULTING WITH ENROLLEES, APPLICANTS, RECIPIENTS, REPRESENTATIVES, ADVOCATES, FAMILY MEMBERS, CAREGIVERS, RESIDENT COUNCILS OF FACILITIES HOUSING A SUBSTANTIAL NUMBER OF MEDICAID APPLICANTS OR RECIPIENTS, AND COMMUNITY GROUPS IN RELATION TO ENROLLEE, APPLICANT AND INDIVIDUAL RIGHTS, MEDICAL ASSISTANCE PROGRAM OPTIONS, BENEFITS, ASSESSMENT, APPEALS, AND ADVERSE EVENTS;

(B) INVESTIGATING AND RESOLVING COMPLAINTS MADE BY OR ON BEHALF OF ENROLLEES, APPLICANTS, AND RECIPIENTS RELATING TO MATTERS THAT MAY AFFECT THE HEALTH, SAFETY, WELFARE, AND RIGHTS OF THESE INDIVIDUALS;

(C) REPRESENTING ENROLLEES, APPLICANTS, AND RECIPIENTS OR THEIR DESIGNATED REPRESENTATIVES IN GRIEVANCES, APPEALS, AND OTHER LEGAL PROCEEDINGS; AND

(D) UNDERTAKING PUBLIC ADVOCACY.

2. THE ICAN ENTITY, IN CONDUCTING THE PROGRAM, SHALL:

(A) FUNCTION WITH INDEPENDENCE FROM STATE AND LOCAL GOVERNMENTS, HEALTH PLANS, AND OTHER INDUSTRY STAKEHOLDERS;

(B) BE CULTURALLY COMPETENT FOR THE POPULATION SERVED;

(C) COLLECT DATA ON THE CASES HANDLED;

(D) COORDINATE AS NEEDED WITH THE EXISTING LONG TERM CARE OMBUDSMAN ON MATTERS RELATING TO THE LONG TERM CARE OMBUDSMAN'S WORK; AND

(E) REPORT ANNUALLY OR AT THE REQUEST OF THE COMMISSIONER OF HEALTH ON ALL PROGRAM ACTIVITIES.

3. THE COMMISSIONER OF HEALTH SHALL:

(A) ENSURE THE ICAN ENTITY IS SUFFICIENTLY FUNDED TO CARRY OUT ITS FUNCTIONS UNDER THIS SECTION;

(B) IMPLEMENT A SYSTEM OF INFORMATION SHARING AND COORDINATION AMONG THE DEPARTMENT OF HEALTH, THE ICAN ENTITY, AND THE LONG TERM CARE OMBUDSMAN PROGRAM;

(C) REQUIRE HEALTH PLANS IN THE MEDICAL ASSISTANCE PROGRAM TO:

(I) COOPERATE WITH THE ICAN ENTITY; AND

(II) APPOINT AN INTERNAL OMBUDSMAN TO HELP ENROLLEES, APPLICANTS, RECIPIENTS, REPRESENTATIVES, CAREGIVERS AND FAMILY MEMBERS WITH INTERNAL PLAN ADVOCACY AND TO WORK WITH THE ICAN ENTITY AND OTHER CONSUMER ADVOCACY PROGRAMS.

(D) REPORT, AT LEAST ONCE EVERY TWO YEARS, TO THE GOVERNOR AND THE LEGISLATURE ON THE WORK OF THE ICAN ENTITY, AND MAKE THE REPORT AVAILABLE ON THE DEPARTMENT OF HEALTH'S WEBSITE.

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 of 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 MIDWAY POINT BETWEEN 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 AND THE AMOUNT THAT WOULD OTHERWISE BE PAID BY PART B OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT; 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 REPRESENTING THE MIDWAY POINT BETWEEN THE AMOUNT THAT WOULD OTHERWISE BE MADE UNDER THIS TITLE IF PROVIDED TO AN ELIGIBLE PERSON WHO IS NOT A BENEFICIARY UNDER PART B OR A QUALIFIED MEDICARE BENEFICIARY AND THE AMOUNT THAT WOULD OTHERWISE BE PAID BY PART C OF TITLE XVIII OF THE FEDERAL SOCIAL SECURITY ACT, LESS THE AMOUNT PAYABLE BY THE PART C HEALTH PLAN.

S 33. Intentionally omitted.

S 34. The commissioner of health is authorized 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 INCLUDING MEDICAL ASSISTANCE. 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.

S 36. Section 364-i of the social services law is amended by adding a new subdivision 1-a to read as follows:

1-A. (A) AN INDIVIDUAL, UPON APPLICATION FOR MEDICAL ASSISTANCE, SHALL BE PRESUMPTIVELY ELIGIBLE FOR IMMEDIATE TEMPORARY PERSONAL CARE OR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES PURSUANT TO PARAGRAPH (E) OF SUBDIVISION TWO OF SECTION THREE HUNDRED SIXTY-FIVE-A OF THIS TITLE OR SECTION THREE HUNDRED SIXTY-FIVE-F OF THIS TITLE, RESPECTIVELY, FROM THE DATE OF APPLICATION, PROVIDED THAT:

(I) SUCH INDIVIDUAL SUBMITS: (A) AN APPLICATION FOR MEDICAL ASSISTANCE, AND (B) A PHYSICIAN'S ORDER THAT (I) RECOMMENDS THE NUMBER OF HOURS OF PERSONAL CARE OR CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES TO BE AUTHORIZED AS IMMEDIATE TEMPORARY PERSONAL CARE SERVICES; (II) DOCUMENTS THAT SUCH INDIVIDUAL NEEDS ASSISTANCE IN THE HOME WITH ONE OR MORE OF TOILETING, TRANSFERRING FROM BED TO CHAIR OR WHEELCHAIR, TURNING OR POSITIONING IN BED, WALKING, OR FEEDING; AND (III) DOCUMENTS THAT IT IS REASONABLY EXPECTED THAT THE INDIVIDUAL'S HEALTH AND SAFETY CAN BE MAINTAINED IN THE HOME; AND

(II) IT REASONABLY APPEARS THAT THE APPLICANT IS OTHERWISE ELIGIBLE TO RECEIVE MEDICAL ASSISTANCE.

(B) MEDICAL ASSISTANCE UNDER THIS SUBDIVISION SHALL BE AVAILABLE TO MEET THE IMMEDIATE NEEDS OF THE INDIVIDUAL PRIOR TO AND AFTER A DETERMINATION THAT SUCH INDIVIDUAL MEETS THE ELIGIBILITY REQUIREMENTS OF THIS TITLE AND UNTIL SUCH INDIVIDUAL EITHER (I) HAS BEEN DETERMINED TO BE FINANCIALLY OR OTHERWISE INELIGIBLE FOR MEDICAL ASSISTANCE OR FOR MEDICAL SERVICES OR SUPPLIES, OR (II) COMMENCES RECEIVING APPROPRIATE COMMUNITY BASED LONG-TERM CARE SERVICES UNDER THE MEDICAL ASSISTANCE PROGRAM.

S 36-a. Subdivision 7 of section 364-i of the social services law is REPEALED.

S 37. Notwithstanding any provision of law to the contrary, monies equal to the amount of enhanced federal medical assistance percentage monies available as a result of the state's participation in the community first choice state plan option under section 1915 of title XIX of the federal social security act, in each state fiscal year shall be made available as additional funds to be used to implement the state's comprehensive plan for serving New Yorkers with disabilities in the most integrated setting, also know as the state's Olmstead plan. Such monies shall be expended for the purposes consistent with the Olmstead plan, including, additional funding for supportive housing, wage supports for home and personal care workers, transportation supports, and the transition of behavioral health services to managed care. The department of health shall, after consultation with stakeholders, relevant state agencies, the division of budget and the Olmstead cabinet, submit a report to the temporary president of the senate, and the speaker of the assembly, the chair of the senate finance committee, the chair of the assembly ways and means committee, and the chairs of the senate and assembly health committees, setting forth the plan to allocate such investments, and no expenditures may be made from these funds until the plan has been approved by the temporary president of the senate and the speaker of the assembly. The commissioner of health shall report annually to the chairs of the assembly and senate committees on health, aging, and mental health, the chair of the senate committee on finance, the chair of the assembly ways and means committee, and the chair of the assembly task force on people with disabilities on the amount of funding received and disbursed pursuant to this section, the projects or proposals supported by these funds, and compliance with this section.

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

27. FOR PERIODS ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, THE COMMISSIONER SHALL AUTHORIZE AN ENERGY EFFICIENCY AND/OR DISASTER PREPAREDNESS STUDY FOR RESIDENTIAL HEALTH CARE FACILITIES.

S 39. Intentionally omitted.

S 40. Intentionally omitted.

S 40-a. Subdivision 8 of section 4403-f of the public health law, as amended by section 21 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

8. Payment rates for managed long term care plan enrollees eligible for medical assistance. The commissioner shall establish payment rates for services provided to enrollees eligible under title XIX of the federal social security act. Such payment rates shall be subject to approval by the director of the division of the budget and shall reflect savings to both state and local governments when compared to costs which would be incurred by such program if enrollees were to receive comparable health and long term care services on a fee-for-service basis in the geographic region in which such services are proposed to be provided. Payment rates shall be risk-adjusted to take into account the characteristics of enrollees, or proposed enrollees, including, but not limited to: frailty, disability level, health and functional status, age, gender, the nature of services provided to such enrollees, and other factors as determined by the commissioner. The risk adjusted premiums may also be combined with disincentives or requirements designed to mitigate any incentives to obtain higher payment categories. IN SETTING SUCH PAYMENT RATES, THE COMMISSIONER SHALL CONSIDER COSTS BORNE BY THE MANAGED CARE PROGRAM UNDER SUBDIVISION NINE OF SECTION FORTY-FOUR HUNDRED SIX-C OF THIS ARTICLE.

S 40-b. Section 4406-c of the public health law is amended by adding a new subdivision 9 to read as follows:

9. (A) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, ANY CONTRACTOR ADMINISTRATIVE SERVICE AGREEMENT BY A HEALTH CARE PLAN WITH CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES AGENCIES, OR FISCAL INTERMEDIARIES IN THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM SHALL ENSURE THAT RESOURCES MADE AVAILABLE BY A HEALTH CARE PLAN UNDER SUCH CONTRACTS OR AGREEMENTS WILL SUPPORT THE RETENTION OF A QUALIFIED WORKFORCE CAPABLE OF PROVIDING QUALITY CARE.

(B) SUCH CONTRACTS SHALL REQUIRE THAT RATES SHALL: (I) IN THE CASE OF CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES AGENCIES LICENSED OR CERTIFIED UNDER ARTICLE THIRTY-SIX OF THIS CHAPTER, SUFFICIENTLY SUPPORT HOME CARE WORKER WAGE PARITY COMPENSATION AS REQUIRED UNDER SECTION THIRTY-SIX HUNDRED FOURTEEN-C OF THIS CHAPTER; RECRUITMENT, TRAINING AND RETENTION OF DIRECT CARE PERSONNEL, INCLUDING WAGE, SALARY AND A SUPPLEMENTAL-BENEFIT RATE, WHICH MAY BE PROVIDED IN ANY COMBINATION OF CASH OR BENEFITS, IN BOTH WAGE PARITY AND NON-WAGE PARITY REGIONS, THE COSTS FOR WHICH SHALL BE DEMONSTRATED BY SUCH AGENCIES, AND THE PROVISION OF PAYMENTS TO SUCH AGENCIES AND PROGRAMS UNDER PARAGRAPH (BB) OF SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED SEVEN-V OF THIS CHAPTER, SUBDIVISIONS EIGHT, NINE AND TEN OF SECTION THIRTY-SIX HUNDRED FOURTEEN OF THIS CHAPTER AND SECTION THREE HUNDRED SIXTY-SEVEN-Q OF THE SOCIAL SERVICES LAW; ALL AS APPLICABLE; AND

(II) IN THE CASE OF THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM, SUPPORT FISCAL INTERMEDIARIES TO COMPENSATE CONSUMER DIRECTED PERSONAL ASSISTANTS UNDER THE PROGRAM INCLUDING WAGE, SALARY AND A SUPPLEMENTAL BENEFIT RATE, WHICH MAY BE PROVIDED IN ANY COMBINATION OF CASH OR BENEFITS. NOTHING CONTAINED IN THIS SUBDIVISION SHALL SUPERSEDE OR DIMINISH THE TERMS OF A COLLECTIVE BARGAINING AGREEMENT.

(C) WHERE A HEALTH CARE PLAN IS NOT IN COMPLIANCE WITH THIS SUBDIVISION, THE HEALTH CARE PLAN MAY BE SUBJECT TO ANY SANCTIONS OR PENALTIES PERMITTED BY FEDERAL OR STATE LAWS AND REGULATIONS, INCLUDING REVOCATION OF THE HEALTH CARE PLAN'S AGREEMENT TO PARTICIPATE IN THE MEDICAL ASSISTANCE PROGRAM. FOR THOSE PATIENTS AFFECTED BY A HEALTH CARE PLAN'S NONCOMPLIANCE WITH THIS SUBDIVISION, THE COMMISSIONER SHALL ENSURE THAT SUCH PATIENTS WILL BE IMMEDIATELY COVERED BY ANOTHER MANAGED HEALTH CARE PLAN OR FEE FOR SERVICE. THIS PARAGRAPH SHALL NOT PRECLUDE ANY OTHER RIGHT OR REMEDY AVAILABLE TO ANY OTHER PARTY.

(D) A HEALTH CARE PLAN THAT CONTRACTS WITH CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES AGENCIES, OR FISCAL INTERMEDIARIES IN THE CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM SHALL ANNUALLY SUBMIT WRITTEN CERTIFICATION TO THE DEPARTMENT THAT IT IS IN COMPLIANCE WITH THIS SUBDIVISION AND THAT EACH SUCH HOME CARE PROVIDER OR FISCAL INTERMEDIARY WITH WHICH IT CONTRACTS IS IN COMPLIANCE WITH THIS SUBDIVISION. THE HEALTH CARE PLAN SHALL ANNUALLY OBTAIN AND SUBMIT TO THE DEPARTMENT WRITTEN CERTIFICATION FROM SUCH HOME CARE PROVIDER OR FISCAL INTERMEDIARY AND ANY OF ITS LABOR SUBCONTRACTORS WHICH ATTESTS THAT THE ENTITY AND THE SUBCONTRACTOR IS IN COMPLIANCE WITH THIS SUBDIVISION. ALL SUCH WRITTEN CERTIFICATIONS SHALL BE ON FORMS PREPARED BY THE DEPARTMENT. THE HEALTH CARE PLAN SHALL OBTAIN INFORMATION FROM THE HOME CARE PROVIDER OR FISCAL INTERMEDIARY AND THEIR LABOR SUBCONTRACTORS NECESSARY TO VERIFY COMPLIANCE WITH THIS SUBDIVISION. SUCH INFORMATION SHALL BE RETAINED BY THE HEALTH CARE PLAN

FOR NOT LESS THAN THREE YEARS, AND MADE AVAILABLE TO THE DEPARTMENT UPON REQUEST.

(E) A FAILURE BY A HOME CARE PROVIDER OR FISCAL INTERMEDIARY TO COMPLY WITH THIS SUBDIVISION OR WITH REGULATIONS THEREUNDER, WHERE THE HEALTH PLAN CONTRACT IS DETERMINED TO BE IN COMPLIANCE WITH THIS SUBDIVISION, SHALL SUBJECT THE NON-COMPLIANT EMPLOYER OR CONTRACTOR TO THE SANCTIONS AND ENFORCEMENT PROCESSES SET FORTH IN THE LABOR LAW OR PENALTIES AVAILABLE UNDER THIS ARTICLE OR SECTION THREE HUNDRED SIXTY-THREE-D OF THE SOCIAL SERVICES LAW.

S 40-c. Subdivision 18 of section 364-j of the social services law is amended by adding a new paragraph (c) to read as follows:

(C) IN SETTING SUCH REIMBURSEMENT METHODOLOGIES, THE DEPARTMENT SHALL CONSIDER COSTS BORNE BY THE MANAGED CARE PROGRAM UNDER SUBDIVISION NINE OF SECTION FORTY-FOUR HUNDRED SIX-C OF THE PUBLIC HEALTH LAW.

S 41. Intentionally omitted.

S 42. Subdivision 12 of section 367-a of the social services law, as amended by section 63-a of part C of chapter 58 of the laws of 2007, is amended to read as follows:

12. Prior to receiving medical assistance under subparagraphs [twelve] FIVE and [thirteen] SIX of paragraph [(a)] (C) of subdivision one of section three hundred sixty-six of this title, a person whose net available income is at least one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, must pay a monthly premium, in accordance with a procedure to be established by the commissioner. The amount of such premium shall be twenty-five dollars for an individual who is otherwise eligible for medical assistance under such subparagraphs, and fifty dollars for a couple, both of whom are otherwise eligible for medical assistance under such subparagraphs. No premium shall be required from a person whose net available income is less than one hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services.

S 43. Intentionally omitted.

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

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

required to document and demonstrate the effective use of funds distributed herein. IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE, THEN THE NONFEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

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

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

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

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

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

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

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

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

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

S 365-D. HEALTH TECHNOLOGY ASSESSMENT COMMITTEE. 1. THE DEPARTMENT OF HEALTH SHALL CONVENE A HEALTH TECHNOLOGY ASSESSMENT COMMITTEE. THE COMMITTEE SHALL, AT THE REQUEST OF THE COMMISSIONER OF HEALTH, PROVIDE ADVICE AND MAKE RECOMMENDATIONS REGARDING COVERAGE OF HEALTH TECHNOLOGY FOR PURPOSES OF THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER OF HEALTH SHALL CONSULT SUCH COMMITTEE PRIOR TO ANY DETERMINATION TO EXCLUDE FROM COVERAGE ANY HEALTH TECHNOLOGY FROM THE MEDICAL ASSISTANCE

PROGRAM. FOR PURPOSES OF THIS SECTION, "HEALTH TECHNOLOGY" MEANS MEDICAL DEVICES AND SURGICAL PROCEDURES USED IN THE PREVENTION, DIAGNOSIS AND TREATMENT OF DISEASE AND OTHER MEDICAL CONDITIONS. THIS SECTION DOES NOT GRANT THE COMMISSIONER OF HEALTH ANY AUTHORITY TO EXCLUDE ANY MEDICAL TECHNOLOGY FROM THE MEDICAL ASSISTANCE PROGRAM OTHER THAN AUTHORITY THE COMMISSIONER OF HEALTH MIGHT HAVE UNDER OTHER LAW.

2. (A) THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL CONSIST OF THIRTEEN MEMBERS, WHO SHALL BE APPOINTED BY THE COMMISSIONER OF HEALTH AND WHO SHALL SERVE THREE YEAR TERMS; EXCEPT THAT FOR THE INITIAL APPOINTMENTS TO THE COMMITTEE, FIVE MEMBERS SHALL SERVE ONE YEAR TERMS, FIVE MEMBERS SHALL SERVE TWO YEAR TERMS, AND THREE MEMBERS SHALL SERVE THREE YEAR TERMS. COMMITTEE MEMBERS MAY BE REAPPOINTED UPON THE COMPLETION OF THEIR TERMS. WITH THE EXCEPTION OF THE CHAIRPERSON, NO MEMBER OF THE COMMITTEE SHALL BE AN EMPLOYEE OF THE STATE OR ANY POLITICAL SUBDIVISION OF THE STATE, OTHER THAN FOR HIS OR HER MEMBERSHIP ON THE COMMITTEE, EXCEPT FOR EMPLOYEES OF HEALTH CARE FACILITIES OR UNIVERSITIES OPERATED BY THE STATE, A PUBLIC BENEFIT CORPORATION, THE STATE UNIVERSITY OF NEW YORK OR MUNICIPALITIES.

(B) THE MEMBERSHIP OF SUCH COMMITTEE SHALL BE AS FOLLOWS:

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

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

(III) ONE PERSON WHO IS A REPRESENTATIVE OF A HEALTH TECHNOLOGY OR MEDICAL DEVICE ORGANIZATION WITH A REGIONAL, STATEWIDE OR NATIONAL CONSTITUENCY AND WHO IS A HEALTH CARE PROFESSIONAL LICENSED UNDER TITLE EIGHT OF THE EDUCATION LAW;

(IV) ONE PERSON WITH EXPERTISE IN HEALTH TECHNOLOGY ASSESSMENT WHO IS A HEALTH CARE PROFESSIONAL LICENSED UNDER TITLE EIGHT OF THE EDUCATION LAW;

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

(VI) A MEMBER OF THE DEPARTMENT OF HEALTH WHO SHALL ACT AS CHAIRPERSON AS DESIGNATED BY THE COMMISSIONER OF HEALTH.

3. THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL BE A PUBLIC BODY UNDER ARTICLE SEVEN OF THE PUBLIC OFFICERS LAW AND SUBJECT TO ARTICLE SIX OF THE PUBLIC OFFICERS LAW. THE DEPARTMENT OF HEALTH SHALL PROVIDE INTERNET ACCESS TO ALL MEETINGS OF SUCH COMMITTEE THROUGH THE DEPARTMENT OF HEALTH'S WEBSITE.

4. THE MEMBERS OF THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL RECEIVE NO COMPENSATION FOR THEIR SERVICES BUT SHALL BE REIMBURSED FOR EXPENSES ACTUALLY AND NECESSARILY INCURRED IN THE PERFORMANCE OF THEIR DUTIES. COMMITTEE MEMBERS SHALL BE DEEMED TO BE EMPLOYEES OF THE DEPARTMENT OF HEALTH FOR PURPOSES OF SECTION SEVENTEEN OF THE PUBLIC OFFICERS LAW, AND SHALL NOT PARTICIPATE IN ANY MATTER FOR WHICH A CONFLICT OF INTEREST EXISTS.

5. THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL, AT THE REQUEST OF THE COMMISSIONER OF HEALTH, CONSIDER ANY MATTER RELATING TO HEALTH TECHNOLOGY ASSESSMENT. THE COMMISSIONER OF HEALTH SHALL PROVIDE THIRTY DAYS PUBLIC NOTICE ON THE DEPARTMENT OF HEALTH'S WEBSITE PRIOR TO ANY MEETING OF THE COMMITTEE TO DEVELOP RECOMMENDATIONS CONCERNING HEALTH TECHNOLOGY COVERAGE DETERMINATIONS. SUCH NOTICE SHALL INCLUDE A DESCRIPTION OF THE PROPOSED HEALTH TECHNOLOGY TO BE REVIEWED, THE CONDITIONS OR DISEASES IMPACTED BY THE HEALTH TECHNOLOGY, AND THE PROPOSALS TO BE CONSIDERED BY

THE COMMITTEE. THE COMMITTEE SHALL ALLOW INTERESTED PARTIES A REASONABLE OPPORTUNITY TO MAKE AN ORAL PRESENTATION TO THE COMMITTEE RELATED TO THE HEALTH TECHNOLOGY TO BE REVIEWED AND TO SUBMIT WRITTEN INFORMATION. THE COMMITTEE SHALL CONSIDER ANY INFORMATION PROVIDED BY ANY INTERESTED PARTY, INCLUDING, BUT NOT LIMITED TO, HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, PATIENTS, CONSUMERS AND MANUFACTURERS.

6. THE COMMISSIONER OF HEALTH SHALL PROVIDE NOTICE OF ANY COVERAGE RECOMMENDATIONS DEVELOPED BY THE COMMITTEE BY MAKING SUCH INFORMATION AVAILABLE ON THE DEPARTMENT OF HEALTH'S WEBSITE. SUCH PUBLIC NOTICE SHALL INCLUDE: A SUMMARY OF THE DELIBERATIONS OF THE COMMITTEE; A SUMMARY OF THE POSITIONS OF THOSE MAKING PUBLIC COMMENTS AT MEETINGS OF THE COMMITTEE; THE RESPONSE OF THE COMMITTEE TO THOSE COMMENTS, IF ANY; THE CLINICAL EVIDENCE UPON WHICH THE COMMITTEE BASES ITS RECOMMENDATION; AND THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE.

7. THE COMMISSIONER OF HEALTH SHALL PROVIDE PUBLIC NOTICE ON THE DEPARTMENT OF HEALTH'S WEBSITE OF HIS OR HER FINAL DETERMINATION, INCLUDING: THE NATURE OF THE DETERMINATION; AN ANALYSIS OF THE IMPACT OF THE COMMISSIONER OF HEALTH'S DETERMINATION ON STATE PUBLIC HEALTH PLAN POPULATIONS AND PROVIDERS; AND THE PROJECTED FISCAL IMPACT TO THE STATE PUBLIC HEALTH PLAN PROGRAMS OF THE COMMISSIONER OF HEALTH'S DETERMINATION. THE COMMISSIONER OF HEALTH'S FINAL DETERMINATION SHALL NOT OCCUR PRIOR TO THE THIRTIETH DAY FROM THE POSTING OF THE COMMITTEE'S RECOMMENDATIONS AND FINDINGS ON THE DEPARTMENT OF HEALTH'S WEBSITE.

8. THE RECOMMENDATIONS OF THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE, MADE PURSUANT TO THIS SECTION, SHALL BE BASED ON CLINICAL EFFECTIVENESS AND SAFETY. THE COMMITTEE SHALL TRIENNIALLY REVIEW PREVIOUS RECOMMENDATIONS OF THE COMMITTEE AND PERMIT ORAL PRESENTATIONS AND THE SUBMISSION OF NEW EVIDENCE AT SUCH TRIENNIAL REVIEW. SUCH REVIEW SHALL OCCUR PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISIONS FIVE AND SIX OF THIS SECTION. THE COMMISSIONER OF HEALTH MAY ALTER OR REVOKE HIS OR HER FINAL DETERMINATION AFTER SUCH TRIENNIAL REVIEW PURSUANT TO THE PROCEDURE ESTABLISHED IN SUBDIVISION SEVEN OF THIS SECTION.

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

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, and section thirty-eight of this act shall expire and be deemed repealed March 31, 2018 provided that:

1. section thirteen of this act shall take effect June 1, 2015;

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

3. the amendments made to section 2807-s of the public health law made by sections twenty-three-a and twenty-three-b of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

4. 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;

5. 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;

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

6-a. the amendments to subdivision eight of section forty-four hundred three-f of the public health law made by section forty-a of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

7. 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;

8. 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;

9. 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;

10. 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

11. 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 ESTABLISHING SUCH FEES. SUCH AMBULATORY BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2017, PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED ABOVE, SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED. THE REPORT REQUIRED UNDER SECTION 16-A OF PART C OF CHAPTER 60 OF THE LAWS OF 2014 SHALL ALSO INCLUDE THE POPULATION OF PATIENTS ENROLLED IN THE CHILD HEALTH INSURANCE PROGRAM PURSUANT TO TITLE ONE-A OF ARTICLE 25 OF THE PUBLIC HEALTH LAW IN ITS EXAMINATION ON THE TRANSITION OF BEHAVIORAL HEALTH SERVICES INTO MANAGED CARE.

S 2. Section 1 of part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 15 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

Section 1. A. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under 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 ESTABLISHING SUCH FEES. SUCH AMBULATORY BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2017, PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED ABOVE, SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED. THE REPORT REQUIRED UNDER SECTION 16-A OF PART C OF CHAPTER 60 OF THE LAWS OF 2014 SHALL ALSO INCLUDE THE POPULATION OF PATIENTS ENROLLED IN THE CHILD HEALTH INSURANCE PROGRAM PURSUANT TO TITLE ONE-A OF ARTICLE 25 OF THE PUBLIC HEALTH LAW IN ITS EXAMINATION ON THE TRANSITION OF BEHAVIORAL HEALTH SERVICES INTO MANAGED CARE.

S 3. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

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

S 5. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect,

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

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

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

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

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

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

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

6. the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section one of this act shall not affect the repeal of such section and shall be deemed repealed therewith 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 section 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] 2017;

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

(vi) Notwithstanding any contrary provision of this paragraph or any other provision of law or regulation to the contrary, for residential health care facilities the assessment shall be six percent of each residential health care facility's gross receipts received from all patient care services and other operating income on a cash basis for the period April first, two thousand two through March thirty-first, two thousand three for hospital or health-related services, including adult day services; provided, however, that residential health care facilities' gross receipts attributable to payments received pursuant to title XVIII of the federal social security act (medicare) shall be excluded from the assessment; provided, however, that for all such gross receipts received on or after April first, two thousand three through March thirty-first, two thousand five, such assessment shall be five percent, and further provided that for all such gross receipts received on or after April first, two thousand five through March thirty-first, two thousand nine, and on or after April first, two thousand nine through March thirty-first, two thousand eleven such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand eleven through March thirty-first, two thousand thirteen such assessment shall be six percent, and further provided that for all such gross receipts received on or after April first, two thousand thirteen through March thirty-first, two thousand fifteen such assessment shall be six percent, AND FURTHER PROVIDED THAT FOR ALL SUCH GROSS RECEIPTS RECEIVED ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN SUCH ASSESSMENT SHALL BE SIX PERCENT.

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

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

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

1. Notwithstanding any inconsistent provision of law or regulation, the trend factors used to project reimbursable operating costs to the rate period for purposes of determining rates of payment pursuant to

article 28 of the public health law for residential health care facilities for reimbursement of inpatient services provided to patients eligible for payments made by state governmental agencies on and after April 1, 1996 through March 31, 1999 and for payments made on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007 and on and after April 1, 2007 through March 31, 2009 and on and after April 1, 2009 through March 31, 2011 and on and after April 1, 2011 through March 31, 2013 and on and after April 1, 2013 through March 31, 2015 , AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017 shall reflect no trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

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

1. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law and section 21 of chapter 1 of the laws of 1999, as amended, and any other inconsistent provision of law or regulation to the contrary, in determining rates of payments by state governmental agencies effective for services provided beginning April 1, 2006, through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017 for inpatient and outpatient services provided by general hospitals and for inpatient services and outpatient adult day health care services provided by residential health care facilities pursuant to article 28 of the public health law, the commissioner of health shall apply a trend factor projection of two and twenty-five hundredths percent attributable to the period January 1, 2006 through December 31, 2006, and on and after January 1, 2007, provided, however, that on reconciliation of such trend factor for the period January 1, 2006 through December 31, 2006 pursuant to paragraph (c) of subdivision 10 of section 2807-c of the public health law, such trend factor shall be the final US Consumer Price Index (CPI) for all urban consumers, as published by the US Department of Labor, Bureau of Labor Statistics less twenty-five hundredths of a percentage point.

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

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

for such period. This value shall be called the 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 statewide target percentage respectively.

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

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

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

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

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

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

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

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

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

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean January 1, 2013 through November 30, 2013, and the 2014 target period shall mean January 1, 2014 through November 30, 2014 and the 2015 target period shall mean January 1, 2015 through November 30, 2015 AND THE 2016 TARGET PERIOD SHALL MEAN JANUARY 1, 2016 THROUGH NOVEMBER 30, 2016, AND THE 2017 TARGET PERIOD SHALL MEAN JANUARY 1, 2017 THROUGH NOVEMBER 30, 2017.

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

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

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

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

regional and program differences in utilization of medicaid and medicare services, for the following regional groups shall be equal to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND 2017 for each regional group, if the medicaid revenue percentage for the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. (a) For each regional group, the 1996 state share reduction amount shall be allocated by the commissioner of health among CHHAs and LTHHCPs

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

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

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

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

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

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

and LTHHCPs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997.

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

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

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

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

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

5-a. Section sixty-four-a of this act shall be deemed to have been in full force and effect on and after April 1, 1995 through March 31, 1999 and on and after July 1, 1999 through March 31, 2000 and on and after April 1, 2000 through March 31, 2003 and on and after April 1, 2003 through March 31, 2007, and on and after April 1, 2007 through March 31, 2009, and on and after April 1, 2009 through March 31, 2011, and on and after April 1, 2011 through March 31, 2013, and on and after April 1, 2013 through March 31, 2015, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017;

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

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

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

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

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

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen and on and after April first, two thousand thirteen through March thirty-first, two thousand fifteen, AND ON AND AFTER APRIL 1, 2015 THROUGH MARCH 31, 2017 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] 2017 and provided further, that the amendments to the provisions of section 364-j of the social services law made by section eight of this act shall only apply to managed care programs approved on or after the effective date of this act;

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

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA)

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

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

(i) the amendments to paragraph (b) and subparagraph (i) of paragraph (g) of subdivision 7 of section 4403-f of the public health law made by section forty-one-b of this act shall expire and be repealed April 1, [2015] 2020;

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] 2020 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] SEVENTEEN, 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] FIVE 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. Intentionally omitted.

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 REPEALED.

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

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

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

(o) sections thirty-eight and thirty-eight-a of this act shall expire and be deemed repealed March 31, [2015] 2020;

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

S 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [2015] 2016 through March 31, [2015] 2016, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the [2015] 2016 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the

public health law, provided, however, that such no greater than zero trend factors attributable to such [2015] 2016 calendar year shall also be applied to rates of payment provided on and after January 1, [2015] 2016 through March 31, [2015] 2016 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, [2015] 2016 through March 31, [2015] 2016, such trend factors attributable to the [2015] 2016 calendar year shall be established at no greater than zero percent.

S 30. Notwithstanding any inconsistent provision of law, rule or regulation, for purposes of implementing the provisions of the public health law and the social services law, references to titles XIX and XXI of the federal social security act in the public health law and the social services law shall be deemed to include and also to mean any successor titles thereto under the federal social security act.

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

S 32. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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

1. the amendments to the opening paragraph of subdivision 7 of section 3614 of the public health law made by section fourteen of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

1-a. 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 thousand fourteen, is greater than five percent; and, for the calendar year beginning on January first, two thousand fifteen, is greater than seven and one-half percent, AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND SIXTEEN, IS GREATER THAN TEN PERCENT; AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND SEVENTEEN, IS GREATER THAN TWELVE AND ONE-HALF PERCENT; AND FOR THE CALENDAR YEAR BEGINNING ON JANUARY FIRST, TWO THOUSAND EIGHTEEN, IS GREATER THAN FIFTEEN PERCENT.

(D) NO LATER THAN THE FIRST OF JULY, TWO THOUSAND FIFTEEN, THE COMMISSIONER SHALL RECONVENE THE MEDICAL REDESIGN TEAM TECHNICAL ASSISTANCE TEAM ON INDIGENT CARE REFORM FORMED AS A RESULT OF RECOMMENDATION THREE OF THE MEDICAID REDESIGN TEAM PAYMENT REFORM AND QUALITY MEASUREMENT WORK GROUP, IN ORDER TO DEVELOP RECOMMENDATIONS TO, IN THE EVENT OF AGGREGATE REDUCTIONS IN FEDERAL MEDICAID DSH FUNDING, ADJUST, 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 IN THE CALENDAR YEAR FOLLOWING THE YEAR IN WHICH SUCH REDUCTIONS IN MEDICAID DSH TAKE EFFECT. SUCH RECOMMENDATIONS SHALL SEEK TO TARGET, TO THE EXTENT PRACTICABLE, THE REMAINING FEDERAL MEDICAID DSH FUNDS TO SUPPORT FACILITIES THAT PROVIDE A DISPROPORTIONATE SHARE OF UNCOMPENSATED CARE TO THE UNINSURED, UNDERINSURED AND MEDICAID POPULATIONS. NO LATER THAN THE FIRST OF DECEMBER, TWO THOUSAND FIFTEEN, THE TECHNICAL ASSISTANCE TEAM SHALL PROVIDE ITS RECOMMENDATIONS TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, AND THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES, INCLUDING ANY ANALYSIS OF FACILITY IMPACTS BY REGION AND SPONSORSHIP AS WELL AS ANY ADDITIONAL INFORMATION IT DEEMS APPROPRIATE.

(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 THAT SHALL ALLOCATE A GREATER PROPORTION OF THE PAYMENTS TO THOSE HOSPITALS PROVIDING A DISPROPORTIONATE SHARE OF UNCOMPENSATED CARE TO THE UNINSURED, UNDERINSURED AND MEDICAID POPULATIONS.

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

Intentionally Omitted

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.

(H) NO HEALTH INSURER WRITING POLICIES IN THE INDIVIDUAL, GROUP, AND LARGE GROUP MARKETS, AS LIMITED BY SUBDIVISION (A) OF THIS SECTION, SHALL ISSUE A POLICY FOR A POLICYHOLDER REQUIRING THE PAYMENT OF THE ASSESSMENT FOR THE OPERATING EXPENSES OF THE NEW YORK HEALTH BENEFIT EXCHANGE BY ANY POLICYHOLDER OR MEMBER IN ADDITION TO THE REGULAR PREMIUM OR CONSIDERATION CHARGED THEREFORE; NOR SHALL ANY SUCH COMPANY HAVE POWER TO LEVY OR COLLECT FUNDS FOR THE NEW YORK HEALTH BENEFIT EXCHANGE ASSESSMENT FROM SUCH POLICYHOLDERS OR MEMBERS. THE NEW YORK HEALTH BENEFIT EXCHANGE ASSESSMENT SHALL BE CONSIDERED A COST OF OPERATION FOR SUCH HEALTH INSURERS AND THE HEALTH INSURER SHALL NOT CHARGE ANY ADDITIONAL FEE NOR INCREASE THE PREMIUM OF A POLICYHOLDER OR MEMBER AS A RESULT OF THE NEW YORK HEALTH BENEFIT EXCHANGE ASSESSMENT. WHEN APPROVING HEALTH INSURANCE PREMIUM INCREASES PROPOSED BY SUCH ACCIDENT AND HEALTH INSURERS THE SUPERINTENDENT SHALL ENSURE THAT NO PORTION OF SUCH PROPOSED PREMIUM INCREASE IS BASED UPON THE COST TO THE INSURER OF PAYING THE NEW YORK HEALTH BENEFIT EXCHANGE ASSESSMENT ESTABLISHED BY THIS SECTION.

S 2. Paragraphs (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. Intentionally omitted.

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 SHALL 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 civil practice law and rules is amended by adding a new section 4519-a to read as follows:
S 4519-A. POSSESSION OF CONDOMS; RECEIPT INTO EVIDENCE. POSSESSION OF A CONDOM MAY NOT BE RECEIVED IN EVIDENCE IN ANY TRIAL, HEARING OR PROCEEDING PURSUANT TO SUBDIVISION ONE OF SECTION TWELVE AND ARTICLE TEN OF THE MULTIPLE DWELLING LAW, SECTIONS TWELVE-A AND TWENTY-THREE HUNDRED TWENTY OF THE PUBLIC HEALTH LAW, SECTION TWO HUNDRED THIRTY-ONE OF THE REAL PROPERTY LAW OR SUBDIVISION FIVE OF SECTION SEVEN HUNDRED ELEVEN AND SECTION SEVEN HUNDRED FIFTEEN OF THE REAL PROPERTY ACTIONS AND PROCEEDINGS LAW AS EVIDENCE OF PROSTITUTION, PATRONIZING A PROSTITUTE, PROMOTING PROSTITUTION, PERMITTING PROSTITUTION, MAINTAINING A PREMISES FOR PROSTITUTION, LEWDNESS OR ASSIGNATION, OR MAINTAINING A BAWDY HOUSE.
S 2-a. 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 ANY OFFENSE, OR AN ATTEMPT TO COMMIT ANY OFFENSE, DEFINED IN ARTICLE TWO HUNDRED THIRTY 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 2-b. Section 841 of the executive law is amended by adding a new subdivision 7-b to read as follows:
7-B. TAKE SUCH STEPS AS MAY BE NECESSARY TO ENSURE THAT ALL POLICE OFFICERS AND PEACE OFFICERS CERTIFIED PURSUANT TO SUBDIVISION THREE OF THIS SECTION RECEIVE APPROPRIATE INSTRUCTION REGARDING THE EVIDENTIARY PROHIBITION SET FORTH IN SECTION 60.47 OF THE CRIMINAL PROCEDURE LAW RELATING TO THE INTRODUCTION OF CONDOMS INTO EVIDENCE IN CERTAIN CRIMINAL PROSECUTIONS;
S 3. The opening paragraph of section 220.03 of the penal law, as amended by chapter 154 of the laws of 2011, is amended to read as follows:
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]; 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] THIS ARTICLE, 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] THIS ARTICLE.

S 4. Section 220.45 of the penal law is REPEALED.

S 5. 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:

2. (A) "Drug-related paraphernalia" consists of the following objects used for the following purposes:

[(a)] (I) Kits, used or designed for the purpose of planting, propagating, cultivating, growing or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived;

[(b)] (II) Kits, used or designed for the purpose of manufacturing, compounding, converting, producing, or preparing controlled substances;

[(c)] (III) Isomerization devices, used or designed for the purpose of increasing the potency of any species of plant which is a controlled substance;

[(d)] (IV) Scales and balances, used or designed for the purpose of weighing or measuring controlled substances;

[(e)] (V) Diluents and adulterants, including but not limited to quinine hydrochloride, mannitol, mannite, dextrose and lactose, used or designed for the purpose of cutting controlled substances;

[(f)] (VI) Separation gins, used or designed for the purpose of removing twigs and seeds in order to clean or refine marihuana;

[(g) Hypodermic syringes, needles and other objects, used or designed for the purpose of parenterally injecting controlled substances into the human body;

(h)] AND

(VII) Objects, used or designed for the purpose of ingesting, inhaling, or otherwise introducing marihuana, cocaine, hashish, or hashish oil into the human body.

(B) "DRUG-RELATED PARAPHERNALIA" SHALL NOT INCLUDE HYPODERMIC NEEDLES, HYPODERMIC SYRINGES AND OTHER OBJECTS USED FOR THE PURPOSE OF PARENTERALLY INJECTING CONTROLLED SUBSTANCES INTO THE HUMAN BODY.

S 6. Section 3381 of the public health law, as amended by section 9-a of part B of chapter 58 of the laws of 2007, subdivisions 1, 2 and 3 as amended by chapter 178 of the laws of 2010, is amended to read as follows:

S 3381. Sale and possession of hypodermic syringes and hypodermic needles. 1. It shall be unlawful for any person to sell or furnish to another person or persons, a hypodermic syringe or hypodermic needle except:

(a) pursuant to a prescription of a practitioner, which for the purposes of this section shall include a patient specific prescription form as provided for in the education law; or

(b) to persons who have been authorized by the commissioner to obtain and possess such instruments; or

(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] FOUR of this section[.] ; OR

(D) UNDER SUBDIVISION THREE OF THIS SECTION.

2. [It shall be unlawful for any person to obtain or possess a hypodermic syringe or hypodermic needle unless such possession has been authorized by the commissioner or is pursuant to a prescription, or is pursuant to subdivision five of this section.

3.] Any person selling or furnishing a hypodermic syringe or hypodermic needle pursuant to a prescription shall record upon the prescription, his or her signature or electronic signature, and the date of the sale or furnishing of the hypodermic syringe or hypodermic needle. Such prescription shall be retained on file for a period of five years and be readily accessible for inspection by any public officer or employee engaged in the enforcement of this section. Such prescription may be refilled not more than the number of times specifically authorized by the prescriber upon the prescription, provided however no such authorization shall be effective for a period greater than two years from the date the prescription is signed.

[4] 3. The commissioner shall, subject to subdivision [five] FOUR of this section, designate persons, or by regulation, classes of persons who may obtain hypodermic syringes and hypodermic needles without prescription and the manner in which such transactions may take place and the records thereof which shall be maintained.

[5] 4. (a) A person eighteen years of age or older may obtain and possess a hypodermic syringe or hypodermic needle pursuant to paragraph (c) of subdivision one of this section.

(b) Subject to regulations of the commissioner, a pharmacy licensed under article one hundred thirty-seven of the education law, a 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, may obtain and possess hypodermic needles or syringes for the purpose of selling or furnishing them pursuant to paragraph (c) of subdivision one of this section or for the purpose of disposing of them[, provided that such pharmacy, health care facility or health care practitioner has registered with the department].

(c) Sale or furnishing of hypodermic syringes or hypodermic needles to direct consumers pursuant to this subdivision by a pharmacy, health care facility, or health care practitioner shall be accompanied by a safety insert. Such safety insert shall be developed or approved by the commissioner and shall include, but not be limited to, (i) information on the proper use of hypodermic syringes and hypodermic needles; (ii) the risk of blood borne diseases that may result from the use of hypodermic syringes and hypodermic needles; (iii) methods for preventing the transmission or contraction of blood borne diseases; (iv) proper hypodermic syringe and hypodermic needle disposal practices; (v) information on the dangers of injection drug use, and how to access drug treatment; (vi) a

toll-free phone number for information on the human immunodeficiency virus; and (vii) information on the safe disposal of hypodermic syringes and hypodermic needles including the relevant provisions of the environmental conservation law relating to the unlawful release of regulated medical waste. The safety insert shall be attached to or included in the hypodermic syringe and hypodermic needle packaging, or shall be given to the purchaser at the point of sale or furnishing in brochure form.

(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.

(e) The commissioner shall promulgate rules and regulations necessary to implement the provisions of this subdivision which shall include: (I) STANDARDS FOR ADVERTISING TO THE PUBLIC THE AVAILABILITY FOR RETAIL SALE OR FURNISHING OF HYPODERMIC SYRINGES OR NEEDLES; AND (II) a requirement that such pharmacies, health care facilities and health care practitioners cooperate in a safe disposal of used hypodermic needles or syringes.

(f) The commissioner may, upon the finding of a violation of this section, suspend for a determinate period of time the sale or furnishing of syringes by a specific entity.

[6] 5. The provisions of this section shall not apply to farmers engaged in livestock production or to those persons supplying farmers engaged in livestock production, provided that:

(a) Hypodermic syringes and needles shall be stored in a secure, locked storage container.

(b) At any time the department may request a document outlining:

(i) the number of hypodermic needles and syringes purchased over the past calendar year;

(ii) a record of all hypodermic needles used over the past calendar year; and

(iii) a record of all hypodermic needles and syringes destroyed over the past calendar year.

(c) Hypodermic needles and syringes shall be destroyed in a manner consistent with the provisions set forth in section thirty-three hundred eighty-one-a of this article.

S 7. Intentionally omitted.

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 renumbered subparagraph (vi) and a new subparagraph (v) is added to read as follows:

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

DIABETES CARE, STERILE PROCEDURES, AND CENTRAL LINE MAINTENANCE SHALL BE PROHIBITED, AND PROVIDED FURTHER THAT A SYSTEM SHALL BE ESTABLISHED THAT ADDRESSES DRUG DIVERSION; (2) SPECIFY THAT PARTICIPATION IN THIS PROGRAM SHALL BE VOLUNTARY AND SUCH ADVANCED TASKS PROVIDED BY AN ADVANCED HOME HEALTH AIDE SHALL BE AT THE OPTION OF THE INDIVIDUAL; (3) 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 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 INITIAL AND THEREAFTER REGULAR AND ONGOING ASSESSMENT OF THE INDIVIDUAL'S NEEDS; PROVIDED THAT THE REGISTERED PROFESSIONAL NURSE RESPONSIBLE FOR SUPERVISING SUCH ADVANCED TASKS SHALL VISIT INDIVIDUALS RECEIVING ACUTE SERVICES NO LESS THAN ONCE PER MONTH AND INDIVIDUALS RECEIVING MAINTENANCE CARE NO LESS THAN ONCE EVERY SIX MONTHS AND PROVIDED FURTHER THAT A REGISTERED PROFESSIONAL NURSE SHALL BE AVAILABLE BY TELEPHONE TO THE ADVANCED HOME HEALTH AIDE TWENTY-FOUR HOURS A DAY, SEVEN DAYS A WEEK; THE COMMISSIONER OF HEALTH SHALL, IN CONSULTATION WITH THE COMMISSIONER, DETERMINE APPROPRIATE STAFFING RATIOS TO ENSURE ADEQUATE NURSING SUPERVISION THAT SHALL NOT EXCEED ONE FULL TIME EQUIVALENT OF A REGISTERED PROFESSIONAL NURSE TO FIFTY INDIVIDUALS RECEIVING SERVICES; (4) ESTABLISH A PROCESS BY WHICH A REGISTERED PROFESSIONAL NURSE MAY DELEGATE ADVANCED TASKS TO AN ADVANCED HOME HEALTH AIDE PROVIDED THAT SUCH PROCESS SHALL INCLUDE, BUT NOT BE LIMITED TO (A) ALLOWING DELEGATION OF ADVANCED TASKS TO AN ADVANCED HOME HEALTH AIDE ONLY WHERE SUCH ADVANCED HOME HEALTH AIDE HAS DEMONSTRATED TO THE SATISFACTION OF THE SUPERVISING REGISTERED PROFESSIONAL NURSE COMPETENCY IN EVERY ADVANCED TASK THAT SUCH ADVANCED HOME HEALTH AIDE IS AUTHORIZED TO PERFORM, (B) AUTHORIZING THE SUPERVISING REGISTERED PROFESSIONAL NURSE TO REVOKE ANY DELEGATED ADVANCED TASK FROM AN ADVANCED HOME HEALTH AIDE FOR ANY REASON, AND (C) AUTHORIZING MULTIPLE REGISTERED PROFESSIONAL NURSES TO JOINTLY AGREE TO DELEGATE ADVANCED TASKS TO AN ADVANCED HOME HEALTH AIDE, PROVIDED FURTHER THAT ONLY ONE REGISTERED PROFESSIONAL NURSE SHALL BE REQUIRED TO DETERMINE THE ADVANCED HOME HEALTH AIDE HAS DEMONSTRATED COMPETENCY IN THE ADVANCED TASK TO BE PERFORMED; (5) PROVIDE THAT ADVANCED TASKS MAY BE PERFORMED ONLY IN ACCORDANCE WITH AND PURSUANT TO AN AUTHORIZED PRACTITIONER'S ORDERED CARE; (6) 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 AS DETERMINED BY THE COMMISSIONER OF HEALTH, HAS SUCCESSFULLY COMPLETED COMPETENCY EXAMINATIONS SATISFACTORY TO AND DEVELOPED OR APPROVED BY THE COMMISSIONER OF HEALTH AND MEETS OTHER APPROPRIATE QUALIFICATIONS AS DETERMINED BY THE COMMISSIONER OF HEALTH MAY PERFORM ADVANCED TASKS AS AN ADVANCED HOME HEALTH AIDE; (7) 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; (8) 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 OF HEALTH; (9) 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; (10) 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; (11) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE IS NOT REQUIRED NOR PERMITTED TO ASSESS THE MEDICATION OR MEDICAL NEEDS OF AN INDIVIDUAL; (12) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE SHALL NOT BE AUTHORIZED TO PERFORM ANY ADVANCED TASKS OR ACTIVITIES PURSUANT TO THIS SUBPARAGRAPH THAT ARE OUTSIDE THE SCOPE OF PRACTICE OF A LICENSED PRACTICAL NURSE OR ANY ADVANCED TASKS THAT HAVE NOT BEEN APPROPRIATELY DELEGATED BY THE SUPERVISING REGISTERED PROFESSIONAL NURSE; (13) PROVIDE THAT AN ADVANCED HOME HEALTH AIDE SHALL DOCUMENT MEDICATION ADMINISTRATION TO EACH INDIVIDUAL THROUGH THE USE OF A MEDICATION ADMINISTRATION RECORD; (14) PROVIDE THAT THE SUPERVISING REGISTERED PROFESSIONAL NURSE SHALL RETAIN THE DISCRETION TO DECIDE WHETHER TO ASSIGN ADVANCED TASKS TO ADVANCED HOME HEALTH AIDES UNDER THIS PROGRAM AND THE ADVANCED HOME HEALTH AIDE SHALL RETAIN THE DISCRETION TO REFUSE A DELEGATED ADVANCED TASK AND SHALL NOT BE SUBJECT TO COERCION OR THE THREAT OF RETALIATION; (15) NOTWITHSTANDING ANY PROVISIONS OF SECTIONS SEVEN HUNDRED FORTY AND SEVEN HUNDRED FORTY-ONE OF THE LABOR LAW TO THE CONTRARY, THE PROTECTIONS PROVIDED IN SUCH SECTIONS SHALL APPLY TO INDIVIDUALS PROVIDING SUPERVISION OR ADVANCED TASKS PURSUANT TO THIS SUBPARAGRAPH; AND (16) PROVIDE THAT NO ADVANCED TASKS, OTHER THAN ADMINISTRATION OF MEDICATION, MAY BE PERFORMED PRIOR TO JANUARY FIRST, TWO THOUSAND SEVENTEEN; PROVIDED THAT IN DEVELOPING SUCH REGULATIONS, THE COMMISSIONER SHALL TAKE INTO ACCOUNT THE RECOMMENDATIONS OF A WORKGROUP OF STAKEHOLDERS CONVENED BY THE COMMISSIONER OF HEALTH IN CONSULTATION WITH THE COMMISSIONER FOR THE PURPOSE OF PROVIDING GUIDANCE ON THE FOREGOING; OR

S 2. Section 206 of the public health law is amended by adding a new subdivision 29 to read as follows:

29. THE COMMISSIONER SHALL NOTIFY THE COMMISSIONER OF EDUCATION IN ANY INSTANCE IN WHICH A REGISTERED PROFESSIONAL NURSE ENGAGES IN IMPROPER BEHAVIOR WHILE SUPERVISING AN ADVANCED HOME HEALTH AIDE PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH A OF SUBDIVISION ONE OF SECTION SIXTY-NINE HUNDRED EIGHT OF THE EDUCATION LAW.

S 3. 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 SIXTY-NINE HUNDRED EIGHT OF THE EDUCATION LAW AND REGULATIONS ISSUED BY THE COMMISSIONER OF EDUCATION RELATING THERETO. THE COMMISSIONER SHALL PROMULGATE REGULATIONS REGARDING SUCH AIDES, WHICH SHALL INCLUDE TRAINING, DEMONSTRATED COMPETENCIES, COMPETENCY EXAMINATIONS, AND OTHER APPROPRIATE QUALIFICATIONS, AS WELL AS A PROCESS FOR THE LIMITATION OR REVOCATION OF THE ADVANCED

HOME HEALTH AIDE'S AUTHORIZATION TO PERFORM ADVANCED TASKS IN APPROPRIATE CASES.

S 4. 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 SIXTY-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 5. 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 take into consideration 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 advanced tasks that appropriately could be performed by advanced home health aides with appropriate training and supervision;

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

(c) qualifications that must be satisfied by advanced home health aides to perform such 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.

On or before July 1, 2015, the commissioner of health shall, in consultation with the commissioner of education, issue a report to the governor and the chairs of the senate and assembly health and higher education committees setting forth the recommendations of the workgroup.

S 6. On or before January 1, 2019, the commissioner of health shall, in consultation with the commissioner of education, issue a report on the implementation of advanced home health aides in the state. Such report shall include the number of advanced home health aides authorized pursuant to this act; the types of advanced tasks that advanced home health aides are performing; the number of individuals who were moved out of institutionalized settings as a direct result of this act; the extent to which advanced home health aides contributed to the improvement of quality care of these individuals; the number of adverse outcomes, including medication errors, that were reported to the department of health; any reports of or issues with drug diversion; and the number of advanced home health aides who had their authorization limited or revoked. Such report shall provide recommendations to the governor and the chairs of the senate and assembly health and higher education committees regarding the extension and/or alteration of these provisions and make any other recommendations related to the implementation of advanced home health aides pursuant to this act.

S 7. This act shall take effect immediately; provided that:

a. section one of this act shall take effect January 1, 2016. Effective immediately, the commissioner of education is authorized to adopt or amend regulations necessary to implement the provisions of section one of this act on or before such effective date; provided, further, that no advanced tasks shall be performed pursuant to 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, until such regulations are adopted and except in conformance with such regulations; and

b. this act shall expire and be deemed repealed June 30, 2019.

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 informa-

tion 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 INCORPORA-

TOR, 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 6-a. The public health law is amended by adding a new section 2827 to read as follows:

S 2827. REDUCTION OF HOURS OR CLOSURE OF A HOSPITAL-SPONSORED OFF-CAMPUS EMERGENCY DEPARTMENT. A FULL CERTIFICATE OF NEED (CON) REVIEW IS REQUIRED FOR HOSPITAL-SPONSORED OFF-CAMPUS EMERGENCY DEPARTMENT REDUCTION OF HOURS OR CLOSURE. 1. NO LATER THAN SIX MONTHS FROM RECEIVING A PROPOSAL FROM A GENERAL HOSPITAL FOR THE REDUCTION OF HOURS OR CLOSURE OF AN EMERGENCY DEPARTMENT OF SUCH GENERAL HOSPITAL, THE COMMISSIONER SHALL INITIATE A FULL CON REVIEW FOR THE PURPOSE OF UNDERSTANDING THE IMPACT OF THE REDUCTION OF HOURS OR GENERAL HOSPITAL'S EMERGENCY DEPARTMENT CLOSURE ON ACCESS TO HEALTH CARE SERVICES OF MEMBERS OF THE SURROUNDING COMMUNITY, INCLUDING BUT NOT LIMITED TO, RECIPIENTS OF MEDICAL ASSISTANCE FOR NEEDY PERSONS, THE UNINSURED, AND UNDERSERVED POPULATIONS.

2. ANY HOSPITAL-SPONSORED OFF-CAMPUS EMERGENCY DEPARTMENT REDUCTION OF HOURS OR CLOSURE PENDING BEFORE THE DEPARTMENT OF HEALTH SHALL BE DELAYED AND SUBJECT TO THE PROVISIONS OF SUBDIVISION ONE OF THIS SECTION.

3. THIS SECTION SHALL ONLY APPLY TO HOSPITAL-SPONSORED OFF-CAMPUS EMERGENCY DEPARTMENTS LOCATED IN TOWNS WITH A POPULATION GREATER THAN TWELVE THOUSAND SIX HUNDRED AND LESS THAN TWELVE THOUSAND SEVEN HUNDRED ACCORDING TO THE 2010 U.S. DECENNIAL CENSUS.

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 OR OFFICE-BASED ANESTHESIA; (iii) unscheduled hospital admission OR ASSIGNMENT TO OBSERVATION SERVICES, within seventy-two hours of the office-based surgery OR OFFICE-BASED ANESTHESIA, 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 HEALTH CARE PROFESSIONAL ACTING WITHIN THE SCOPE OF PRACTICE OF HIS OR HER LICENSE OR CERTIFICATION UNDER TITLE EIGHT OF THE EDUCATION LAW 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 THE SUBSEQUENT 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 CERTIFICATION BY AN APPROPRIATE CERTIFYING ORGANIZATION, 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 department. The department may disclose reports of aggregate data to the public.

2. The information required to be collected, maintained and reported directly to the department AND 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 DETERMINATION TO DISCONTINUE FLUORIDATION OF THE WATER SUPPLY, INCLUDING THE DATE OF SUCH DISCONTINUANCE AND ALTERNATIVES TO FLUORIDATION, IF ANY, THAT WILL BE MADE AVAILABLE IN THE COMMUNITY, AND THAT INCLUDES INFORMATION AS MAY BE REQUIRED UNDER THE SANITARY CODE.

4. THE COMMISSIONER IS HEREBY AUTHORIZED, WITHIN AMOUNTS APPROPRIATED THEREFOR, TO MAKE GRANTS TO COUNTIES, CITIES, TOWNS OR VILLAGES THAT OWN THEIR PUBLIC WATER SYSTEM AND THE WATER SUPPLY FOR SUCH SYSTEM, INCLUDING A COUNTY WHEREIN A PUBLIC AUTHORITY OWNS BOTH ITS PUBLIC WATER SYSTEM AND THE WATER SUPPLY FOR SUCH SYSTEM, FOR THE PURPOSE OF PROVIDING ASSISTANCE TOWARDS THE COSTS OF INSTALLATION, INCLUDING BUT NOT LIMITED TO TECHNICAL AND ADMINISTRATIVE COSTS ASSOCIATED WITH PLANNING, DESIGN AND CONSTRUCTION, AND START-UP OF FLUORIDATION SYSTEMS, AND REPLACING, REPAIRING OR UPGRADING OF FLUORIDATION EQUIPMENT FOR SUCH PUBLIC WATER SYSTEMS. GRANT FUNDING SHALL NOT BE AVAILABLE FOR ASSISTANCE TOWARDS THE COSTS AND EXPENSES OF OPERATION OF THE FLUORIDATION SYSTEM, AS DETERMINED BY THE DEPARTMENT. THE GRANT APPLICATIONS SHALL

INCLUDE SUCH INFORMATION AS REQUIRED BY THE COMMISSIONER. IN MAKING THE GRANT AWARDS, THE COMMISSIONER SHALL CONSIDER THE DEMONSTRATED NEED FOR INSTALLATION OF NEW FLUORIDATION EQUIPMENT OR REPLACING, REPAIRING OR UPGRADING OF EXISTING FLUORIDATION EQUIPMENT, AND SUCH OTHER CRITERIA AS DETERMINED BY THE COMMISSIONER. GRANT AWARDS SHALL BE MADE ON A COMPETITIVE BASIS AND BE SUBJECT TO SUCH CONDITIONS AS MAY BE DETERMINED BY THE COMMISSIONER.

S 2. This act shall take effect immediately.

PART N

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

S 2. Office of community living feasibility study. (a) There is hereby created an advisory committee to conduct an office of community living feasibility study. Such committee shall consist of: the director of the state office for the aging, who will also chair the committee; the commissioner of the department of health; the director of the office for people with developmental disabilities; the commissioner of the department of housing and community renewal; the commissioner of the office of temporary and disability assistance; the commissioner of the department of transportation; the commissioner of the office of mental health; the commissioner of the office of alcoholism and substance abuse services; the director of the division of veterans' affairs; one representative who is an advocate for older adults; one representative who is an advocate for persons with mental illness; one representative who is an advocate for persons with a substance use disorder; and one representative who is an advocate for persons with disabilities. The director of the office for the aging may also consult with any other agency that the director determines should be consulted.

(b) The office of community living feasibility study shall focus on several areas including, but not 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; reviewing the available services across all agencies to identify the adequacy of existing services to seniors, persons with disabilities, and persons with behavioral health disorders; investigating overlap between agencies and gaps in available services; determining the efficacy of current programs and service delivery methods; evaluating methods for service delivery improvements; analyzing the fiscal impact of creating such an office on services, individuals, and providers; and exploring what impacts such an office might have on supporting older adults, persons with disabilities, and persons with behavioral health disorders currently living in the community, or who could be living in the community. The advisory committee 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.

(c) In order to ensure meaningful public input and comment for the office of community living feasibility study, there shall be a series of public meetings held across the state, organized to ensure that stake-

holders in all regions of the state are afforded an opportunity to comment.

S 3. Office of community living feasibility study report. The advisory committee shall submit to the governor, and to the temporary president of the senate and the speaker of the assembly a preliminary report by September 30, 2015. This preliminary report shall explain data collection efforts, illustrate public comment received and state any preliminary findings. The advisory committee shall submit a final report to the governor, the temporary president of the senate, and the speaker of the assembly by December 31, 2015 that outlines the results and findings associated with the aforementioned collection of data and solicitation of feedback.

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, 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 commissioner of mental health, in consultation with the commissioner of education, 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 and annually thereafter, on the number of children hospitalized in hospitals operated by the officer of mental health who received educational services from school districts and boards of cooperative educational services pursuant to the provisions of this act in the most recent school year and the projected number to be served in the subsequent school year, the services provided to these children, and the actual or projected cost of such services. Such report shall also provide detailed proposals regarding whether additional actions should be taken to ensure that children hospitalized in hospitals operated by the office of mental health continue to receive education programming and services as required by state and federal 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 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.

PART Q

Intentionally Omitted

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, CERTIFIED OR APPROVED BY THE OFFICE FOR PEOPLE WITH 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 PERSON CENTERED PLAN OF CARE FOR SUCH PERSON.

D. THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL UNDERTAKE OR ARRANGE FOR THE DEVELOPMENT OF A WRITTEN PERSON CENTERED PLAN OF CARE FOR EACH PERSON ENROLLED IN THE WAIVER. SUCH PERSON CENTERED 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 1-a. Subparagraph (v) of paragraph a of subdivision 1 of section 6908 of the education law, as amended by section 1 of part A of chapter 58 of the laws of 2014, is amended to read as follows:

(v) tasks provided by a direct support staff in programs certified or approved by the office for people with developmental disabilities AND HOLDING AN OPERATING CERTIFICATE PURSUANT TO PARAGRAPH 4 OF SUBDIVISION (A) OF SECTION 16.03 OF THE MENTAL HYGIENE LAW, when performed under the supervision of a registered professional nurse and pursuant to a memo-

randum of understanding between the office for people with developmental disabilities and the department, in accordance with and pursuant to an authorized practitioner's ordered care, provided that: (1) a registered professional nurse determines, in his or her professional judgment, which tasks are to be performed based upon the complexity of the tasks, the skill and experience of the direct support staff, and the health status of the individual being cared for; (2) only a direct support staff who has completed training as required by the commissioner of the office for people with developmental disabilities may perform tasks pursuant to this subparagraph; (3) appropriate protocols shall be established to ensure safe administration of medications; (4) a direct support staff shall not assess the medication needs of an individual; (5) adequate nursing supervision is provided, including training and periodic inspection of performance of the tasks. The amount and type of nursing supervision shall be determined by the registered professional nurse responsible for supervising such task based upon the complexity of the tasks, the skill and experience of the direct support staff, and the health status of the individual being cared for; (6) a direct support staff 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; (7) a direct support staff shall not represent himself or herself, or accept employment, as a person licensed to practice nursing under the provisions of this article; (8) direct support staff providing medication administration, tube feeding, or diabetic care shall be separately certified, and shall be recertified on an annual basis; (9) the registered professional nurse shall ensure that there is a consumer specific medication sheet for each medication that is administered; and (10) appropriate staffing ratios shall be determined by the office for people with developmental disabilities and the department to ensure adequate nursing supervision. No direct support staff shall perform tasks under this subparagraph until the office for people with developmental disabilities and the department have entered into a memorandum of understanding to effectuate the provisions of this subparagraph. The office for people with developmental disabilities shall complete a criminal background check pursuant to section 16.33 of the mental hygiene law and an agency background check pursuant to section 16.34 of the mental hygiene law on the direct support staff prior to the commencement of any provision of service provided under this subparagraph if such direct support staff is a new hire. Individuals providing supervision or direct support tasks pursuant to this subparagraph shall have protection pursuant to sections seven hundred forty and seven hundred forty-one of the labor law, where applicable;

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 PARAGRAPH 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)] ONE or [(2)] TWO 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. Intentionally omitted.

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) ANY PROVIDER OF SERVICES THAT HOLDS AN OPERATING CERTIFICATE PURSUANT TO PARAGRAPH FOUR OF SUBDIVISION (A) OF SECTION 16.03 OF THE MENTAL HYGIENE LAW, SHALL BE AUTHORIZED TO EMPLOY PERSONS LICENSED TO PRACTICE NURSING PURSUANT TO ARTICLE ONE HUNDRED THIRTY-NINE OF THE EDUCATION LAW AND EXEMPT INDIVIDUALS AUTHORIZED TO PERFORM TASKS PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH A OF SUBDIVISION ONE OF SECTION SIXTY-NINE HUNDRED EIGHT OF THE EDUCATION LAW.

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 PROVIDER OF SERVICES AS DESCRIBED IN PARAGRAPH FOUR OF SUBDIVISION A 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 8-a. Subdivision (c) of section 16.05 of the mental hygiene law is amended by adding a new paragraph 6-a to read as follows:

(6-A) IN THE CASE OF A PROVIDER OF SERVICES SEEKING TO PROVIDE NURSING TASKS BY NON-LICENSED PERSONS AUTHORIZED TO PROVIDE SUCH TASKS PURSUANT TO SUBPARAGRAPH (V) OF PARAGRAPH A OF SUBDIVISION ONE OF SECTION SIXTY-NINE HUNDRED EIGHT OF THE EDUCATION LAW, SUCH PROVIDER SHALL AFFIRM THAT IT WILL PROVIDE SERVICES AND TASKS IN A SAFE AND COMPETENT MANNER AND WILL FULLY COMPLY WITH THE REQUIREMENTS OF SUCH SUBPARAGRAPH AND ANY MEMORANDUM OF UNDERSTANDING BETWEEN THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND THE STATE EDUCATION DEPARTMENT PURSUANT TO SUCH SUBPARAGRAPH. NO OPERATING CERTIFICATE SUBJECT TO THIS PARAGRAPH SHALL BE GRANTED WITHOUT SUCH AFFIRMATION.

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 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 PERIODIC VISITATION AND REVIEW OF EACH FACILITY. REVIEWS SHALL BE MADE AS FREQUENTLY AS THE COMMISSIONER MAY DEEM NECESSARY BUT IN ANY EVENT SUCH INSPECTIONS SHALL BE MADE ON AT LEAST TWO OCCASIONS DURING EACH CALENDAR YEAR WHICH SHALL BE WITHOUT PRIOR NOTICE, PROVIDED, HOWEVER, THAT WHERE, IN THE DISCRETION OF THE COMMISSIONER, AN OPERATING CERTIFICATE HAS BEEN ISSUED TO A PROGRAM WITH A HISTORY OF COMPLIANCE AND A RECORD OF PROVIDING A HIGH QUALITY OF CARE, THE PERIODIC INSPECTION AND VISITATION REQUIRED BY THIS SUBDIVISION SHALL BE MADE AT LEAST ONCE DURING EACH CALENDAR YEAR PROVIDED SUCH VISIT 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. PERIODIC REVIEW OF SUCH PROVIDERS OF SERVICES SHALL BE MADE AS FREQUENTLY AS THE COMMISSIONER MAY DEEM NECESSARY BUT IN ANY EVENT SUCH REVIEWS SHALL BE MADE ON AT LEAST TWO OCCASIONS DURING EACH CALENDAR YEAR, PROVIDED, HOWEVER, THAT WHERE, IN THE DISCRETION OF THE COMMISSIONER, AN OPERATING CERTIFICATE HAS BEEN ISSUED TO A PROVIDER OF SERVICE WITH A HISTORY OF COMPLIANCE AND A RECORD OF PROVIDING A HIGH QUALITY OF CARE, THE PERIODIC REVIEW REQUIRED BY THIS SUBDIVISION SHALL BE MADE AT LEAST ONCE DURING EACH CALENDAR YEAR.

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 SERVICES, person or entity which holds an operating certificate issued by the office, into the operation of any facility, SERVICES 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] A REVIEW or investigation, the commissioner or his OR HER authorized representative shall have the power to [inspect] REVIEW 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] REVIEW 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] REVIEW, 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] REVIEW 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] REVIEW or investigation.

S 12. Section 16.17 of the mental hygiene law, as added by chapter 786 of the laws of 1983, subdivision (a), subparagraph b of paragraph 1 and paragraph 2 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 SERVICES, 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 SERVICES 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 SERVICES 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 SERVICES, 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.

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

7-B. SERVICES AND NEEDS ASSESSMENT. ON OR BEFORE JANUARY FIRST, TWO THOUSAND SIXTEEN, THE ASSESSMENT COMPLETED PURSUANT TO SUBDIVISION SEVEN-A OF THIS SECTION SHALL BE COMPLETED BY A SCIENTIFICALLY VALID AND RELIABLE ASSESSMENT TOOL. SUCH TOOL MUST MEET INTER-RATER RELIABILITY STANDARDS ESTABLISHED BY THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES IN CONJUNCTION WITH STAKEHOLDER INPUT. THE ASSESSMENT SHALL ALSO INCLUDE AN EVALUATION OF THE INDIVIDUAL'S HOME ENVIRONMENT, INCLUDING BUT NOT LIMITED TO, THE ABILITY OF FAMILY AND/OR CAREGIVERS TO PROVIDE SUPPORTS OUTSIDE OF THOSE WITHIN THE WAIVER, INCLUDING BUT NOT LIMITED TO, ACTIVITIES OF DAILY LIVING.

S 15. This act shall take effect immediately.

PART T

Intentionally Omitted

PART U

Intentionally Omitted

PART V

Section 1. Section 19.09 of the mental hygiene law is amended by adding a new subdivision (j) to read as follows:

(J) THE COMMISSIONER, IN CONSULTATION WITH THE NEW YORK STATE GAMING COMMISSION, IS AUTHORIZED AND DIRECTED TO COMMISSION A STATEWIDE EVALUATION REGARDING THE EXTENT OF LEGAL AND ILLEGAL GAMBLING BY NEW YORK STATE RESIDENTS, INCLUDING, BUT NOT LIMITED TO THE LOTTERY, HORSE RACING, NATIVE AMERICAN CASINOS, INTERNET GAMBLING, SPORTS BETTING, AND POKER. SUCH EVALUATION SHALL BE DELIVERED TO THE GOVERNOR AND LEGISLATURE NO LATER THAN DECEMBER FIRST, TWO THOUSAND SEVENTEEN. THE EVALUATION SHALL BE PREPARED IN CONSULTATION WITH PERTINENT STAKEHOLDERS, INCLUDING BUT NOT LIMITED TO, VOLUNTARY AGENCIES, LOCAL GOVERNMENTAL UNITS, INDIVIDUALS WITH PROFESSIONAL RESEARCH EXPERIENCE AND EXPERTISE IN THE APPROPRIATE FIELDS, AND ANY OTHER PERTINENT STAKEHOLDERS DEEMED NECESSARY BY THE COMMISSIONER AND NEW YORK STATE GAMING COMMISSION TO EFFECTUATE THE PURPOSE OF THIS SUBDIVISION.

(1) SUCH EVALUATION SHALL INCLUDE:
(A) THE PERCENTAGE OF NEW YORK RESIDENTS PARTICIPATING IN EACH GAMBLING ACTIVITY BY:
(I) AGE;
(II) RACE;
(III) INCOME;
(IV) EDUCATION;
(V) SEX; AND
(VI) ANY OTHER DEMOGRAPHIC THAT WOULD BE RELEVANT TO THE EVALUATION; AND
(B) AN ESTIMATE OF THE AMOUNT OF MONEY BEING WAGERED AND LOST BY NEW YORK RESIDENTS IN EACH GAMBLING ACTIVITY.
(2) SUCH EVALUATION SHALL PROVIDE A CRITICAL ANALYSIS OF THE RELATIONSHIPS BETWEEN PROBLEM GAMBLING AND BANKRUPTCY, DOMESTIC VIOLENCE, SUICIDE, CRIME, AND ANY OTHER SOCIAL PROBLEM THAT IS RELEVANT TO THE EVALUATION.
S 2. This act shall take effect immediately.

PART W

Section 1. Section 19.09 of the mental hygiene law is amended by adding two new subdivisions (j) and (k) to read as follows:
(J) THE COMMISSIONER SHALL CREATE EDUCATIONAL MATERIALS REGARDING COMPULSIVE GAMBLING FOR THE PURPOSE OF EDUCATING INDIVIDUALS THAT VOLUNTARILY PLACE THEMSELVES ON A SELF EXCLUSION LIST OF AN ASSOCIATION OR CORPORATION LICENSED OR ENFRANCHISED BY THE NEW YORK STATE GAMING COMMISSION PURSUANT TO SECTION ONE HUNDRED ELEVEN OF THE RACING, PARI-MUTUEL WAGERING AND BREEDING LAW IMMEDIATELY UPON PLACEMENT ON SUCH LIST. THE EDUCATIONAL MATERIALS SHALL BE MADE AVAILABLE ON THE WEBSITE OF THE OFFICE AND SHALL INCLUDE BUT NOT BE LIMITED TO RESOURCES TO TREATMENT.
(K) THE COMMISSIONER, IN CONSULTATION WITH THE NEW YORK STATE GAMING COMMISSION SHALL ESTABLISH A PROBLEM GAMBLING EDUCATION PROGRAM TO BE COMPLETED BY ALL INDIVIDUALS THAT HAVE PLACED THEMSELVES ON A SELF EXCLUSION LIST PURSUANT TO SECTION ONE HUNDRED ELEVEN OF THE RACING, PARI-MUTUEL WAGERING AND BREEDING LAW, WHOM SUBSEQUENTLY REQUEST REMOVAL FROM SUCH EXCLUSION LIST. THIS EDUCATION PROGRAM SHALL BE MADE AVAILABLE ON THE WEBSITES OF BOTH THE OFFICE AND THE NEW YORK STATE GAMING COMMISSION AND SHALL INCLUDE BUT NOT BE LIMITED TO RESOURCES TO TREATMENT.
S 2. Paragraphs (a) and (c) of subdivision 2 of section 111 of the racing, pari-mutuel wagering and breeding law, as added by section 1 of part A of chapter 60 of the laws of 2012, are amended to read as follows:
(a) The commission shall promulgate rules and regulations pursuant to which people may: voluntarily exclude themselves from entering the premises of an association or corporation licensed or enfranchised by the commission pursuant to this chapter; RECEIVE THE REQUIRED EDUCATIONAL MATERIALS PURSUANT TO SUBDIVISION (J) OF SECTION 19.09 OF THE MENTAL HYGIENE LAW; AND, UPON REQUEST TO BE REMOVED FROM THE SELF EXCLUSION LIST, COMPLETE THE PROBLEM GAMBLING EDUCATION PROGRAM PURSUANT TO SUBDIVISION (K) OF SECTION 19.09 OF THE MENTAL HYGIENE LAW.
(c) No voluntary order or request to exclude persons from entering the premises of any such association, corporation, or facility may be rescinded, canceled, or declared null and void until [seven days after a request] SUCH INDIVIDUAL WHO IS SELF EXCLUDED COMPLETES IN PAPER OR ELECTRONIC FORMAT, AN EDUCATIONAL PROGRAM APPROVED BY THE OFFICE PURSU-

ANT TO THE PROVISIONS OF SUBDIVISION (K) OF SECTION 19.09 OF THE MENTAL HYGIENE LAW AND PROOF OF COMPLETION has been received by such association, corporation, or facility to cancel such order or request.

S 3. This act shall take effect on the sixtieth day after it shall have become a law.

PART X

Section 1. Section 4 of chapter 495 of the laws of 2004, amending the insurance law and the public health law relating to the New York state health insurance continuation assistance demonstration project, as amended by section 1 of part GG of chapter 57 of the laws of 2014, is amended to read as follows:

S 4. This act shall take effect on the sixtieth day after it shall have become a law; provided, however, that this act shall remain in effect until July 1, [2015] 2016 when upon such date the provisions of this act shall expire and be deemed repealed; provided, further, that a displaced worker shall be eligible for continuation assistance retroactive to July 1, 2004.

S 2. This act shall take effect immediately.

PART Y

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

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

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

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

S 3. This act shall take effect immediately.

PART Z

Section 1. Paragraph (a) of subdivision 1 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 18 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(a) The superintendent of [insurance] FINANCIAL SERVICES and the commissioner of health or their designee shall, from funds available in the hospital excess liability pool created pursuant to subdivision 5 of this section, purchase a policy or policies for excess insurance coverage, as authorized by paragraph 1 of subsection (e) of section 5502 of the insurance law; or from an insurer, other than an insurer described

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

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

S 2. Subdivision 3 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 19 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

(3)(a) The superintendent of [insurance] FINANCIAL SERVICES shall determine and certify to each general hospital and to the commissioner of health the cost of excess malpractice insurance for medical or dental malpractice occurrences between July 1, 1986 and June 30, 1987, between July 1, 1988 and June 30, 1989, between July 1, 1989 and June 30, 1990, between July 1, 1990 and June 30, 1991, between July 1, 1991 and June 30, 1992, between July 1, 1992 and June 30, 1993, between July 1, 1993 and June 30, 1994, between July 1, 1994 and June 30, 1995, between July 1, 1995 and June 30, 1996, between July 1, 1996 and June 30, 1997, between July 1, 1997 and June 30, 1998, between July 1, 1998 and June 30, 1999, between July 1, 1999 and June 30, 2000, between July 1, 2000 and June 30, 2001, between July 1, 2001 and June 30, 2002, between July 1, 2002 and June 30, 2003, between July 1, 2003 and June 30, 2004, between July 1, 2004 and June 30, 2005, between July 1, 2005 and June 30, 2006, between July 1, 2006 and June 30, 2007, between July 1, 2007 and June 30, 2008, between July 1, 2008 and June 30, 2009, between July 1, 2009 and June 30, 2010, between July 1, 2010 and June 30, 2011, between July 1, 2011 and June 30, 2012, between July 1, 2012 and June 30, 2013, and between July 1, 2013 and June 30, 2014, [and] between July 1, 2014 and June 30, 2015, AND BETWEEN JULY 1, 2015 AND JUNE 30, 2016 allocable to each general hospital for physicians or dentists certified as eligible for purchase of a policy for excess insurance coverage by such general hospital in accordance with subdivision 2 of this section, and may amend such determination and certification as necessary.

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

S 3. Paragraphs (a), (b), (c), (d) and (e) of subdivision 8 of section 18 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 20 of part B of chapter 60 of the laws of 2014, are amended to read as follows:

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

(b) Each provider of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or covering the period July 1, 2006 to June 30, 2007, or covering the period July 1, 2007 to June 30, 2008, or covering the period July 1, 2008 to June 30, 2009, or covering the period July 1, 2009 to June 30, 2010, or covering the period July 1, 2010 to June 30, 2011, or covering the period July 1, 2011 to June 30, 2012, or covering the period July 1, 2012 to June 30, 2013, or covering the period July 1, 2013 to June 30, 2014, or covering the period July 1, 2014 to

June 30, 2015, OR COVERING THE PERIOD JULY 1, 2015 TO JUNE 30, 2016 shall notify a covered physician or dentist by mail, mailed to the address shown on the last application for excess insurance coverage or equivalent excess coverage, of the amount due to such provider from such physician or dentist for such coverage period determined in accordance with paragraph (a) of this subdivision. Such amount shall be due from such physician or dentist to such provider of excess insurance coverage or equivalent excess coverage in a time and manner determined by the superintendent of [insurance] FINANCIAL SERVICES.

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

(d) Each provider of excess insurance coverage or equivalent excess coverage shall notify the superintendent of [insurance] FINANCIAL SERVICES and the commissioner of health or their designee of each physician and dentist eligible for purchase of a policy for excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, or covering the period July 1, 1993 to June 30, 1994, or covering the period July 1, 1994 to June 30, 1995, or covering the period July 1, 1995 to June 30, 1996, or covering the period July 1, 1996 to June 30, 1997, or covering the period July 1, 1997 to June 30, 1998, or covering the period July 1, 1998 to June 30, 1999, or covering the period July 1, 1999 to June 30, 2000, or covering the period July 1, 2000 to June 30, 2001, or covering the period July 1, 2001 to October 29, 2001, or covering the period April 1, 2002 to June 30, 2002, or covering the period July 1, 2002 to June 30, 2003, or covering the period July 1, 2003 to June 30, 2004, or covering the period July 1, 2004 to June 30, 2005, or covering the period July 1, 2005 to June 30, 2006, or

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

(e) A provider of excess insurance coverage or equivalent excess coverage shall refund to the hospital excess liability pool any amount allocable to the period July 1, 1992 to June 30, 1993, and to the period July 1, 1993 to June 30, 1994, and to the period July 1, 1994 to June 30, 1995, and to the period July 1, 1995 to June 30, 1996, and to the period July 1, 1996 to June 30, 1997, and to the period July 1, 1997 to June 30, 1998, and to the period July 1, 1998 to June 30, 1999, and to the period July 1, 1999 to June 30, 2000, and to the period July 1, 2000 to June 30, 2001, and to the period July 1, 2001 to October 29, 2001, and to the period April 1, 2002 to June 30, 2002, and to the period July 1, 2002 to June 30, 2003, and to the period July 1, 2003 to June 30, 2004, and to the period July 1, 2004 to June 30, 2005, and to the period July 1, 2005 to June 30, 2006, and to the period July 1, 2006 to June 30, 2007, and to the period July 1, 2007 to June 30, 2008, and to the period July 1, 2008 to June 30, 2009, and to the period July 1, 2009 to June 30, 2010, and to the period July 1, 2010 to June 30, 2011, and to the period July 1, 2011 to June 30, 2012, and to the period July 1, 2012 to June 30, 2013, and to the period July 1, 2013 to June 30, 2014, and to the period July 1, 2014 to June 30, 2015, AND TO THE PERIOD JULY 1, 2015 TO JUNE 30, 2016 received from the hospital excess liability pool for purchase of excess insurance coverage or equivalent excess coverage covering the period July 1, 1992 to June 30, 1993, and covering the period July 1, 1993 to June 30, 1994, and covering the period July 1, 1994 to June 30, 1995, and covering the period July 1, 1995 to June 30, 1996, and covering the period July 1, 1996 to June 30, 1997, and covering the period July 1, 1997 to June 30, 1998, and covering the period July 1, 1998 to June 30, 1999, and covering the period July 1, 1999 to June 30, 2000, and covering the period July 1, 2000 to June 30, 2001, and covering the period July 1, 2001 to October 29, 2001, and covering the period April 1, 2002 to June 30, 2002, and covering the period July 1, 2002 to June 30, 2003, and covering the period July 1, 2003 to June 30, 2004, and covering the period July 1, 2004 to June 30, 2005, and covering the period July 1, 2005 to June 30, 2006, and covering the period July 1, 2006 to June 30, 2007, and covering the period July 1, 2007 to June 30, 2008, and covering the period July 1, 2008 to June 30, 2009, and covering the period July 1, 2009 to June 30, 2010, and covering the period July 1, 2010 to June 30, 2011, and covering the period July 1, 2011 to June 30, 2012, and covering the period July 1, 2012 to June 30, 2013, and covering the period July 1, 2013 to June 30, 2014, and covering the period July 1, 2014 to June 30, 2015, AND COVERING THE PERIOD JULY 1, 2015 TO JUNE 30, 2016 for a physician or dentist where such excess insurance coverage or equivalent excess coverage is cancelled in accordance with paragraph (c) of this subdivision.

S 4. Section 40 of chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and

professional medical conduct, as amended by section 21 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

S 40. The superintendent of [insurance] FINANCIAL SERVICES shall establish rates for policies providing coverage for physicians and surgeons medical malpractice for the periods commencing July 1, 1985 and ending June 30, [2015] 2016; provided, however, that notwithstanding any other provision of law, the superintendent shall not establish or approve any increase in rates for the period commencing July 1, 2009 and ending June 30, 2010. The superintendent shall direct insurers to establish segregated accounts for premiums, payments, reserves and investment income attributable to such premium periods and shall require periodic reports by the insurers regarding claims and expenses attributable to such periods to monitor whether such accounts will be sufficient to meet incurred claims and expenses. On or after July 1, 1989, the superintendent shall impose a surcharge on premiums to satisfy a projected deficiency that is attributable to the premium levels established pursuant to this section for such periods; provided, however, that such annual surcharge shall not exceed eight percent of the established rate until July 1, [2015] 2016, at which time and thereafter such surcharge shall not exceed twenty-five percent of the approved adequate rate, and that such annual surcharges shall continue for such period of time as shall be sufficient to satisfy such deficiency. The superintendent shall not impose such surcharge during the period commencing July 1, 2009 and ending June 30, 2010. On and after July 1, 1989, the surcharge prescribed by this section shall be retained by insurers to the extent that they insured physicians and surgeons during the July 1, 1985 through June 30, [2015] 2016 policy periods; in the event and to the extent physicians and surgeons were insured by another insurer during such periods, all or a pro rata share of the surcharge, as the case may be, shall be remitted to such other insurer in accordance with rules and regulations to be promulgated by the superintendent. Surcharges collected from physicians and surgeons who were not insured during such policy periods shall be apportioned among all insurers in proportion to the premium written by each insurer during such policy periods; if a physician or surgeon was insured by an insurer subject to rates established by the superintendent during such policy periods, and at any time thereafter a hospital, health maintenance organization, employer or institution is responsible for responding in damages for liability arising out of such physician's or surgeon's practice of medicine, such responsible entity shall also remit to such prior insurer the equivalent amount that would then be collected as a surcharge if the physician or surgeon had continued to remain insured by such prior insurer. In the event any insurer that provided coverage during such policy periods is in liquidation, the property/casualty insurance security fund shall receive the portion of surcharges to which the insurer in liquidation would have been entitled. The surcharges authorized herein shall be deemed to be income earned for the purposes of section 2303 of the insurance law. The superintendent, in establishing adequate rates and in determining any projected deficiency pursuant to the requirements of this section and the insurance law, shall give substantial weight, determined in his discretion and judgment, to the prospective anticipated effect of any regulations promulgated and laws enacted and the public benefit of stabilizing malpractice rates and minimizing rate level fluctuation during the period of time necessary for the development of more reliable statistical experience as to the efficacy of such laws and regulations affecting medical, dental or podiatric malpractice

enacted or promulgated in 1985, 1986, by this act and at any other time. Notwithstanding any provision of the insurance law, rates already established and to be established by the superintendent pursuant to this section are deemed adequate if such rates would be adequate when taken together with the maximum authorized annual surcharges to be imposed for a reasonable period of time whether or not any such annual surcharge has been actually imposed as of the establishment of such rates.

S 5. Section 5 and subdivisions (a) and (e) of section 6 of part J of chapter 63 of the laws of 2001, amending chapter 266 of the laws of 1986, amending the civil practice law and rules and other laws relating to malpractice and professional medical conduct, as amended by section 22 of part B of chapter 60 of the laws of 2014, are amended to read as follows:

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

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

(e) The commissioner of health shall transfer for deposit to the hospital excess liability pool created pursuant to section 18 of chapter 266 of the laws of 1986 such amounts as directed by the superintendent of [insurance] FINANCIAL SERVICES for the purchase of excess liability insurance coverage for eligible participating physicians and dentists for the policy year July 1, 2001 to June 30, 2002, or July 1, 2002 to June 30, 2003, or July 1, 2003 to June 30, 2004, or July 1, 2004 to June 30, 2005, or July 1, 2005 to June 30, 2006, or July 1, 2006 to June 30, 2007, as applicable, and the cost of administering the hospital excess

liability pool for such applicable policy year, pursuant to the program established in chapter 266 of the laws of 1986, as amended, no later than June 15, 2002, June 15, 2003, June 15, 2004, June 15, 2005, June 15, 2006, June 15, 2007, June 15, 2008, June 15, 2009, June 15, 2010, June 15, 2011, June 15, 2012, June 15, 2013, June 15, 2014, [and] June 15, 2015, AND JUNE 15, 2016, as applicable.

S 6. Notwithstanding any law, rule or regulation to the contrary, only physicians or dentists who were eligible, and for whom the superintendent of financial services and the commissioner of health, or their designee, purchased, with funds available in the hospital excess liability pool, a full or partial policy for excess coverage or equivalent excess coverage for the coverage period ending the thirtieth of June, two thousand fifteen, shall be eligible to apply for such coverage for the coverage period beginning the first of July, two thousand fifteen; provided, however, if the total number of physicians or dentists for whom such excess coverage or equivalent excess coverage was purchased for the policy year ending the thirtieth of June, two thousand fifteen exceeds the total number of physicians or dentists certified as eligible for the coverage period beginning the first of July, two thousand fifteen, then the general hospitals may certify additional eligible physicians or dentists in a number equal to such general hospital's proportional share of the total number of physicians or dentists for whom excess coverage or equivalent excess coverage was purchased with funds available in the hospital excess liability pool as of the thirtieth of June, two thousand fifteen, as applied to the difference between the number of eligible physicians or dentists for whom a policy for excess coverage or equivalent excess coverage was purchased for the coverage period ending the thirtieth of June, two thousand fifteen and the number of such eligible physicians or dentists who have applied for excess coverage or equivalent excess for the coverage period beginning the first of July, two thousand fifteen.

S 7. This act shall take effect immediately.

PART AA

Section 1. Section 213 of the insurance law, as added by section 1 of part L of chapter 57 of the laws of 2007, is amended to read as follows:

S 213. New York state health [care quality and cost containment] INSURANCE MODERNIZATION AND QUALITY CARE commission. (a) There is hereby established within the department a commission, to be known as the "New York state health [care quality and cost containment] INSURANCE MODERNIZATION AND QUALITY CARE commission". The commission shall consist of thirteen members appointed by the governor, one of whom shall be the superintendent OR THEIR REPRESENTATIVE, one of whom shall be the commissioner of health OR THEIR REPRESENTATIVE, ONE OF WHOM SHALL BE THE EXECUTIVE DIRECTOR OF THE NEW YORK STATE HEALTH INSURANCE EXCHANGE OR THEIR REPRESENTATIVE and six of whom shall be appointed on the recommendation of the legislative leaders, two on the recommendation of the temporary president of the senate, two on the recommendation of the speaker of the assembly, one on the recommendation of the minority leader of the senate, and one on the recommendation of the minority leader of the assembly. All members shall serve at the pleasure of the governor, and vacancies shall be appointed in the same manner as original appointments. Members of the commission shall serve without compensation, but shall be reimbursed for reasonable travel expenses. [In making appointments to the commission, the governor shall ensure that the interests of

health care consumers, small businesses, the medical community and health plans are represented on the commission.] THE GOVERNOR AND APPOINTING MEMBERS OF THE LEGISLATURE SHALL ENSURE THAT THE COMMISSION SHALL INCLUDE ONE REPRESENTATIVE AFFILIATED WITH EACH OF THE FOLLOWING GROUPS: (I) THE MEDICAL SOCIETY OF THE STATE OF NEW YORK; (II) THE AFL-CIO; (III) HEALTH CARE FOR ALL NEW YORK; (IV) THE NEW YORK HEALTH PLAN ASSOCIATION; (V) THE CONSUMER'S UNION; AND (VI) THE AMERICAN ASSOCIATION OF RETIRED PERSONS.

(b)(1) The purpose of the commission shall be to [analyze the impact on health insurance costs and quality of proposed legislation which would mandate that health benefits be offered or made available in individual and group health insurance policies, contracts and comprehensive health service plans, including legislation that affects the delivery of health benefits or services or the reimbursement of health care providers] ESTABLISH THE PROCESS FOR EVALUATING PROPOSED HEALTH INSURANCE MANDATES IN ORDER TO ENSURE THAT THE CITIZENS OF NEW YORK RECEIVE THE MOST MODERN HEALTH CARE TECHNOLOGIES AND PRACTICES AVAILABLE ON AN ONGOING BASIS.

(2) BY SEPTEMBER FIRST OF THE YEAR TWO THOUSAND FIFTEEN, THE COMMISSION SHALL PRODUCE AN INITIAL REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, AND TO THE SPEAKER OF THE ASSEMBLY TO DESCRIBE THE PROCESS BY WHICH, IF AUTHORIZED IN STATUTE, NEW HEALTH INSURANCE MANDATES WOULD BE FUNDED AND IMPLEMENTED AND TO ESTABLISH A PROCESS FOR DETERMINING THE NET IMPACT OF ANY BENEFIT MANDATES ON PREMIUMS. AT A MINIMUM, THE REPORT SHALL DESCRIBE THE METHOD BY WHICH, CONSISTENT WITH THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT, INSURERS OR POLICYHOLDERS ARE REIMBURSED FOR ANY PREMIUM INCREASES TRIGGERED BY SUCH NEW HEALTH INSURANCE MANDATES, AND THE MEANS BY WHICH NEW YORK STATE MAY FUND THESE NEW HEALTH INSURANCE MANDATES.

[(2)] (3) The governor, the chair of the senate insurance committee [and] OR the chair of the assembly insurance committee may request in writing that the commission evaluate THE COST AND MEANS OF IMPLEMENTING a PARTICULAR proposed mandated benefit. Upon receiving such a request, the commission [may, by a majority vote of its members,] SHALL undertake an evaluation of such proposed mandated benefit.

[(3)] (4) In evaluating a proposed mandated benefit, the commission shall:

(A) investigate the current practices of health plans with regard to the proposed mandated benefit[, and, to the extent possible, self-funded health benefit plans];

(B) investigate the potential premium impact of the proposed mandated [benefits] BENEFIT on all segments of the insurance market[, as well as the potential for avoided costs through early detection and treatment of conditions, or more cost-effective delivery of medical services] AND WHETHER THE MANDATE WOULD TRIGGER AN ASSUMPTION OF COSTS BY THE STATE AS DESCRIBED IN SECTION 10104 (E) (1) OF THE FEDERAL AFFORDABLE CARE ACT;

(C) STATE WHETHER SUCH BENEFIT MAY BE IMPLEMENTED ACCORDING TO THE PROCESS DEVELOPED PURSUANT TO PARAGRAPH (2) OF SUBDIVISION (B) OF THIS SECTION; and

[(C)] (D) analyze the most current medical literature regarding the proposed mandated benefit to determine its impact on health care quality.

[(4)] (5) In evaluating a proposed mandated benefit, the commission may hold one or more public hearings, and shall strive to obtain independent and verifiable information from diverse sources within the

healthcare industry, medical community and among health care consumers with regard to the proposed mandated benefit.

(c) [To assist the commission in its duties, and upon the direction of the commission, the superintendent is authorized to enter into one or more contracts with independent entities and organizations with demonstrable expertise in health care quality, finance, utilization and actuarial services. For the purposes of this section, the superintendent shall not enter into contracts with health plans, entities or organizations owned or controlled by health plans, or with significant business relationships with health plans.

(d) Upon completion of its] WITHIN SIXTY DAYS OF A REQUEST FOR AN evaluation of a proposed mandated benefit pursuant to this section, the commission shall deliver a written [report of its findings] IMPLEMENTATION PLAN to the chair of the assembly insurance committee and the chair of the senate insurance committee.

S 2. This act shall take effect immediately.

PART BB

Section 1. Section 215-b of the elder law, as added by section 27 of part A of chapter 58 of the laws of 2008, is amended to read as follows:

S 215-b. Enriched social adult day services [demonstration project]. 1. Legislative intent. Social adult day services programs are resources that can help communities maintain the independence of [elderly residents] FUNCTIONALLY IMPAIRED ADULTS. The level of services needed by some [elderly persons] FUNCTIONALLY IMPAIRED ADULTS exceeds the level of assistance currently available through social model adult day services programs but is not at the level of support provided in an adult day health care program. Social adult day services programs cannot enroll new participants whose needs exceed the services that can be provided in the current social adult day services programs. Additionally, these programs must discharge current participants when their needs cannot be met. Therefore, an enriched social adult day services project shall be established as a demonstration project for the purposes of maintaining [elderly persons] FUNCTIONALLY IMPAIRED ADULTS in the community by deterring or delaying institutionalization.

2. Definitions. For purposes of this section, the following terms shall have the following meanings:

(a) ["Elderly" or "elderly persons" shall mean persons who are sixty years of age or older.

(b)] "Eligible participant" shall mean [elderly or elderly persons as defined in this section,] INDIVIDUALS who are functionally impaired, as defined in section two hundred fifteen of this title, and in need of services that exceed the level of assistance currently available through social adult day services programs but not at the level of support provided by adult day health care programs.

[(c)] (B) "Eligible entity" shall mean any not-for-profit or government entity, including the governing body or council of an Indian tribal reservation, who has demonstrated to the office and the department of health, based on criteria developed by the director and the commissioner of health, that it can safely provide either directly or through a contract with a licensed health care practitioner or licensed home care provider as defined in section thirty-six hundred five of the public health law, social adult day care services as defined in section two hundred fifteen of this title, as well as additional allowable medical

services as developed by the director and the commissioner of health, and optional services as defined in this section.

[(d) "Enriched social adult day services demonstration project" or "project" shall mean programs eligible under this section that provide all of the services currently required for social adult day services programs under section two hundred fifteen of this title in addition to enriched services, and may include optional services.

(e)] (C) "Enriched services" shall include the [provision of total assistance with toileting, mobility, transferring and eating;] dispensing of medications by a registered nurse; health education; counseling; case management; restorative therapies lasting less than six months and maintenance therapies. [Total assistance with toileting, mobility, transferring and eating shall be provided under the supervision of a licensed health care provider.] Restorative and maintenance therapies shall be provided by an appropriately licensed health care provider.

[(f)] (D) "Optional services" shall mean other non-medical services approved by the director designed to improve the quality of life of eligible participants by extending their independence, avoiding unnecessary hospital and nursing home stays, and sustaining their informal supports.

3. [Demonstration project. The director, in conjunction with the commissioner of health, is authorized and directed to establish an enriched social adult day services demonstration project for the purposes of testing innovative ways that social adult day services programs can successfully enable eligible participants to remain independent in their communities by deterring or delaying institutionalization through the use of enriched services.

4.] Duties of the director. (a) The director, in conjunction with the commissioner of health, [may make up to twenty grants available on a competitive basis to eligible entities under this section. Such grants may be available for up to two hundred thousand dollars for each enriched social adult day services demonstration project and shall be for up to one hundred percent of allowable expenditures for approved services and expenses under this section] SHALL DEVELOP AN APPLICATION PROCESS WHEREBY ELIGIBLE ENTITIES MAY APPLY FOR APPROVAL TO OFFER ENRICHED SERVICES, OPTIONAL SERVICES, OR BOTH. SUCH APPLICATION SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) AN ESTIMATE OF THE NUMBER OF ELIGIBLE PARTICIPANTS TO WHOM THE ELIGIBLE ENTITY COULD EFFECTIVELY PROVIDE THE SERVICES FOR WHICH THEY ARE APPLYING TO OFFER PURSUANT TO THIS SECTION; AND

(2) A PLAN UNDER WHICH THE ELIGIBLE ENTITY WOULD OFFER THE SERVICES FOR WHICH THEY ARE APPLYING PURSUANT TO THIS SECTION.

(b) In [making grants] CONSIDERING APPLICATIONS MADE PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION, the director, in conjunction with the commissioner of health, may consider:

(1) [projects] ELIGIBLE ENTITIES that can effectively serve eligible participants residing in rural, urban, or suburban settings;

(2) [projects] ELIGIBLE ENTITIES that effectively serve culturally diverse populations;

(3) [projects] ELIGIBLE ENTITIES that demonstrate innovative use of technology, coordination, partnerships, transportation or other services to enable eligible participants to be effectively served; AND

(4) [the capacity of the eligible entity to identify eligible participants for enriched adult day services demonstration projects; and

(5)] any other criteria determined to be appropriate.

[5.] 4. Evaluation. On or before January thirtieth, two thousand [eleven] SIXTEEN, the director shall provide the governor, the speaker of the assembly, the temporary president of the senate, and the chairpersons of the assembly and senate aging and health committees with a written evaluation of the program. The evaluation shall examine the effectiveness of the project in forestalling institutional placement, the costs of providing enriched services in a day care setting, participant satisfaction and program quality, and identification of the program design elements necessary for successful replication.

[6. Funds.] 5. GRANTS. (A) THE DIRECTOR, IN CONJUNCTION WITH THE COMMISSIONER OF HEALTH, MAY, WITHIN AMOUNTS APPROPRIATED THEREFOR, MAKE UP TO TWENTY GRANTS AVAILABLE ON A COMPETITIVE BASIS TO ELIGIBLE ENTITIES UNDER THIS SECTION. SUCH GRANTS MAY BE AVAILABLE FOR UP TO TWO HUNDRED THOUSAND DOLLARS FOR EACH ELIGIBLE ENTITY AND SHALL BE FOR ONE HUNDRED PERCENT OF ALLOWABLE EXPENDITURES FOR APPROVED SERVICES AND EXPENSES UNDER THIS SECTION.

(B) IN MAKING GRANTS, THE DIRECTOR, IN CONJUNCTION WITH THE COMMISSIONER OF HEALTH, MAY CONSIDER THE CRITERIA ESTABLISHED UNDER SUBDIVISION THREE OF THIS SECTION.

(C) Funds made available under this [section] SUBDIVISION shall supplement and not supplant any federal, state, or local funds expended by any entity, including a unit of general purpose local government or not-for-profit, to provide services under this section. Funds under this [section] SUBDIVISION cannot pay for individuals who are eligible under title nineteen of the federal social security act.

S 2. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to particular provider pharmacies and prescription drug coverage, as amended by section 37 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

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

S 3. This act shall take effect immediately.

PART CC

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

(D) 1. THE COMMISSIONER SHALL ENSURE FOR CONTINUITY OF CARE FOR INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY TRANSITIONING TO LESS RESTRICTIVE SETTINGS PURSUANT TO ANY CLOSURE, CONSOLIDATION, MERGER OR ANY OTHER ACTION THAT DIMINISHES CURRENT STATE OPERATED SERVICES. THE COMMISSIONER SHALL ENSURE THAT INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY SO AFFECTED ARE GIVEN THE OPTION OF TRANSITIONING TO STATE OPERATED SERVICES WITHIN THE DEVELOPMENTALLY DISABLED SERVICE OFFICES REGION WHERE THEY ARE CURRENTLY RECEIVING SERVICES. IF NO SUCH STATE SERVICE AS REQUESTED BY THE INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY OR THEIR PARENT, GUARDIAN OR ADVOCATE ARE AVAILABLE THEN SUCH INDIVIDUAL SHALL REMAIN IN THE FACILITY OR RESIDENCE UNTIL SAID SERVICES ARE AVAILABLE. THE COMMISSIONER SHALL DOCUMENT EACH OFFER OF STATE OPERATED OPPORTUNITIES AND SHALL RETAIN A RECORD OF THE SERVICES OFFERED.

2. IN THE EVENT NO SERVICES DESIRED BY THE INDIVIDUALS THAT ARE DEVELOPMENTALLY DISABLED ARE EITHER AVAILABLE OR EXIST WITHIN CURRENT STATE OPERATED SERVICES, THE OFFICE SHALL RECORD THE NAME, PARENT, GUARDIAN OR ADVOCATE AND SERVICES THEY ARE SEEKING. THE COMMISSIONER SHALL DEVELOP A RECORD OF SERVICES FOR STATE OPERATED SUPPORTIVE PLACEMENT OPTIONS THAT ARE NOT AVAILABLE WITH A PLAN TO ADDRESS THE UNMET NEEDS FOR THE FOLLOWING FISCAL YEAR. SUCH COMMISSIONER SHALL SUBMIT THE PLAN TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY NO LATER THAN DECEMBER THIRTY-FIRST OF EACH YEAR.

S 2. This act shall take effect immediately.

PART DD

Section 1. Subdivision 1 of section 364-i of the social services law, as amended by chapter 693 of the laws of 1996, is amended to read as follows:

1. (A) An individual, upon application for medical assistance, shall be presumed eligible for such assistance for a period of sixty days from the date of transfer from a general hospital, as defined in section twenty-eight hundred one of the public health law to a certified home health agency or long term home health care program, as defined in section thirty-six hundred two of the public health law, or to a hospice as defined in section four thousand two of the public health law, or to a residential health care facility as defined in section twenty-eight hundred one of the public health law, if the local department of social services determines that the applicant meets each of the following criteria: [(a)] (I) the applicant is receiving acute care in such hospital; [(b)] (II) a physician certifies that such applicant no longer requires acute hospital care, but still requires medical care which can be provided by a certified home health agency, long term home health care program, hospice or residential health care facility; [(c)] (III) the applicant or his representative states that the applicant does not have insurance coverage for the required medical care and that such care cannot be afforded; [(d)] (IV) it reasonably appears that the applicant is otherwise eligible to receive medical assistance; [(e)] (V) it reasonably appears that the amount expended by the state and the local social services district for medical assistance in a certified home health agency, long term home health care program, hospice or residential health care facility, during the period of presumed eligibility, would be less than the amount the state and the local social services district would expend for continued acute hospital care for such person; and [(f)] (VI) such other determinative criteria as the commissioner OF HEALTH shall provide by rule or regulation. If a person has been deter-

mined to be presumptively eligible for medical assistance, pursuant to this subdivision, and is subsequently determined to be ineligible for such assistance, the commissioner OF HEALTH, on behalf of the state and the local social services district shall have the authority to recoup from the individual the sums expended for such assistance during the period of presumed eligibility.

(B) AN INDIVIDUAL, UPON APPLICATION FOR MEDICAL ASSISTANCE, SHALL BE PRESUMED ELIGIBLE FOR SUCH ASSISTANCE FOR A PERIOD OF SIXTY DAYS FROM THE DATE OF RELEASE FROM A STATE CORRECTIONAL FACILITY AS DEFINED IN PARAGRAPH (A) OF SUBDIVISION FOUR OF SECTION TWO OF THE CORRECTION LAW OR A LOCAL CORRECTIONAL FACILITY AS DEFINED IN PARAGRAPH (A) OF SUBDIVISION SIXTEEN OF SECTION TWO OF THE CORRECTION LAW. IF A PERSON HAS BEEN DETERMINED TO BE PRESUMPTIVELY ELIGIBLE FOR MEDICAL ASSISTANCE, PURSUANT TO THIS SUBDIVISION, AND IS SUBSEQUENTLY DETERMINED TO BE INELIGIBLE FOR SUCH ASSISTANCE, THE COMMISSIONER OF HEALTH, ON BEHALF OF THE STATE AND THE LOCAL SOCIAL SERVICES DISTRICT SHALL HAVE THE AUTHORITY TO RECOUP FROM THE INDIVIDUAL THE SUMS EXPENDED FOR SUCH ASSISTANCE DURING THE PERIOD OF PRESUMED ELIGIBILITY.

S 2. Subdivision 1 of section 368-a of the social services law is amended by adding a new paragraph (aa) to read as follows:

(AA) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF LAW, REIMBURSEMENT BY THE STATE FOR PAYMENTS MADE, WHETHER BY THE DEPARTMENT OF HEALTH ON BEHALF OF A LOCAL SOCIAL SERVICES DISTRICT PURSUANT TO SECTION THREE HUNDRED SIXTY-SEVEN-B OF THIS TITLE OR BY A LOCAL SOCIAL SERVICES DISTRICT DIRECTLY, FOR MEDICAL ASSISTANCE FURNISHED TO AN INDIVIDUAL PRESUMED ELIGIBLE FOR MEDICAL ASSISTANCE UNDER PARAGRAPH (B) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-FOUR-I OF THIS TITLE, DURING THE PRESUMPTIVE ELIGIBILITY PERIOD, SHALL BE MADE FOR THE FULL AMOUNT EXPENDED FOR SUCH ASSISTANCE, AFTER FIRST DEDUCTING THEREFROM ANY FEDERAL FUNDS PROPERLY RECEIVED OR TO BE RECEIVED ON ACCOUNT OF SUCH EXPENDITURE.

S 3. This act shall take effect immediately.

PART EE

Section 1. The mental hygiene law is amended by adding a new section 7.46 to read as follows:

S 7.46 MENTAL HEALTH CRISIS INTERVENTION DEMONSTRATION PROGRAM.

(A) PROGRAM. (1) THE COMMISSIONER SHALL ESTABLISH A MENTAL HEALTH CRISIS INTERVENTION DEMONSTRATION PROGRAM FOR THE PURPOSE OF ASSISTING LAW ENFORCEMENT OFFICERS IN RESPONDING TO CRISIS SITUATIONS INVOLVING PERSONS WITH MENTAL ILLNESS.

(2) THE COMMISSIONER SHALL ESTABLISH WITHIN THE OFFICE THE POSITION OF MENTAL HEALTH CRISIS INTERVENTION TEAM TRAINING PROGRAM COORDINATOR WHO WILL SERVE AT THE PLEASURE OF THE COMMISSIONER AND WHO SHALL WORK WITH ANY LAW ENFORCEMENT AGENCY IN THE STATE THAT IS A PARTICIPANT IN THE DEMONSTRATION PROGRAM ESTABLISHED PURSUANT TO THIS SECTION OR REQUESTS ASSISTANCE TO COORDINATE THE PROVISION OF CRISIS INTERVENTION TEAM TRAINING TO ITS FIRST RESPONDERS AS PART OF SPECIALIZED RESPONSE TEAM OR AS PART OF THE TRAINING FOR FIRST RESPONDERS.

(3) THE CRISIS INTERVENTION TEAM TRAINING PROGRAM COORDINATOR SHALL:

(I) WORK WITH COMMUNITIES TO DEVELOP PARTNERSHIPS, COORDINATE ACTIVITIES AND PROMOTE COOPERATION AND COLLABORATION BETWEEN THE OFFICE, LAW ENFORCEMENT AGENCIES, COMMUNITY BASED MENTAL HEALTH TREATMENT PROVIDERS, AND PEOPLE WITH PSYCHIATRIC OR OTHER DISABILITIES AND THEIR FAMILIES TO PROVIDE CRISIS INTERVENTION TEAM TRAINING;

(II) PROVIDE SUPPORT, TRAINING AND COMMUNITY COORDINATION TO FACILITATE RELATIONSHIPS AND COLLABORATIVE EFFORTS BETWEEN MENTAL HEALTH SERVICE PROVIDERS IN THE COMMUNITY AND LAW ENFORCEMENT AGENCIES;

(III) PROVIDE ASSISTANCE AS DEEMED APPROPRIATE BY THE COMMISSIONER IN ESTABLISHING AND IMPLEMENTING THE CRISIS INTERVENTION TEAMS UNDER THIS PROGRAM; AND

(IV) SUBMIT A REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ON OR BEFORE NOVEMBER FIFTEENTH OF EACH YEAR THAT CONTAINS THE FOLLOWING:

(A) A REVIEW OF ALL LAW ENFORCEMENT AGENCIES THAT HAVE PROVIDED CRISIS INTERVENTION TEAM TRAINING TO THEIR OFFICERS AND THE NUMBER OF OFFICERS THAT HAVE COMPLETED THE TRAINING;

(B) A LIST OF COMMUNITIES IN THIS STATE THAT HAVE IMPLEMENTED THE CRISIS INTERVENTION TEAM TRAINING PROGRAM THROUGH TRAINING AND COORDINATION, INCLUDING THE LENGTH OF IMPLEMENTATION AND CURRENT STATUS OF THE PROGRAM;

(C) THE NUMBER OF RESPONSES MADE BY EACH CRISIS INTERVENTION TEAM INVOLVING AN INDIVIDUAL SUSPECTED OF EXPERIENCING A CRISIS RELATED TO A MENTAL HEALTH DIAGNOSIS AND THE OUTCOME OF SUCH INTERACTION;

(D) AN ANALYSIS OF THE GOALS DESCRIBED UNDER PARAGRAPH TWO OF SUBDIVISION (B) OF THIS SECTION AND ANY RECOMMENDATIONS ON HOW OUTCOMES MAY BE IMPROVED;

(E) RECOMMENDATIONS FOR IMPROVEMENT IN THE COMMUNITY BASED PARTNERSHIPS THAT SUPPORT CRISIS INTERVENTION TEAM RESPONSES; AND

(F) RECOMMENDATIONS FOR IMPROVEMENT IN THE LAW ENFORCEMENT AND PUBLIC SAFETY AGENCIES THAT PROVIDE CRISIS INTERVENTION TEAM RESPONSES.

(B) CRISIS INTERVENTION TEAMS. (1) THE COMMISSIONER IN CONSULTATION WITH THE NEW YORK STATE DIVISION OF CRIMINAL JUSTICE SERVICES, SHALL:

(I) ESTABLISH CRITERIA FOR THE DEVELOPMENT OF CRISIS INTERVENTION TEAMS; AND

(II) ESTABLISH, AND IMPLEMENT ON AN ONGOING BASIS, A TRAINING PROGRAM FOR ALL CURRENT AND NEW EMPLOYEES REGARDING THE POLICIES AND PROCEDURES ESTABLISHED PURSUANT TO THIS SECTION.

(2) THE GOALS OF THE CRISIS INTERVENTION TEAM PROGRAM SHALL INCLUDE BUT NOT BE LIMITED TO:

(I) PROVIDING IMMEDIATE RESPONSE BY SPECIFICALLY TRAINED LAW ENFORCEMENT OFFICERS;

(II) REDUCE THE LIKELIHOOD OF PHYSICAL CONFRONTATION;

(III) IDENTIFY UNDERSERVED POPULATIONS WITH MENTAL ILLNESS AND REFER THEM TO APPROPRIATE CARE;

(IV) DECREASE THE USE OF ARREST AND DETENTION OF PERSONS EXPERIENCING MENTAL HEALTH CRISES BY PROVIDING BETTER ACCESS TO TIMELY TREATMENT;

(V) PROVIDE THERAPEUTIC LOCATIONS OR PROTOCOL FOR OFFICERS TO BRING INDIVIDUALS IN CRISIS FOR ASSESSMENT THAT IS NOT AN INPATIENT HOSPITAL SETTING, LAW ENFORCEMENT OR JAIL FACILITY; AND

(VI) DECREASE INJURIES TO LAW ENFORCEMENT OFFICERS DURING CRISIS EVENTS.

(3) OTHER STATE AGENCIES SHALL PROVIDE COOPERATION AND ASSISTANCE TO THE PROGRAM TO ASSIST IN THE EFFECTIVE PERFORMANCE OF ITS DUTIES.

S 2. The mental hygiene law is amended by adding a new section 7.47 to read as follows:

S 7.47 INPATIENT DIVERSION PROGRAM.

(A) A LOCAL GOVERNMENTAL UNIT MAY APPLY TO ESTABLISH OR SEEK APPROVAL OF AN EXISTING INPATIENT DIVERSION PROGRAM, IN ACCORDANCE WITH THE PROVISIONS OF THIS SECTION.

(B) THE COMMISSIONER MAY APPROVE AN INPATIENT DIVERSION PROGRAM IF HE OR SHE DETERMINES THAT:

(I) SUCH PROGRAM IS LOCATED IN A FACILITY CERTIFIED UNDER ARTICLE THIRTY-ONE OF THIS CHAPTER, OR CO-LOCATED IN A HOSPITAL CERTIFIED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW;

(II) THE PRIMARY GOAL OF THE PROGRAM IS TO DIVERT INDIVIDUALS IN MENTAL HEALTH CRISIS FROM INPATIENT HOSPITALIZATION;

(III) THE PROGRAM HAS A MULTIDISCIPLINARY TEAM EQUIPPED TO PROVIDE APPROPRIATE SERVICES TO INDIVIDUALS IN MENTAL HEALTH CRISIS; AND

(IV) THE PROGRAM MEETS ANY OTHER REQUIREMENTS THE COMMISSIONER DEEMS NECESSARY TO ENSURE THE DELIVERY OF APPROPRIATE SERVICES TO INDIVIDUALS IN MENTAL HEALTH CRISIS.

(C) APPROVAL OF A PROGRAM UNDER THIS SECTION SHALL CONTINUE FOR A PERIOD OF TWO YEARS, UNLESS THE COMMISSIONER SEEKS TO DISCONTINUE THE APPROVAL OF A PROGRAM FOR GOOD CAUSE. THE LOCAL GOVERNMENTAL UNIT SHALL HAVE NOTICE AND AN OPPORTUNITY TO BE HEARD ON SUCH DISCONTINUANCE. GOOD CAUSE SHALL INCLUDE, BUT NOT BE LIMITED TO, THE INABILITY OF THE PROGRAM TO CONTINUE TO CARE FOR PEOPLE IN MENTAL HEALTH CRISIS AS EVIDENCED BY THE FAILURE TO MEET THE REQUIREMENTS IN SUBDIVISION (B) OF THIS SECTION.

(D) THE LOCAL GOVERNMENTAL UNIT SHALL REAPPLY FOR APPROVAL OF AN INPATIENT DIVERSION PROGRAM EVERY TWO YEARS. SUCH APPLICATION SHALL CONTAIN THE FOLLOWING INFORMATION:

(I) THE NUMBER OF INDIVIDUALS TREATED;

(II) THE NUMBER OF INDIVIDUALS DIVERTED FROM INPATIENT HOSPITALIZATION;

(III) THE NUMBER OF INDIVIDUALS HOSPITALIZED;

(IV) THE NUMBER OF INDIVIDUALS LINKED TO SERVICES; AND

(V) ANY OTHER INFORMATION THE COMMISSIONER DEEMS NECESSARY TO EVALUATE THE EFFECTIVENESS OF THE PROGRAM.

(E) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF ANY GENERAL, SPECIAL OR LOCAL LAW, AN AMBULANCE SERVICE AS DEFINED BY SUBDIVISION TWO OF SECTION THREE THOUSAND ONE OF THE PUBLIC HEALTH LAW AND ANY MEMBER THEREOF WHO IS AN EMERGENCY MEDICAL TECHNICIAN OR AN ADVANCED EMERGENCY MEDICAL TECHNICIAN TRANSPORTING A PERSON TO A HOSPITAL AS AUTHORIZED BY THIS SECTION, ANY PEACE OFFICERS, WHEN ACTING PURSUANT TO THEIR SPECIAL DUTIES, ANY POLICE OFFICERS, WHO ARE MEMBERS OF AN AUTHORIZED POLICE DEPARTMENT OR FORCE OR OF A SHERIFF'S DEPARTMENT, AND ANY MEMBERS OF MOBILE CRISIS OUTREACH TEAMS APPROVED BY THE COMMISSIONER PURSUANT TO SECTION 9.58 OF THIS CHAPTER, WHO ARE TAKING INTO CUSTODY AND TRANSPORTING A PERSON TO AN INPATIENT DIVERSION PROGRAM APPROVED UNDER THIS SECTION, AND ANY EMPLOYEE OF A LICENSED COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM, SPECIALLY TRAINED IN ACCORDANCE WITH STANDARDS DEVELOPED BY THE COMMISSIONER, WHO TRANSPORTS A PERSON TO A HOSPITAL, SHALL NOT BE LIABLE FOR DAMAGES FOR INJURIES ALLEGED TO HAVE BEEN SUSTAINED BY SUCH PERSON OR FOR THE DEATH OF SUCH PERSON ALLEGED TO HAVE OCCURRED BY REASON OF AN ACT OR OMISSION PROVIDED THAT SUCH EMERGENCY MEDICAL TECHNICIAN, ADVANCED EMERGENCY MEDICAL TECHNICIAN, PEACE OFFICER, POLICE OFFICER, MOBILE CRISIS OUTREACH TEAM MEMBER, OR SPECIALLY TRAINED EMPLOYEE OF A LICENSED COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM ACTED REASONABLY AND IN GOOD FAITH. NOTHING IN THIS SECTION SHALL BE DEEMED TO RELIEVE OR ALTER THE LIABILITY OF ANY SUCH AMBULANCE SERVICE OR MEMBERS THEREOF, PEACE OFFICERS, POLICE OFFICERS OR SPECIALLY TRAINED EMPLOYEES OF A LICENSED COMPREHENSIVE PSYCHIATRIC EMERGENCY PROGRAM FOR DAMAGES OR INJURIES OR DEATH ARISING OUT OF THE OPERATION OF MOTOR VEHICLES.

S 3. This act shall take effect immediately.

PART FF

Section 1. Section 13.15 of the mental hygiene law is amended by adding a new subdivision (c) to read as follows:

(C) SUBJECT TO AVAILABLE APPROPRIATIONS THEREFOR, THE COMMISSIONER SHALL CONDUCT A GEOGRAPHIC ANALYSIS OF SUPPORTS AND SERVICES IN COMMUNITY SETTINGS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES. THIS ANALYSIS SHALL ALSO IDENTIFY GAPS BETWEEN REQUIRED SUPPORTS AND SERVICES BY REGION OF THE STATE.

(1) IN ORDER TO PERFORM THE GEOGRAPHIC ANALYSIS OR TO GATHER DATA FOR PURPOSES OF PERFORMING THE GEOGRAPHIC ANALYSIS, THE COMMISSIONER MAY WORK IN COOPERATION AND AGREEMENT WITH OTHER OFFICES, DEPARTMENTS OR AGENCIES OF THE STATE, LOCAL OR FEDERAL GOVERNMENT, OR OTHER ORGANIZATIONS AND INDIVIDUALS, WHICH MAY INCLUDE PROVIDERS OF SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, REPRESENTATIVES FROM EMPLOYEE ORGANIZATIONS REPRESENTING DIRECT CARE WORKERS, CONSUMER REPRESENTATIVES INCLUDING PERSONS WITH DEVELOPMENTAL DISABILITIES, OR THEIR PARENTS OR GUARDIANS.

(2) SUCH ANALYSIS SHOULD INCLUDE BUT NOT BE LIMITED TO THE STATEWIDE NUMBER OF INDIVIDUALS SEEKING SERVICES, INCLUDING THOSE AWAITING PLACEMENT AND SHALL BE ORGANIZED BY THE TOTAL NUMBER OF INDIVIDUALS WITHIN EACH REGIONAL OFFICE'S SERVICE GEOGRAPHIC AREA WHO ARE AWAITING RESIDENTIAL PLACEMENT, DAY SERVICE SUPPORT, HOME AND COMMUNITY-BASED WAIVER SUPPORT, EMPLOYMENT SUPPORT, BEHAVIORAL HEALTH SERVICES AND SUPPORTS, OR OTHER COMMUNITY-BASED SUPPORT. SUCH ANALYSIS INFORMATION SHOULD ALSO BE CATEGORIZED BY THE AGE OF THE INDIVIDUAL AWAITING COMMUNITY SERVICES AND SUPPORTS AND THE AGE OF THEIR CAREGIVER, IF ANY, AND INCLUDE WAITLIST AND PLACEMENT INFORMATION SUCH AS:

(I) THE TYPE OF SUPPORTS AND SERVICES SUCH INDIVIDUALS ARE EXPECTED TO REQUIRE DIVIDED INTO CERTIFIED OUT-OF-HOME, SUPERVISED, SUPPORTIVE PLACEMENT NEEDS AND OTHER NON-PLACEMENT NEEDS AND THE NUMBER OF SUCH PERSONS WHO ARE MEDICALLY FRAIL REQUIRING INTENSIVE MEDICAL CARE;

(II) NON-CERTIFIED RESIDENTIAL PLACEMENTS OUTSIDE THE PARENT'S OR PARENTS' OR OTHER CAREGIVER'S HOME;

(III) THE NUMBER OF INDIVIDUALS EXPECTED TO REQUIRE HOME AND COMMUNITY SERVICES WAIVER-FUNDED HABILITATION SERVICES AT HOME;

(IV) THE TOTAL NUMBER OF INDIVIDUALS, WHO HAVE BEEN IDENTIFIED AS IN NEED OF SUPPORTS AND SERVICES WHO HAVE RECEIVED THESE SUPPORTS AND SERVICES AND ANY GAP BETWEEN REQUIRED SUPPORTS AND SERVICES AND THE SUPPORTS AND SERVICES PROVIDED;

(V) THE NUMBER OF EMERGENCY NEED RESIDENTIAL PLACEMENTS FOR THE PAST YEAR AND OTHER SUPPORTS AND SERVICES PROVIDED ON AN EMERGENCY BASIS;

(VI) THE NUMBER OF INDIVIDUALS WHO ARE CURRENTLY RECEIVING SUPPORTS AND SERVICES, INCLUDING RESIDENTIAL SERVICES, WHOSE CURRENT LIVING SITUATION IS NOT ADEQUATE TO MEET THEIR NEEDS AND WHO ARE AWAITING AN ALTERNATIVE PLACEMENT OR ALTERNATIVE SUPPORT AND SERVICE DELIVERY OPTIONS;

(VII) PROJECTED FUNDING REQUIREMENTS FOR INDIVIDUALS IDENTIFIED AS IN NEED OF SERVICES PURSUANT TO SUBPARAGRAPH (IV) OF THIS PARAGRAPH;

(VIII) AN UPDATED FIVE YEAR PROJECTION OF INDIVIDUALS WHO WILL REQUIRE ADDITIONAL IN-HOME SUPPORTS AND SERVICES AND/OR OUT-OF-HOME RESIDENTIAL PLACEMENTS; AND

(IX) ANY OTHER INFORMATION DEEMED NECESSARY BY THE COMMISSIONER.

(3) THE COMMISSIONER SHALL PREPARE ANNUALLY FOR THE GOVERNOR AND THE LEGISLATURE A WRITTEN EVALUATION REPORT CONCERNING THE DELIVERY OF SUPPORTS AND SERVICES IN THE COMMUNITY, INCLUDING THE AGGREGATE DATA COLLECTED PURSUANT TO THIS SECTION. ON OR BEFORE DECEMBER FIRST EACH

YEAR, THE COMMISSIONER SHALL SUBMIT A COPY OF SUCH REPORT, AND SUCH RECOMMENDATION AS HE OR SHE DEEMS APPROPRIATE, TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, AND THE RESPECTIVE MINORITY LEADERS OF EACH SUCH HOUSE. THE FIRST SUCH REPORT SHALL BE DUE BY NO LATER THAN MARCH FIRST, TWO THOUSAND SIXTEEN. THE REPORT SHALL ALSO BE MADE AVAILABLE TO THE PUBLIC AND SHALL BE PUBLISHED ON THE OFFICE'S WEBSITE IN AN APPROPRIATE LOCATION AT THE SAME TIME AS ITS SUBMISSION TO STATE OFFICIALS.

S 2. This act shall take effect immediately.

PART GG

Section 1. The mental hygiene law is amended by adding a new section 13.42 to read as follows:

S 13.42 TRANSFORMATION WORKGROUP.

1. THE COMMISSIONER OF THE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES SHALL ESTABLISH A TRANSFORMATION WORKGROUP FOR THE PURPOSE OF DEVELOPING A TRANSFORMATION PLAN WHICH WILL INCLUDE RECOMMENDATIONS AND STRATEGIES FOR MAINTAINING THE FISCAL VIABILITY OF SERVICE AND SUPPORT DELIVERY SYSTEM FOR PERSONS WITH DISABILITIES AND INCLUDE STRATEGIES THAT WILL ENABLE THE OFFICE TO COMPLY WITH FEDERAL AND STATE SERVICE DELIVERY REQUIREMENTS AND PROVIDE APPROPRIATE LEVELS OF CARE.

2. THE WORKGROUP SHALL BE COMPRISED OF THE COMMISSIONER OR HIS OR HER DESIGNEE; ORGANIZATIONS OR ASSOCIATIONS WHICH REPRESENT THE INTERESTS OF PERSONS WITH DISABILITIES, WHICH MAY INCLUDE PROVIDERS OF SERVICES, CONSUMER REPRESENTATIVES, ADVOCACY GROUPS, PERSONS WITH DEVELOPMENTAL DISABILITIES OR THEIR PARENTS OR GUARDIANS; AND AT THE DISCRETION OF THE COMMISSIONER ANY OTHER INDIVIDUAL, ENTITY, OR STATE AGENCY ABLE TO SUPPORT THE WORKGROUP IN COMPLETING ITS TASKS DESCRIBED UNDER THIS SECTION.

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

4. TRANSFORMATION PLAN. THE WORKGROUP SHALL DEVELOP A TRANSFORMATION PLAN AS WELL AS MAKE RECOMMENDATIONS FOR THE EXECUTION OF SUCH PLAN. THE PLAN WILL INCLUDE BUT NOT BE LIMITED TO AN ANALYSIS OF THE FOLLOWING:

(A) IDENTIFYING THE NEED FOR HOUSING AND RESIDENTIAL OPPORTUNITIES FOR PEOPLES WITH DISABILITIES, AND AN IDENTIFICATION OF ANY SHORTFALLS IN SERVICES, SUPPORTS, OR OPPORTUNITIES;

(B) PROVIDING A TIMELINE FOR TRANSITIONING SHELTERED WORKSHOPS TO A MORE INTEGRATED SETTING AND TRANSITIONING INDIVIDUALS, TO THE EXTENT CONSISTENT WITH THEIR SERVICE PLAN, INTO INTEGRATED EMPLOYMENT;

(C) INCREASING INTEGRATED EMPLOYMENT OPPORTUNITIES AND ALTERNATIVES TO INTEGRATED EMPLOYMENT FOR INDIVIDUALS WITH DISABILITIES WHO MAY NOT BENEFIT FROM SUCH WORK ENVIRONMENT;

(D) IDENTIFYING A TIMELINE FOR IMPLEMENTING AN EVIDENCE BASED AND EMPIRICALLY VALIDATED ASSESSMENT TOOL; AND

(E) FISCAL VIABILITY AND CLINICAL APPROPRIATENESS OF TRANSITIONING OPWDD SERVICES AND SUPPORTS INTO A MANAGED CARE PAYMENT MODEL.

5. THE WORKGROUP SHALL PUBLISH AND SUBMIT A SEMI-ANNUAL REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, AND THE SPEAKER OF THE ASSEMBLY BY DECEMBER FIRST, TWO THOUSAND FIFTEEN AND EVERY SIX MONTHS THEREAFTER. THE OFFICE SHALL POST SUCH REPORT ON ITS OFFICIAL WEBSITE. THE REPORT SHALL INCLUDE ALL RECOMMENDATIONS AND STRATEGIES DEVELOPED BY THE WORKGROUP INCLUDING ANY POLICY, RULE, OR REGULATION CHANGE AND ESTIMATED DATES AND TIMEFRAME TO IMPLEMENT ANY RECOMMENDATION OR STRATEGY.

S 2. This act shall take effect immediately.

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

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