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

4207

2015-2016 Regular Sessions

I N S E N A T E

March 9, 2015

Introduced by COMMITTEE ON RULES -- read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT to amend the education law, in relation to delivery of prescriptions off premises of a pharmacy; to amend the public health law, in relation to physician profiles, the promotion of public and private umbilical cord blood banking, financial responsibility and reimbursement data for early intervention program and electronic health records; to amend the state finance law, in relation to establishing the state health innovation plan account; to provide more accountability in expenditures made by the Statewide Health Information Network for New York (SHIN-NY); to repeal subdivision 9 of section 2803 of the public health law relating to reports to the commissioner of health by general hospitals regarding working conditions and limits on working hours for certain members of the hospital's staff; and to repeal paragraph (e) of subdivision 13 of section 2995-a of the public health law relating to physician profiles (Part A); to amend the social services law, in relation to the codification of the global cap; to amend the public health law, in relation to hospital payments; to amend parts A and B of chapter 1 of the laws of 2002, relating to the health care reform act of 2000, in relation to upper payment limits; to amend 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 public health law, in relation to establishing an energy efficiency and/or disaster preparedness demonstration program for residential health care facilities; 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 case payment rates for pediatric ventilator services; to authorize the commissioner of health to estab-

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

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lish young adult special populations demonstration programs; to amend the public health law, in relation to rates of payments at residential health care facilities and directing the commissioner of health to allow the provision of off-site services; to amend the social services law, in relation to prescriber determination and classes of drugs in Medicaid managed care, establishing a health technology assessment committee within the medical assistance program; to amend the public health law, in relation to establishing a hospital-home care-physician collaboration program; to amend the public health law, in relation to universal standards for coding of payment of claims for long term care and electronic payment of claims; to amend the social services law, in relation to services provided by school-based health centers; 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 health law, in relation to reporting by the commissioner of health on the health information technology demonstration program; to amend the social services law, in relation to provision and reimbursement of transportation costs; to amend the public health law, in relation to temporary adjustment to reimbursement rates for vital access providers; to amend the social services law, in relation to expansion of medical assistance coverage; to amend part H of chapter 59 of the laws of 2011, amending the public health law and other laws relating to general hospital inpatient reimbursement for annual rates, in relation to medicaid payments to nursing homes; to amend the public health law, in relation to residential health care facilities; to amend the public health law, in relation to requiring the commissioner of health to establish an office of accountability; to amend the social services law, in relation to supplemental medical assistance rates; to amend the public health law, in relation to quality related measures for general hospitals receiving payments for inpatient services; to repeal sections 50, 51, 52 and 53 of part C of chapter 60 of the laws of 2014 amending the social services law and other laws relating to eliminating prescriber prevails for brand name drugs with generic equivalents, in relation to eligibility for medical assistance and the basic health program; to amend the social services law, in relation to requiring the independent actuary to provide a complete actuarial memorandum; to repeal certain provisions of the social services law relating to prescriber determination and classes of drugs in Medicaid managed care; to repeal section 365-d of the social services law relating to early and periodic screening diagnosis and treatment outreach demonstration projects; to repeal paragraph (e) of subdivision 8 of section 2511 of the public health law relating to subsidy payments; and providing for the repeal of certain provisions upon expiration thereof (Part B); to amend part A of chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to rates of payment paid to certain providers by the Child Health Plus Program; and to amend part H of chapter 111 of the laws of 2010 relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, in relation to rates of payment paid to certain providers by the Child Health Plus Program (Part C); to amend chapter 884 of the laws of 1990, amending the public health law relating to authorizing bad debt and charity care allowances for certified home health agencies, in

relation to the effectiveness thereof; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to the effectiveness thereof; to amend the public health law, in relation to hospital assessments; to amend chapter 659 of the laws of 1997, constituting the long term care integration and finance act of 1997, in relation to the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential health care facilities, in relation to the effectiveness thereof; to amend part C of chapter 58 of the laws of 2007, amending the social services law and other laws relating to enacting the major components of legislation necessary to implement the health and mental hygiene budget for the 2007-2008 state fiscal year, in relation to delay of certain administrative costs; to amend chapter 81 of the laws of 1995, amending the public health law and other laws relating to medical reimbursement and welfare reform, in relation to reimbursements and the effectiveness thereof; to amend chapter 474 of the laws of 1996, amending the education law and other laws relating to rates for residential healthcare facilities, in relation to reimbursements; to amend chapter 451 of the laws of 2007, amending the public health law, the social services law and the insurance law, relating to providing enhanced consumer and provider protections, in relation to the effectiveness thereof; to amend the public health law, in relation to rates of payment for long term home health care programs and making such provisions permanent; to amend chapter 303 of the laws of 1999, amending the New York state medical care facilities finance agency act relating to financing health facilities, in relation to the effectiveness thereof; to amend chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, in relation to the effectiveness thereof; to amend the public authorities law, in relation to the transfer of certain funds; to amend subdivision (i) of section 111 of part H of chapter 59 of the laws of 2011, relating to enacting into law major components of legislation necessary to implement the health and mental hygiene budget for the 2011-2012 state fiscal plan, in relation to the effectiveness of program oversight and administration of managed long term care plans; to amend chapter 659 of the laws of 1997, amending the public health law and other laws relating to creation of continuing care retirement communities, in relation to the effectiveness thereof; to amend the public health law, in relation to residential health care facility, and certified home health agency services payments; to amend part B of chapter 109 of the laws of 2010, amending the social services law relating to transportation costs; to amend the social services law, in relation to contracting for transportation services; to amend chapter 459 of the laws of 1996 amending the public health law relating to recertification of persons providing emergency medical care, in relation to making such provisions permanent; to amend chapter 505 of the laws of 1995, amending the public health law relating to the operation of department of health facilities, in relation to making such provisions permanent; to amend the insurance law, in relation to exempting certain insurance companies from risk-based capital for property/casualty insurance; and to amend the insurance law, in relation to certain medical malpractice rates; to amend subdivision (o) of section 111 of part H of chapter 59 of the laws of 2011, amending the public health law relating to state wide planning and research cooperative system and general powers and

duties, in relation to the effectiveness of certain provisions; to amend chapter 56 of the laws of 2013 amending chapter 59 of the laws of 2011 amending the public health law and other laws relating to general hospital reimbursement for annual rates relating to the cap on local Medicaid expenditures, in relation to extending the provisions of such chapter; to amend chapter 58 of the laws of 2008 amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, in relation to the effectiveness thereof (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 insurance law, in relation to rating of individual and small group health insurance contracts and policies (Part G); to amend the public health law, in relation to the establishment and operation of limited services clinics (Part H); intentionally omitted (Part I); intentionally omitted (Part J); to amend the public health law, in relation to streamlining the certificate of need process for hospitals and diagnostic and treatment clinics providing primary care, public health and health planning council reviews, defining "construction" for purposes of hospitals, eliminating the requirement for a public need for a hospital prior to its approval by the public health and health planning council, applications for construction of hospitals and the improper delegation of authority to a management consultant by the governing authority of a general hospital (Part K); to amend the public health law, in relation to office-based surgery workgroups, facility fees, reporting and ambulatory surgery center accreditation (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); intentionally omitted (Part N); to amend chapter 111 of the laws of 2010 relating to the recovery of exempt income by the office of mental health for community residences and family-based treatment programs, in relation to the effectiveness thereof (Part O); to amend the education law, in relation to authorizing contracts for the provision of special education and related services for certain patients hospitalized in hospitals operated by the office of mental health; and to amend part M of chapter 56 of the laws of 2012 amending the education law, relating to authorizing contracts for the provision of special education and related services for certain patients hospitalized in hospitals operated by the office of mental health, in relation to the effectiveness thereof (Part P); to amend the public health law and the public authorities law, in relation to establishing a private equity pilot program (Part Q); to amend part A of chapter 111 of the laws of 2010 amending the mental hygiene law relating to the receipt of federal and state benefits received by individuals receiving care in facilities operated by an office of the department of mental hygiene, in relation to the effectiveness thereof (Part R); to amend the social services law, the executive law and the mental hygiene law, in relation to providing professional services to individuals with developmental disabilities in non-certified settings; in relation to the exemption of the nurse practice act for direct care staff in non-certified settings funded, authorized or approved by the office for people with developmental disabilities; and to repeal certain provisions of the mental hygiene law relating thereto (Part S); to amend the mental hygiene law, in relation to clarifying the authority of the commissioners in the department of mental hygiene to design and implement time-limited demonstration programs (Part T); to

amend the mental hygiene law, in relation to directing the commissioner of developmental disabilities to establish a procedure through which persons with developmental disabilities may choose to remain in a nonintegrated setting (Part U); to amend the mental hygiene law, in relation to providing state operated opportunities for people with developmental disabilities (Part V); to amend the mental hygiene law, in relation to monthly status reports on community investments (Part W); relating to the administration of services to people with developmental disabilities (Part X); to amend the mental hygiene law, in relation to requiring an annual geographic analysis of supports and services in community settings for individuals with developmental disabilities (Part Y); to amend the education law, in relation to including nurse practitioners as a provider of services for purposes of collaborative drug therapy management; and 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 making the authorization for pharmacists to perform collaborative drug therapy management permanent (Part Z); to amend the mental hygiene law, in relation to establishing a community housing wait list (Part AA); to amend the public health law and the education law, in relation to providing for the use of opioid antagonists in schools for opioid overdose prevention (Part BB); 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 establishing rate protections for behavioral health essential providers and the effectiveness thereof; to amend 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, in relation to transfer of funds and the effectiveness thereof (Part CC); to amend the mental hygiene law, in relation to integrated housing for individuals with developmental disabilities (Part DD); to amend the mental hygiene law, in relation to a temporary adjustment to reimbursement rates for behavioral health (Part EE); to amend the public health law, in relation to requiring the commissioner of health to provide certain records to the temporary president of the senate and the speaker of the assembly; requiring the commissioner of health to convene a task force to evaluate and make recommendations related to increasing the transparency and accountability of the health care reform act resources fund; and to amend the public health law, in relation to physician loan repayment awards and the distribution of grants for the health workforce retraining program; in relation to covered lives assessments in the Rochester region (Part FF); and to amend the public health law, in relation to the capital restructuring program (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 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

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

S 6. Intentionally omitted.

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

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

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

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

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

S 8. Paragraph (h) of subdivision 1 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, is amended to read as follows:

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

S 9. The opening paragraph of subdivision 1-a of section 2995-a of the public health law, as added by section 8 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

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

S 10. Subdivisions 3, 4, 6 and 9 of section 2995-a of the public health law, subdivisions 3, 6 and 9 as added by chapter 542 of the laws of 2000, and subdivision 4 as amended by chapter 477 of the laws of 2008, are amended to read as follows:

3. Each physician who is self-insured for professional medical malpractice shall periodically report to the department on forms and in the time and manner required by the commissioner the information specified in paragraph [(f)] (E) of subdivision one of this section, except that the physician shall report the dollar amount (to the extent of the physician's information and belief) for each judgment, award and settlement and not a level of significance or context.

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

6. A physician may elect to have his or her profile omit certain information provided pursuant to paragraphs (l), (m)[,] AND (n) [and (q)] of subdivision one of this section. In collecting information for such profiles and disseminating the same, the department shall inform physicians that they may choose not to provide such information required pursuant to paragraphs (l), (m)[,] AND (n) [and (q)] of subdivision one of this section.

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

S 11. Paragraph (d) of subdivision 13 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, is amended to read as follows:

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

S 12. Paragraph (e) of subdivision 13 of subdivision 2995-a of the public health law is REPEALED.

S 13. Subdivision 16 of section 2995-a of the public health law, as added by chapter 542 of the laws of 2000, is amended to read as follows:

16. [If, after initial dissemination of the physician data required by this section, the department determines that any such data is not useful for making quality determinations, the department shall recommend to the legislature the necessary statutory changes] HEALTH CARE PLANS SHALL PROVIDE THE DEPARTMENT WITH A LISTING, BY SPECIALTY, OF ALL PARTICIPATING PROVIDERS AS REQUIRED TO BE DISCLOSED UNDER PARAGRAPH SEVENTEEN OF SUBSECTION (A) OF SECTION THREE THOUSAND TWO HUNDRED SEVENTEEN-A OF THE INSURANCE LAW, PARAGRAPH SEVENTEEN OF SUBSECTION (A) OF SECTION FOUR THOUSAND THREE HUNDRED TWENTY-FOUR OF THE INSURANCE LAW, AND PARAGRAPH (R) OF SUBDIVISION ONE OF SECTION FORTY-FOUR HUNDRED EIGHT OF THIS CHAPTER. THE HEALTH CARE PLAN SHALL NOTIFY THE DEPARTMENT WITHIN FIFTEEN

DAYS OF THE ADDITION OR TERMINATION OF A PROVIDER FROM THE PLAN'S NETWORK. THE DEPARTMENT SHALL PROVIDE THIS INFORMATION TO THE PHYSICIANS AT ISSUE AND MAKE THIS INFORMATION AVAILABLE IN PHYSICIAN PROFILES REQUIRED UNDER THIS SECTION.

S 14. The public health law is amended by adding a new article 43-C to read as follows:

ARTICLE 43-C

PUBLIC AND PRIVATE UMBILICAL CORD BLOOD BANKING

SECTION 4371. PUBLIC AND PRIVATE UMBILICAL CORD BLOOD BANKING PROGRAM.

S 4371. PUBLIC AND PRIVATE UMBILICAL CORD BLOOD BANKING PROGRAM. 1. THE PUBLIC AND PRIVATE UMBILICAL CORD BLOOD BANKING PROGRAM IS HEREBY ESTABLISHED WITHIN THE DEPARTMENT TO PROMOTE PUBLIC AWARENESS OF THE POTENTIAL BENEFITS OF PUBLIC OR PRIVATE UMBILICAL CORD BLOOD BANKING TO FACILITATE PRE-DELIVERY ARRANGEMENTS FOR PUBLIC OR PRIVATE BANKING OF UMBILICAL CORD BLOOD DONATIONS.

2. THE DEPARTMENT SHALL:

A. DEVELOP A PUBLIC EDUCATION AND OUTREACH CAMPAIGN VIA WRITTEN MATERIALS, BROCHURES AND THE INTERNET TO PROMOTE PUBLIC OR PRIVATE UMBILICAL CORD BLOOD BANKING AWARENESS AND EDUCATION OF THE GENERAL PUBLIC AND POTENTIAL UMBILICAL CORD BLOOD DONORS OF THE BENEFITS OF PUBLIC OR PRIVATE UMBILICAL CORD BLOOD BANKING; AND

B. DEVELOP EDUCATIONAL MATERIALS AND BROCHURES WHICH SHALL BE MADE AVAILABLE TO THE GENERAL PUBLIC AND POTENTIAL UMBILICAL CORD BLOOD DONORS THROUGH LOCAL DEPARTMENTS OF HEALTH; HEALTH CARE PRACTITIONERS, INCLUDING OBSTETRICIANS, GYNECOLOGISTS, PEDIATRICIANS, AND MIDWIVES; HEALTH MAINTENANCE ORGANIZATIONS; HOSPITALS; CLINICS, WALK-IN MEDICAL CENTERS, MOBILE CARE UNITS, SURGI-CENTERS, AND URGENT CARE CENTERS; AND CLINICS AND ORGANIZATIONS SERVING PREGNANT WOMEN.

3. THE COMMISSIONER SHALL ACCEPT AND EXPEND ANY GRANTS, AWARDS, OR OTHER FUNDS OR APPROPRIATIONS AS MAY BE MADE AVAILABLE FOR THE PURPOSES OF THIS ARTICLE, SUBJECT TO LIMITATIONS AS TO THE APPROVAL OF EXPENDITURES AND AUDIT AS PRESCRIBED FOR STATE FUNDS BY THE STATE FINANCE LAW.

S 15. Section 2557 of the public health law is amended by adding a new subdivision 4 to read as follows:

4. THE COMMISSIONER SHALL COLLECT DATA, BY MUNICIPALITY, ON THE EARLY INTERVENTION PROGRAM AUTHORIZED UNDER THIS TITLE FOR PURPOSES OF IMPROVING THE EFFICIENCY, COST, EFFECTIVENESS, AND QUALITY OF SUCH PROGRAM. SUCH MUNICIPALITY DATA COLLECTION SHALL INCLUDE BUT NOT BE LIMITED TO:

(A) THE NUMBER AND AGES OF CHILDREN ENROLLED IN THE EARLY INTERVENTION PROGRAM;

(B) THE TOTAL NUMBER OF CHILDREN, WITHIN A MUNICIPALITY, RECEIVING A SINGLE SERVICE, THE PERCENTAGE OF THOSE CHILDREN BY SERVICE TYPE, AND THE AVERAGE FREQUENCY OF VISITS PER WEEK FOR SUCH SERVICE TYPE;

(C) THE TOTAL NUMBER OF CHILDREN, WITHIN A MUNICIPALITY, RECEIVING MULTIPLE SERVICES, THE PERCENTAGE OF THOSE CHILDREN BY SERVICE TYPE, THE AVERAGE FREQUENCY OF VISITS PER WEEK FOR SUCH SERVICE TYPE AND THE AVERAGE NUMBER OF SERVICE TYPES THAT EACH CHILD RECEIVES;

(D) THE TOTAL NUMBER OF CHILDREN, WITHIN A MUNICIPALITY, RECEIVING SERVICES BY SERVICE TYPE PER WEEK AND THE TOTAL NUMBER OF SERVICES BY SERVICE TYPE PER WEEK AUTHORIZED BY EARLY INTERVENTION PROVIDERS BY PROVIDER TYPE INCLUDING APPROVED AGENCIES, INSTITUTIONS, ORGANIZATIONS AND INDEPENDENT PROVIDERS;

(E) THE NUMBER OF NEW YORK STATE APPROVED AGENCIES, INSTITUTIONS, OR ORGANIZATIONS PROVIDING EARLY INTERVENTION SERVICES BY SERVICE SPECIALTY OR SPECIALTIES AND THE NUMBER OF NEW YORK STATE APPROVED INDEPENDENT

PROVIDERS OF EARLY INTERVENTION SERVICES BY SERVICE SPECIALTY OR SPECIALTIES;

(F) THE NUMBER AND PERCENTAGE OF CHILDREN RECEIVING A SINGLE SERVICE BY TYPE OF NEW YORK APPROVED SERVICE PROVIDER, AND THE NUMBER AND PERCENTAGE OF CHILDREN RECEIVING MULTIPLE SERVICES BY TYPE OF NEW YORK STATE APPROVED SERVICE PROVIDER;

(G) THE NUMBER OF SERVICES, BY SERVICE TYPE AND PROVIDER TYPE, THAT WERE IDENTIFIED ON THE IFSP THAT WERE NOT DELIVERED TO A CHILD;

(H) THE OVERALL NUMBER OF NEW YORK STATE APPROVED EVALUATORS;

(I) THE NUMBER OF FAMILIES RECEIVING FAMILY SUPPORTIVE SERVICES SUCH AS FAMILY TRAINING, COUNSELING, PARENT SUPPORT GROUPS, AND RESPITE;

(J) THE NUMBER OF CHILDREN THAT HAVE THIRD PARTY REIMBURSEMENT;

(K) THE NUMBER OF MEDICAL ASSISTANCE CLAIMS SUBMITTED. THE PERCENTAGE OF MEDICAL ASSISTANCE CLAIMS DENIED AND THE PERCENTAGE OF MEDICAL ASSISTANCE CLAIMS PAID. THE REASONS FOR THE DENIALS.

(L) THE NUMBER OF CLAIMS SUBMITTED FOR OTHER THAN MEDICAL ASSISTANCE. THE PERCENTAGE OF CLAIMS DENIED FOR OTHER THAN MEDICAL ASSISTANCE AND THE PERCENTAGE OF CLAIMS PAID FOR OTHER THAN MEDICAL ASSISTANCE. THE REASONS FOR THE DENIALS.

(M) BY MUNICIPALITY, THE LAPSE IN TIME BETWEEN THE COMPLETION OF A FINAL IFSP AND THE INITIATION OF SERVICES FOR ALL CHILDREN; AND

(N) THE NUMBER AND DOLLAR AMOUNTS OF CLAIMS SUBMITTED, BY PAYOR, THAT WERE NOT PAID WITHIN NINETY DAYS AND THE REASONS FOR NON-PAYMENT.

THE COMMISSIONER SHALL COLLECT AND ANALYZE SUCH DATA TO DETERMINE SERVICE AND UTILIZATION PATTERNS AND PROVIDE APPROPRIATE OVERSIGHT OF THE PROGRAM. THE COMMISSIONER SHALL REPORT THE INFORMATION AND ANALYSIS REQUIRED BY THIS SUBDIVISION TO THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE MINORITY LEADER OF THE SENATE, AND THE MINORITY LEADER OF THE ASSEMBLY FOR THE PERIOD MAY FIRST, TWO THOUSAND FIFTEEN TO DECEMBER THIRTY-FIRST, TWO THOUSAND FIFTEEN ON OR BEFORE MARCH FIRST, TWO THOUSAND SIXTEEN AND FOR EACH CALENDAR YEAR THEREAFTER ON OR BEFORE MARCH FIRST FOR THE PRECEDING CALENDAR YEAR.

S 16. Title 1 of article 29-D of the public health law is amended by adding a new section 2997-f to read as follows:

S 2997-F. ELECTRONIC HEALTH RECORDS. 1. ALL HOSPITALS LICENSED UNDER ARTICLE TWENTY-EIGHT OF THIS CHAPTER, ALL OFFICE-BASED SURGERY PRACTICES ACCREDITED PURSUANT TO SECTION TWO HUNDRED THIRTY-D OF THIS CHAPTER, AND ANY HEALTH CARE PROVIDER LICENSED PURSUANT TO TITLE EIGHT OF THE EDUCATION LAW WHO OPERATES A PRACTICE WHICH ACCEPTS UNSCHEDULED, WALK-IN APPOINTMENTS FROM PATIENTS THAT ARE NOT REGULARLY SEEN BY THE PRACTITIONER AND HAS EXTENDED HOURS OF OPERATION SHALL UTILIZE AND MAINTAIN AN ELECTRONIC HEALTH RECORD SYSTEM THAT CONNECTS TO THE LOCAL REGIONAL HEALTH INFORMATION ORGANIZATION TO FACILITATE THE EXCHANGE OF HEALTH INFORMATION.

2. EACH REGIONAL HEALTH INFORMATION ORGANIZATION SHALL ENSURE IT IS ACCESSIBLE AND CAPABLE OF CONNECTING ALL HOSPITALS AND HEALTH CARE PROVIDERS UNDER THIS SECTION, AND ANY OTHER HEALTH CARE PROVIDER OR QUALIFIED HEALTH ENTITY AND THEIR ELECTRONIC HEALTH RECORD VENDORS, INCLUDING, BUT NOT LIMITED TO, PRIVATE PHYSICIAN PRACTICES AND COUNTY HEALTH DEPARTMENTS THAT WISH TO CONNECT TO THE REGIONAL HEALTH INFORMATION ORGANIZATION.

3. HEALTH CARE PROVIDERS MAY APPLY FOR ANY FUNDING AVAILABLE FOR HEALTH INFORMATION TECHNOLOGY AND ELECTRONIC HEALTH RECORD INFRASTRUCTURE INCLUDING, BUT NOT LIMITED TO, THE STATE ELECTRONIC HEALTH RECORDS LOAN PROGRAM UNDER SECTION TWENTY-EIGHT HUNDRED TWELVE OF THIS CHAPTER.

4. THE COMMISSIONER SHALL ESTABLISH A PROCESS BY WHICH THE HEALTH CARE PROVIDERS COVERED BY THIS SECTION MAY APPLY FOR A WAIVER FROM THE ELECTRONIC HEALTH RECORD REQUIREMENTS IMPOSED BY THIS SECTION DUE TO ECONOMIC HARDSHIP, TECHNOLOGICAL LIMITATIONS THAT ARE NOT REASONABLY WITHIN THE CONTROL OF THE HEALTH CARE PROVIDER, OR OTHER EXCEPTIONAL CIRCUMSTANCE DEMONSTRATED BY THE HEALTH CARE PROVIDER.

S 17. The state finance law is amended by adding a new section 97-yyyy to read as follows:

S 97-YYYY. STATE HEALTH INNOVATION PLAN ACCOUNT. 1. THERE IS HEREBY ESTABLISHED IN THE JOINT CUSTODY OF THE STATE COMPTROLLER AND THE COMMISSIONER OF HEALTH AN ACCOUNT OF THE MISCELLANEOUS SPECIAL REVENUE FUND TO BE KNOWN AS THE "STATE HEALTH INNOVATION PLAN ACCOUNT".

2. NOTWITHSTANDING ANY OTHER PROVISION OF LAW, RULE OR REGULATION TO THE CONTRARY, THE STATE COMPTROLLER IS HEREBY AUTHORIZED AND DIRECTED TO RECEIVE FOR DEPOSIT TO THE CREDIT OF THE STATE HEALTH INNOVATION PLAN ACCOUNT, MONIES RECEIVED PURSUANT TO THE STATE INNOVATION MODEL INITIATIVE FROM THE CENTERS FOR MEDICARE AND MEDICAID INNOVATION.

3. MONEYS OF THE ACCOUNT, FOLLOWING APPROPRIATION BY THE LEGISLATURE, SHALL BE MADE AVAILABLE TO THE DEPARTMENT OF HEALTH FOR SERVICES AND EXPENSES OF THE STATE HEALTH INNOVATION PLAN.

S 18. Notwithstanding any other provision of law to the contrary, for periods beginning on or after April 1, 2015, any funds provided to support the Statewide Health Information Network (SHIN-NY) shall be contingent on the submission of a plan to the legislature, prepared by the commissioner of health in consultation with representatives of hospitals, physicians, other providers and consumers, detailing specifically how funds will be used to:

(1) support hospitals, physicians, and other providers in the achievement of federal meaningful use requirements;

(2) support DSRIP health information exchange and data requirements to help performing provider systems and the state meet DSRIP quality goals;

(3) increase participation in regional health information organizations by providers at reasonable costs to the providers;

(4) finalize patient consent requirements; and

(5) address concerns regarding liability of providers that lawfully share data that is then misused by other health information exchange participants.

S 19. This act shall take effect immediately except that:

(a) section seven of this act shall be deemed to have been in full force and effect on and after October 21, 2014;

(b) section fourteen of this act shall take effect on the one hundred eightieth day after it shall have become a law; provided that effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of such section on its effective date are authorized and directed to be made and completed on or before such effective date; and

(c) section sixteen of this act shall take effect two years after it shall have become a law; provided, however, that, effective immediately, the commissioner of health is authorized to promulgate any rules and regulations necessary to ensure that regional health care organizations are capable of complying with the provisions of such section on its effective date.

PART B

Section 1. Intentionally omitted.

S 2. Intentionally omitted.
S 3. Intentionally omitted.
S 4. Intentionally omitted.
S 5. Intentionally omitted.
S 6. Intentionally omitted.
S 7. Intentionally omitted.
S 8. The social services law is amended by adding a new section 368-g to read as follows:

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

(B) EXCEPT AS PROVIDED IN PARAGRAPH (C) OF THIS SUBDIVISION, FOR STATE FISCAL YEAR TWO THOUSAND THIRTEEN-TWO THOUSAND FOURTEEN OR ANY FISCAL YEAR THEREAFTER, THE SPENDING LIMIT CALCULATED PURSUANT TO PARAGRAPH (A) OF THIS SUBDIVISION SHALL BE INCREASED BY AN AMOUNT EQUAL TO THE DIFFERENCE BETWEEN THE TOTAL SOCIAL SERVICES DISTRICT MEDICAL ASSISTANCE EXPENDITURE AMOUNTS CALCULATED FOR SUCH PERIOD IN CONFORMANCE WITH SUBDIVISIONS (B), (C), (C-1), AND (D) OF SECTION ONE OF PART C OF CHAPTER FIFTY-EIGHT OF THE LAWS OF TWO THOUSAND FIVE AND THE TOTAL SOCIAL SERVICES DISTRICT MEDICAL EXPENDITURE AMOUNTS THAT WOULD HAVE RESULTED IF THE PROVISIONS OF SUBDIVISION (C-1) OF SUCH SECTION HAD NOT BEEN APPLIED.

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

2. SAVINGS ALLOCATION PLAN. NOTWITHSTANDING SECTION NINETY-TWO OF PART H OF CHAPTER FIFTY-NINE OF THE LAWS OF TWO THOUSAND ELEVEN, AS AMENDED, AND ANY OTHER CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR STATE FISCAL YEARS TWO THOUSAND ELEVEN-TWO THOUSAND TWELVE THROUGH TWO THOUSAND FIFTEEN-TWO THOUSAND SIXTEEN, THE DIRECTOR OF THE BUDGET, IN CONSULTATION WITH THE COMMISSIONER, SHALL ASSESS ON A MONTHLY BASIS, AS REFLECTED IN MONTHLY REPORTS ISSUED PURSUANT TO SUBDIVISION FIVE OF THIS SECTION, KNOWN AND PROJECTED DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE EXPENDITURES BY CATEGORY OF SERVICE AND BY GEOGRAPHIC REGIONS, AS DEFINED BY THE COMMISSIONER, AND IF THE DIRECTOR OF THE BUDGET DETERMINES THAT SUCH EXPENDITURES ARE EXPECTED TO CAUSE MEDICAL ASSISTANCE DISBURSEMENTS FOR SUCH PERIOD TO EXCEED THE PROJECTED DEPARTMENT MEDICAL ASSISTANCE STATE FUNDS DISBURSEMENTS IN THE ENACTED BUDGET FINANCIAL PLAN PURSUANT TO SUBDIVISION THREE

OF SECTION TWENTY-THREE OF THE STATE FINANCE LAW, THE COMMISSIONER, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL DEVELOP A MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN TO LIMIT SUCH SPENDING TO THE AGGREGATE LIMIT LEVEL SPECIFIED IN THE ENACTED BUDGET FINANCIAL PLAN, PROVIDED, HOWEVER, SUCH PROJECTIONS MAY BE ADJUSTED BY THE DIRECTOR OF THE BUDGET TO ACCOUNT FOR ANY CHANGES IN THE NEW YORK STATE FEDERAL MEDICAL ASSISTANCE PERCENTAGE AMOUNT ESTABLISHED PURSUANT TO THE FEDERAL SOCIAL SECURITY ACT, CHANGES IN PROVIDER REVENUES, REDUCTIONS TO LOCAL SOCIAL SERVICES DISTRICT MEDICAL ASSISTANCE ADMINISTRATION, AND BEGINNING APRIL FIRST, TWO THOUSAND TWELVE, THE OPERATIONAL COSTS OF THE NEW YORK STATE MEDICAL INDEMNITY FUND. SUCH PROJECTIONS MAY BE ADJUSTED BY THE DIRECTOR OF THE BUDGET TO ACCOUNT FOR INCREASED OR EXPEDITED DEPARTMENT OF HEALTH STATE FUNDS MEDICAL ASSISTANCE EXPENDITURES AS A RESULT OF A NATURAL OR OTHER TYPE OF DISASTER, INCLUDING A GOVERNMENTAL DECLARATION OF EMERGENCY. SUCH MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN SHALL BE DESIGNED TO REDUCE THE DEPARTMENT STATE FUNDS MEDICAL ASSISTANCE DISBURSEMENTS AUTHORIZED BY APPROPRIATIONS IN COMPLIANCE WITH THE FOLLOWING GUIDELINES:

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

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

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

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

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

(F) THE COMMISSIONER SHALL SEEK THE INPUT OF THE LEGISLATURE, AS WELL AS INPUT FROM ORGANIZATIONS REPRESENTING HEALTH CARE PROVIDERS, CONSUMERS, BUSINESSES, WORKERS, HEALTH INSURERS, AND OTHERS WITH RELEVANT EXPERTISE, IN DEVELOPING SUCH MEDICAL ASSISTANCE SAVINGS ALLOCATION PLAN TO THE EXTENT THAT ALL OR PART OF SUCH PLAN IS LIKELY, AS DETERMINED BY

THE COMMISSIONER, TO HAVE A MATERIAL IMPACT ON THE OVERALL MEDICAL ASSISTANCE PROGRAM, OR ON PARTICULAR CATEGORIES OF SERVICE, OR ON PARTICULAR GEOGRAPHIC REGIONS OF THE STATE;

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

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

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

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

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

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

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

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

4. CAP DIVIDEND. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, FOR STATE FISCAL YEARS BEGINNING ON AND AFTER APRIL FIRST, TWO THOUSAND FOURTEEN, THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, SHALL, PRIOR TO JANUARY FIRST OF EACH YEAR, DETERMINE THE EXTENT OF SAVINGS THAT HAVE BEEN ACHIEVED AS A RESULT OF THE APPLICATION OF THE PROVISIONS OF SUBDIVISIONS ONE AND TWO OF THIS SECTION, AND SHALL

FURTHER DETERMINE THE AVAILABILITY OF SUCH SAVINGS FOR DISTRIBUTION DURING THE LAST QUARTER OF SUCH STATE FISCAL YEAR. IN DETERMINING SUCH SAVINGS THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, MAY EXEMPT THE MEDICAL ASSISTANCE ADMINISTRATION PROGRAM FROM DISTRIBUTIONS UNDER THIS SECTION. THE COMMISSIONER OF HEALTH, IN CONSULTATION WITH THE DIRECTOR OF THE BUDGET, MAY DISTRIBUTE FUNDS UP TO AN AMOUNT EQUAL TO SUCH AVAILABLE SAVINGS IN ACCORDANCE WITH A DIVIDEND ALLOCATION PLAN THAT UTILIZES A METHODOLOGY THAT DISTRIBUTES SUCH FUNDS PROPORTIONATELY AMONG PROVIDERS AND PLANS IN NEW YORK'S MEDICAL ASSISTANCE PROGRAM. IN DEVELOPING SUCH DIVIDEND ALLOCATION PLAN THE COMMISSIONER OF HEALTH SHALL SEEK THE INPUT OF THE LEGISLATURE, AS WELL AS ORGANIZATIONS REPRESENTING HEALTH CARE PROVIDERS, CONSUMERS, BUSINESSES, WORKERS, HEALTH CARE INSURERS AND OTHERS WITH RELEVANT EXPERTISE. SUCH DIVIDEND ALLOCATION PLAN SHALL UTILIZE THREE YEARS OF THE MOST RECENTLY AVAILABLE SYSTEM-WIDE EXPENDITURE DATA REFLECTING BOTH MMIS AND MANAGED CARE ENCOUNTERS. DISTRIBUTIONS TO MANAGED CARE PLANS SHALL BE BASED ON THE ADMINISTRATIVE OUTLAYS STEMMING FROM PARTICIPATION IN THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER OF HEALTH MAY IMPOSE MINIMUM THRESHOLD AMOUNTS IN DETERMINING PROVIDER ELIGIBILITY FOR DISTRIBUTIONS PURSUANT TO THIS SECTION. NO LESS THAN FIFTY PERCENT OF THE AMOUNT AVAILABLE FOR DISTRIBUTION SHALL BE MADE AVAILABLE FOR THE PURPOSE OF ASSISTING ELIGIBLE PROVIDERS UTILIZING THE METHODOLOGY OUTLINED ABOVE. THE REMAINDER OF THE DISTRIBUTIONS PURSUANT TO THIS SECTION SHALL BE MADE AVAILABLE FOR THE PURPOSES OF ENSURING A MINIMUM LEVEL OF ASSISTANCE TO FINANCIALLY DISTRESSED AND CRITICALLY NEEDED PROVIDERS AS IDENTIFIED BY THE COMMISSIONER. THE COMMISSIONER OF HEALTH SHALL POST THE MEDICAL ASSISTANCE SAVINGS DIVIDEND ALLOCATION PLAN ON THE DEPARTMENT OF HEALTH'S WEBSITE AND SHALL PROVIDE WRITTEN COPIES OF SUCH PLAN TO THE CHAIRS OF THE SENATE FINANCE AND THE ASSEMBLY WAYS AND MEANS COMMITTEES AT LEAST THIRTY DAYS BEFORE THE DATE ON WHICH IMPLEMENTATION IS EXPECTED TO BEGIN. THE COMMISSIONER OF HEALTH IS AUTHORIZED TO SEEK SUCH FEDERAL APPROVALS AS MAY BE REQUIRED TO EFFECTUATE THE PROVISIONS OF THIS SECTION, INCLUDING, BUT NOT LIMITED TO, TO PERMIT PAYMENT OF SUCH DISTRIBUTIONS AS LUMPS SUMS AND TO SECURE WAIVERS FROM OTHERWISE APPLICABLE FEDERAL UPPER PAYMENT LIMIT RESTRICTIONS ON SUCH PAYMENTS. THE PROVISIONS OF THIS SECTION ARE SUBJECT TO THE REPORTING REQUIREMENTS SET FORTH IN SUBDIVISION SEVEN OF THIS SECTION.

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

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

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

(C) THE PRICE, INCLUDING, THE BASE RATE PLUS ANY UPCOMING RATE ADJUSTMENT; UTILIZATION, INCLUDING CURRENT ENROLLMENT, PROJECTED ENROLLMENT CHANGES AND ACUITY; MEDICAL ASSISTANCE REDESIGN TEAM INITIATIVES;

ONE-TIME INITIATIVES AND OTHER INITIATIVES DESCRIBING THE PROPOSED BUDGET ACTION IMPACT; AND ANY PRIOR YEAR INITIATIVE WITH CURRENT AND FUTURE YEAR IMPACTS FOR THE FOLLOWING CATEGORIES:

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

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

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

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

(F) THE MONTHLY REPORTS REQUIRED BY THIS SUBDIVISION SHALL BE PROVIDED TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE, THE SPEAKER OF THE ASSEMBLY, THE CHAIR OF THE SENATE FINANCE COMMITTEE, THE CHAIR OF THE ASSEMBLY WAYS AND MEANS COMMITTEE, AND THE CHAIRS OF THE SENATE AND ASSEMBLY HEALTH COMMITTEES. SUCH REPORTS AND RELATED DOCUMENTS PROVIDED TO THE LEGISLATURE SHALL ALSO BE POSTED ON THE WEBSITE AS MAINTAINED BY THE DEPARTMENT.

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

(A) THE STATE MEDICAL ASSISTANCE STATE FUNDS EXPENDITURES ON THE CLOSE OUT OF THE PRIOR YEAR;
(B) A CURRENT YEAR RE-ESTIMATE;
(C) THE PROSPECTIVE TWO-YEAR ESTIMATE; AND
(D) ANY OTHER INFORMATION DEEMED NECESSARY AND APPROPRIATE.

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

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

S 9. Intentionally omitted.

S 10. Intentionally omitted.
S 11. Intentionally omitted.
S 12. Intentionally omitted.
S 13. Subdivision (e) of section 2826 of the public health law, as added by section 27 of part C of chapter 60 of the laws of 2014, is amended to read as follows:
(e) Notwithstanding any law to the contrary, general hospitals defined as critical access hospitals pursuant to title XVIII of the federal social security act shall be allocated no less than [five] SEVEN million FIVE HUNDRED THOUSAND dollars annually pursuant to this section. The department of health shall provide a report to the governor and legislature no later than [December] JUNE first, two thousand [fourteen] FIFTEEN providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals, INCLUDING AN EXAMINATION OF PERMANENT MEDICAID RATE METHODOLOGY CHANGES.
S 14. Section 2826 of the public health law is amended by adding a new subdivision (f) to read as follows:
(F) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, NO LESS THAN TEN MILLION DOLLARS SHALL BE ALLOCATED TO PROVIDERS DESCRIBED IN THIS SUBDIVISION; PROVIDED, HOWEVER THAT IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE FOR ANY ELIGIBLE PROVIDER, OR FOR ANY POTENTIAL INVESTMENT UNDER THIS SUBDIVISION THEN THE NON-FEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.
(I) PROVIDERS SERVING RURAL AREAS AS SUCH TERM IS DEFINED IN SECTION TWO THOUSAND NINE HUNDRED FIFTY-ONE OF THIS CHAPTER, INCLUDING BUT NOT LIMITED TO HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AMBULATORY SURGERY CENTERS AND CLINICS SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT UNDER A SUPPLEMENTAL RATE METHODOLOGY FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING THE QUALITY OF CARE.
(II) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, AND SUBJECT TO FEDERAL FINANCIAL PARTICIPATION, ESSENTIAL COMMUNITY PROVIDERS, WHICH, FOR THE PURPOSES OF THIS SECTION, SHALL MEAN A PROVIDER THAT OFFERS HEALTH SERVICES WITHIN A DEFINED AND ISOLATED GEOGRAPHIC REGION WHERE SUCH SERVICES WOULD OTHERWISE BE UNAVAILABLE TO THE POPULATION OF SUCH REGION, SHALL BE ELIGIBLE FOR ENHANCED PAYMENTS OR REIMBURSEMENT UNDER A SUPPLEMENTAL RATE METHODOLOGY FOR THE PURPOSE OF PROMOTING ACCESS AND IMPROVING QUALITY OF CARE. ELIGIBLE PROVIDERS UNDER THIS PARAGRAPH MAY INCLUDE, BUT ARE NOT LIMITED TO, HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, AMBULATORY SURGERY CENTERS AND CLINICS.
(III) IN MAKING SUCH PAYMENTS THE COMMISSIONER MAY CONTEMPLATE THE EXTENT TO WHICH ANY SUCH PROVIDER RECEIVES ASSISTANCE UNDER SUBDIVISION (A) OF THIS SECTION AND MAY REQUIRE SUCH PROVIDER TO SUBMIT A WRITTEN PROPOSAL DEMONSTRATING THAT THE NEED FOR MONIES UNDER THIS SUBDIVISION EXCEEDS MONIES OTHERWISE DISTRIBUTED PURSUANT TO THIS SECTION.
(IV) PAYMENTS UNDER THIS SUBDIVISION MAY INCLUDE, BUT NOT BE LIMITED TO, TEMPORARY RATE ADJUSTMENTS, LUMP SUM MEDICAID PAYMENTS, SUPPLEMENTAL RATE METHODOLOGIES AND ANY OTHER PAYMENTS AS DETERMINED BY THE COMMISSIONER.
(V) PAYMENTS UNDER THIS SUBDIVISION SHALL BE SUBJECT TO APPROVAL BY THE DIRECTOR OF THE BUDGET.
(VI) THE COMMISSIONER MAY PROMULGATE REGULATIONS TO EFFECTUATE THE PROVISIONS OF THIS SUBDIVISION.

S 15. Subparagraph (iv) of paragraph (b) of subdivision 6 of section 367-a of the social services law, as amended by section 40 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

(iv) individuals [enrolled in health maintenance organizations or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs, except that such persons, other than persons otherwise exempted from co-payments pursuant to subparagraphs (i), (ii), (iii) and (v) of this paragraph, and other than those persons enrolled in a managed long term care program, shall be subject to co-payments as described in subparagraph (v) of paragraph (d) of this subdivision] WHOSE FAMILY INCOME IS LESS THAN ONE HUNDRED PERCENT OF THE FEDERAL POVERTY LINE, AS DEFINED IN SUBPARAGRAPH FOUR OF PARAGRAPH (A) OF SUBDIVISION ONE OF SECTION THREE HUNDRED SIXTY-SIX OF THIS TITLE, FOR A FAMILY OF THE SAME SIZE; and

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 adjust-

ment determinations after the disproportionate share hospital payment adjustment caps have been calculated for such period under sections 1923(f) and (g) of the federal social security act. Such adjustment payment may be added to rates of payment or made as aggregate payments to eligible public general hospitals.

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

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

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

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

S 24. Intentionally omitted.

S 25. Intentionally omitted.

S 26. Intentionally omitted.

S 27. Intentionally omitted.

S 28. Sections 50, 51, 52 and 53 of part C of chapter 60 of the laws of 2014 amending the social services law and other laws relating to eliminating prescriber prevails for brand name drugs with generic equivalents are REPEALED.

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

Section 1. (a) Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for professional services provided by physicians, nurse practitioners and physician assistants who are participating in a plan for the management of clinical practice at the State University of New York, in accordance with title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, in amounts that will increase fees for such professional services to an amount equal to the average commercial or Medicare rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule [or], made as aggregate lump sum payments to eligible clinical practice plans authorized to receive professional fees OR MADE AS SUPPLEMENTAL PAYMENTS MADE FOR SUCH PURPOSE AS DESCRIBED HEREIN TO MEDICAID MANAGED CARE ORGANIZATIONS. SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS UNDER THIS SECTION SHALL BE DISTRIBUTED TO PROVIDERS AS DETERMINED BY THE MANAGED CARE MODEL CONTRACT AND MAY UTILIZE MANAGED CARE ORGANIZATION REPORTED ENCOUNTER DATA AND OTHER SUCH METRICS AS DETERMINED BY THE DEPARTMENT OF HEALTH IN ORDER TO ENSURE RATES OF PAYMENT EQUIVALENT TO THE AVERAGE COMMERCIAL OR MEDICARE RATE THAT WOULD OTHERWISE BE RECEIVED FOR SUCH SERVICES RENDERED BY SUCH PHYSICIANS, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.

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

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

S 93. 1. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, and subject to the availability of federal financial participation, effective for the period April 1, 2011 through March 31, 2012, and each state fiscal year thereafter, the department of health is authorized to make supplemental Medicaid payments OR SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS for professional services provided by physicians, nurse practitioners and physician assistants who are employed by a public benefit corporation or a non-state operated public general hospital operated by a public benefit corporation or who are providing professional services at a facility of such public benefit corporation as either a member of a practice plan or an employee of a professional corporation or limited liability corporation under contract to provide services to patients of such a public benefit corporation, in

accordance with title 11 of article 5 of the social services law for patients eligible for federal financial participation under title XIX of the federal social security act, in amounts that will increase fees for such professional services to an amount equal to either the Medicare rate or the average commercial rate that would otherwise be received for such services rendered by such physicians, nurse practitioners and physician assistants, provided, however, that such supplemental fee payments shall not be available with regard to services provided at facilities participating in the Medicare Teaching Election Amendment. The calculation of such supplemental fee payments shall be made in accordance with applicable federal law and regulation and subject to the approval of the division of the budget. Such supplemental Medicaid fee payments may be added to the professional fees paid under the fee schedule [or], made as aggregate lump sum payments to entities authorized to receive professional fees OR MADE AS SUPPLEMENTAL PAYMENTS MADE FOR SUCH PURPOSE AS DESCRIBED HEREIN TO MEDICAID MANAGED CARE ORGANIZATIONS. SUPPLEMENTAL MEDICAID MANAGED CARE PAYMENTS UNDER THIS SECTION SHALL BE DISTRIBUTED TO PROVIDERS AS DETERMINED BY THE MANAGED CARE MODEL CONTRACT AND MAY UTILIZE MANAGED CARE ORGANIZATION REPORTED ENCOUNTER DATA AND OTHER SUCH METRICS AS DETERMINED BY THE DEPARTMENT OF HEALTH IN ORDER TO ENSURE RATES OF PAYMENT EQUIVALENT TO THE AVERAGE COMMERCIAL OR MEDICARE RATE THAT WOULD OTHERWISE BE RECEIVED FOR SUCH SERVICES RENDERED BY SUCH PHYSICIANS, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.

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

S 31. Intentionally omitted.

S 32. Intentionally omitted.

S 33. Intentionally omitted.

S 34. Transportation assessment for people with developmental disabilities and other populations. (a) The commissioner of the office for people with developmental disabilities is authorized to contract with one or more entities to conduct an assessment of the mobility and transportation needs of persons with disabilities, including for integrated employment opportunities in accordance with section 13.41 of the mental hygiene law, as well as the mentally ill, those who engage in chemical abuse or are chemically dependent, and the aging. The contractor shall consult with the office for people with developmental disabilities,

department of transportation, department of health, office for the aging, office of mental health, office of alcoholism and substance abuse services, and stakeholders including consumer groups, transportation providers and transportation systems in conducting the assessment. The assessment shall include but not be limited to: the identification of locally based transportation providers and transportation systems equipped to participate in a possible pilot demonstration program; considerations regarding the availability of public transportation, public safety concerns and the duplication of services; reporting requirements for cost savings and evaluation of whether specialized care needs are being met; recommendations for the implementation of shared software to enable entities to track services, manage costs among providers, consolidate routes and provide a registry identifying participating clients and any specialized care needs that must be met in order to effectively provide transportation; recommendations for rate adjustments or reimbursement changes; and identification of any legal, statutory or regulatory, and funding barriers.

(b) Following the assessment, the contractor shall consult with the office for people with developmental disabilities, department of transportation, department of health, office for the aging, office of mental health, office of alcoholism and substance abuse services, and stakeholders including consumer groups, transportation providers and transportation systems for the development of a pilot demonstration program to coordinate medical and non-medical transportation services, maximize funding sources, enhance community integration and any other related tasks.

(c) The contractor shall report its findings from its assessment and make recommendations regarding the creation of a transportation pilot demonstration program for persons with disabilities, including for integrated employment opportunities in accordance with section 13.41 of the mental hygiene law, as well as the mentally ill, those who engage in chemical abuse or are chemically dependent, and the aging, to the governor, the temporary president of the senate and the speaker of the assembly no later than January 1, 2016. Any transportation pilot demonstration program resulting from the assessment authorized pursuant to this section shall be subject to legislative approval.

S 35. Intentionally omitted.

S 36. Intentionally omitted.

S 37. Intentionally omitted.

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

27. FOR PERIODS ON OR AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, THE COMMISSIONER SHALL AUTHORIZE AN ENERGY EFFICIENCY AND/OR DISASTER PREPAREDNESS DEMONSTRATION PROGRAM FOR RESIDENTIAL HEALTH CARE FACILITIES. SUCH PROGRAM SHALL INCLUDE AN EVALUATION OF FACILITY ENERGY EFFICIENCY AND DISASTER PREPAREDNESS STATUS AND A FACILITY BASED COST/BENEFIT ANALYSIS OF POTENTIAL MODIFICATIONS. THE DEPARTMENT SHALL DEVELOP A PLAN FOR THE PROGRAM, SUBJECT TO A MEMORANDUM OF UNDERSTANDING WITH THE LEGISLATURE THAT, AT A MINIMUM, DETAILS: ELIGIBILITY FOR PARTICIPATION, FUNDING SOURCES, PROJECTED COST SAVINGS TO FACILITIES AND THE STATE, THE MANNER IN WHICH SAVINGS MAY BE SHARED BETWEEN THE STATE AND FACILITIES, AN IMPLEMENTATION TIMELINE AND ANY OTHER PLAN SPECIFIC INFORMATION AS APPROPRIATE.

S 39. Intentionally omitted.

S 40. Intentionally omitted.

S 41. Intentionally omitted.

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

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

S 43. Subparagraph 6 of paragraph (b) of subdivision 1 of section 366 of the social services law, as added by section 1 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

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

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

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

account size and scope of provider operations as a factor relevant to eligibility for such funds. Each recipient of such funds shall be required to document and demonstrate the effective use of funds distributed herein. IF FEDERAL FINANCIAL PARTICIPATION IS UNAVAILABLE, THEN THE NONFEDERAL SHARE OF PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS STATE GRANTS.

S 45. Intentionally omitted.

S 46. Intentionally omitted.

S 47. Intentionally omitted.

S 48. Intentionally omitted.

S 49. Subparagraph (i) of paragraph (e-2) of subdivision 4 of section 2807-c of the public health law, as added by section 13 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

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

S 50. Young adult special populations demonstration programs. The commissioner of health shall be authorized to establish up to four young adult special populations demonstration programs to provide cost effective, necessary services and enhanced quality of care for targeted populations in order to demonstrate the effectiveness of the programs. Eligible individuals shall have severe and chronic medical or health problems, or multiple disabling conditions which may be combined with developmental disabilities. The programs shall provide more appropriate settings and services for these individuals, help prevent out of state placements and allow repatriation back to their home communities. Eligible operator applicants shall be not-for-profit with demonstrated expertise in caring for the targeted population including persons with severe and chronic medical or health problems or multiple disabling conditions and a record of providing quality care.

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

Of the four demonstrations:

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

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

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

S 51. Paragraph d of subdivision 20 of section 2808 of the public health law, as added by section 8 of part H of section 59 of the laws of 2011, is amended to read as follows:

d. Notwithstanding any contrary provision of law, rule or regulation, for rate periods on and after April first, two thousand eleven THROUGH MARCH THIRTY-FIRST, TWO THOUSAND FIFTEEN, the commissioner may reduce or eliminate the payment factor for return on or return of equity in the capital cost component of Medicaid rates of payment for services provided by residential health care facilities.

S 52. Section 2803 of the public health law is amended by adding a new subdivision 11 to read as follows:

11. NOTWITHSTANDING ANY PROVISION OF LAW, RULE OR REGULATION TO THE CONTRARY, THE COMMISSIONER SHALL ALLOW DIAGNOSTIC AND TREATMENT CENTERS AND OUTPATIENT CLINICS OF GENERAL HOSPITALS TO PROVIDE OFF-SITE SERVICES TO EXISTING PATIENTS IN NEED OF PROFESSIONAL SERVICES AVAILABLE AT THE DIAGNOSTIC AND TREATMENT CENTER OR GENERAL HOSPITAL OUTPATIENT CLINIC, BUT, DUE TO THE INDIVIDUAL'S MEDICAL CONDITION, IS UNABLE TO RECEIVE ON-SITE SERVICES AT THE DIAGNOSTIC AND TREATMENT CENTER OR GENERAL HOSPITAL OUTPATIENT CLINIC.

S 53. 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] 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]. IF the prescriber[,] DETERMINES after consulting with the managed care provider, that such drugs, in the prescriber's reasonable professional judgment, are medically necessary and warranted, THE PRESCRIBER'S DETERMINATION SHALL BE FINAL.

S 54. Subdivision 25-a of section 364-j of the social services law is REPEALED.

S 55. 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 SHALL CONVENE A HEALTH TECHNOLOGY ASSESSMENT COMMITTEE. THE COMMITTEE SHALL, AT THE REQUEST OF THE COMMISSIONER, PROVIDE ADVICE AND MAKE RECOMMENDATIONS REGARDING COVERAGE OF HEALTH TECHNOLOGY FOR PURPOSES OF THE MEDICAL ASSISTANCE PROGRAM. THE COMMISSIONER 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.

2. (A) THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE SHALL CONSIST OF THIRTEEN MEMBERS, SEVEN OF WHOM SHALL BE APPOINTED BY THE COMMISSIONER, THREE MEMBERS SHALL BE APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE, AND THREE MEMBERS SHALL BE APPOINTED BY THE SPEAKER OF THE ASSEMBLY. MEMBERS SHALL SERVE THREE YEAR TERMS; EXCEPT THAT FOR THE

INITIAL APPOINTMENTS TO THE COMMITTEE, THREE MEMBERS APPOINTED BY THE COMMISSIONER, AND ONE OF THE MEMBERS APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE AND BY THE SPEAKER OF THE ASSEMBLY, SHALL SERVE ONE YEAR TERMS, THREE MEMBERS APPOINTED BY THE COMMISSIONER, AND ONE OF THE MEMBERS APPOINTED BY THE TEMPORARY PRESIDENT OF THE SENATE AND BY THE SPEAKER OF THE ASSEMBLY, SHALL SERVE TWO YEAR TERMS; AND THE REMAINING 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) THREE PERSONS LICENSED AND ACTIVELY ENGAGED IN THE PRACTICE OF MEDICINE IN THIS STATE;

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

(III) ONE PERSON WHO IS A REPRESENTATIVE OF A HEALTH TECHNOLOGY OR MEDICAL DEVICE ORGANIZATION WITH A REGIONAL, STATEWIDE OR NATIONAL CONSTITUENCY;

(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;

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

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

(VIII) ONE PERSON WHO IS A HEALTH ECONOMIST; AND

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

(C) THE COMMITTEE MAY INVITE AND CONSULT WITH SCIENTIFIC, TECHNICAL OR CLINICAL EXPERTS WITH DEMONSTRATABLE EXPERIENCE OR KNOWLEDGE OF THE TECHNOLOGY UNDER REVIEW.

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 SHALL PROVIDE INTERNET ACCESS TO ALL MEETINGS OF SUCH COMMITTEE THROUGH THE DEPARTMENT'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 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, CONSIDER ANY MATTER RELATING TO HEALTH TECHNOLOGY ASSESSMENT. THE COMMISSIONER SHALL PROVIDE MEMBERS OF THE COMMITTEE WITH ANY EVIDENCE OR INFORMATION RELATED TO THE HEALTH TECHNOLOGY ASSESSMENT INCLUDING, BUT NOT LIMITED TO, INFORMATION SUBMITTED BY

MEMBERS OF THE PUBLIC. THE COMMISSIONER SHALL PROVIDE SIXTY DAYS PUBLIC NOTICE ON THE DEPARTMENT'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, THE PROPOSALS TO BE CONSIDERED BY THE COMMITTEE, AND THE SYSTEMATIC EVIDENCE-BASED ASSESSMENT PREPARED IN ACCORDANCE WITH THIS SUBDIVISION. THE COMMITTEE SHALL ALLOW INTERESTED PARTIES A REASONABLE OPPORTUNITY TO MAKE AN ORAL PRESENTATION TO THE COMMITTEE RELATED TO THE HEALTH TECHNOLOGY TO BE REVIEWED AND TO SUBMIT WRITTEN INFORMATION. THE COMMITTEE SHALL CONSIDER ANY INFORMATION PROVIDED BY ANY INTERESTED PARTY, INCLUDING, BUT NOT LIMITED TO, HEALTH CARE PROVIDERS, HEALTH CARE FACILITIES, PATIENTS, CONSUMERS AND MANUFACTURERS. FOR ALL HEALTH TECHNOLOGIES SELECTED FOR REVIEW, THE COMMISSIONER SHALL CONDUCT A SYSTEMATIC EVIDENCE-BASED ASSESSMENT OF THE HEALTH TECHNOLOGY'S SAFETY AND CLINICAL EFFICACY. THE ASSESSMENT SHALL USE ESTABLISHED SYSTEMATIC REVIEW ELEMENTS, SUCH AS A PICO (POPULATION, INTERVENTION, COMPARATOR AND OUTCOMES) STATEMENT, KEY QUESTIONS, PRESPECIFIED INCLUSION AND EXCLUSION CRITERIA, STUDY QUALITY ASSESSMENT, AND DATA SYNTHESIS. UPON COMPLETION, THE SYSTEMATIC, EVIDENCE-BASED ASSESSMENT SHALL BE MADE AVAILABLE TO THE PUBLIC.

6. THE COMMISSIONER SHALL PROVIDE NOTICE OF ANY COVERAGE RECOMMENDATIONS DEVELOPED BY THE COMMITTEE BY MAKING SUCH INFORMATION AVAILABLE ON THE DEPARTMENT'S WEBSITE. SUCH PUBLIC NOTICE SHALL INCLUDE: A SUMMARY OF THE DELIBERATIONS OF THE COMMITTEE; A SUMMARY OF THE POSITIONS OF THOSE MAKING PUBLIC COMMENTS AT MEETINGS OF THE COMMITTEE AND ANY SAFETY AND HEALTH OUTCOMES DATA SUBMITTED BY ANY INTERESTED PARTY; THE RESPONSE OF THE COMMITTEE TO THOSE COMMENTS, IF ANY; THE CLINICAL EVIDENCE UPON WHICH THE COMMITTEE BASES ITS RECOMMENDATIONS; AND THE FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE INCLUDING A FINAL EVIDENCE-BASED SYSTEMATIC ASSESSMENT.

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

8. THE RECOMMENDATIONS OF THE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE, MADE PURSUANT TO THIS SECTION, SHALL BE BASED ON A REVIEW OF THE EVIDENCE PRESENTED TO THE COMMITTEE, INCLUDING CLINICAL EFFECTIVENESS, PATIENT OUTCOMES, IMPACT ON AT RISK AND UNDERSERVED POPULATIONS, 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 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 SHALL PROVIDE ADMINISTRATIVE SUPPORT TO THE COMMITTEE.

S 56. The public health law is amended by adding a new section 2805-x to read as follows:

S 2805-X. HOSPITAL-HOME CARE-PHYSICIAN COLLABORATION PROGRAM. 1. THE PURPOSE OF THIS SECTION SHALL BE TO FACILITATE INNOVATION IN HOSPITAL,

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

2. FOR PURPOSES OF THIS SECTION:

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

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

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

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

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

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

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

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

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

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

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

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

(VI) HEALTH HOME DEVELOPMENT;

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

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

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

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

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

(A) TRAINING OF HOSPITAL NURSES IN HOME CARE;

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

(C) DUAL PERSONAL CARE AIDE/HHA CERTIFICATION;

(III) SALARY/BENEFIT ENHANCEMENT;

(IV) CAREER LADDER DEVELOPMENT; AND

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

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

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

S 56-a. The public health law is amended by adding two new sections 3614-d and 3614-e to read as follows:

S 3614-D. UNIVERSAL STANDARDS FOR CODING OF PAYMENT OF CLAIMS FOR LONG TERM CARE. STANDARDS FOR THE CODES OF CLAIMS OF PAYMENTS FOR PERSONAL CARE, HOME HEALTH CARE SERVICES OR OTHER LONG TERM CARE SERVICES. IN THE PROCESSING OF CODES OF CLAIMS SUBMITTED UNDER CONTRACTS OR AGREEMENTS ISSUED OR ENTERED INTO OR BETWEEN CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES PROGRAMS, INSURERS, MANAGED LONG TERM CARE PLANS, MANAGED CARE PLANS OR ORGANIZATIONS LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW, OR THE INSURANCE LAW AND FOR ALL BILLS FOR PERSONAL CARE, HOME HEALTH CARE SERVICES OR OTHER LONG TERM CARE SERVICES RENDERED BY LICENSED HOME CARE SERVICES PROGRAMS, CERTIFIED HOME HEALTH AGENCIES OR LONG TERM HOME HEALTH CARE PROGRAMS PURSUANT TO SUCH CONTRACTS OR AGREEMENTS, ANY CERTIFIED HOME HEALTH CARE AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, INSURER, MANAGED LONG TERM CARE PLANS, MANAGED CARE PLAN, OR ORGANIZATIONS LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW, THE EXECUTIVE LAW OR THE INSURANCE LAW SHALL BE BASED ON UNIVERSAL BILLING CODES APPROVED BY THE DEPARTMENT OR A NATIONALLY ACCREDITED ORGANIZATION AS APPROVED BY THE DEPARTMENT; PROVIDED, HOWEVER, SUCH CODING SHALL BE CONSISTENT WITH ANY CODES DEVELOPED AS PART OF THE UNIFORM ASSESSMENT SYSTEM FOR LONG TERM CARE ESTABLISHED BY THE DEPARTMENT.

S 3614-E. ELECTRONIC PAYMENT OF CLAIMS. IN THE PAYMENT OF CLAIMS SUBMITTED UNDER CONTRACTS OR AGREEMENTS ISSUED OR ENTERED INTO OR BETWEEN CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS, LICENSED HOME CARE SERVICES PROGRAMS, FISCAL INTERMEDIARIES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW, INSURERS, MANAGED LONG TERM CARE PLANS, MANAGED CARE PLANS OR ORGANIZATIONS LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW OR THE INSURANCE LAW AND FOR ALL BILLS

FOR PERSONAL CARE, HOME HEALTH CARE SERVICES, CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW OR OTHER LONG TERM CARE SERVICES RENDERED BY LICENSED HOME CARE SERVICES PROGRAMS, CERTIFIED HOME HEALTH AGENCIES, LONG TERM HOME HEALTH CARE PROGRAMS OR A FISCAL INTERMEDIARY OPERATING PURSUANT TO SECTION THREE HUNDRED SIXTY-FIVE-F OF THE SOCIAL SERVICES LAW PURSUANT TO SUCH CONTRACTS OR AGREEMENTS, ANY CERTIFIED HOME HEALTH CARE AGENCY, LONG TERM HOME HEALTH CARE PROGRAM, INSURER, MANAGED LONG TERM CARE PLAN, MANAGED CARE PLAN OR ORGANIZATION LICENSED OR OPERATED PURSUANT TO THE PROVISIONS OF THIS CHAPTER, THE SOCIAL SERVICES LAW, THE EXECUTIVE LAW OR THE INSURANCE LAW, SUCH CLAIMS SHALL BE PAID VIA ELECTRONIC FUNDS TRANSFER.

S 57. Subdivision 1 of section 364-j of the social services law is amended by adding two new paragraphs (w) and (w-1) to read as follows:

(W) "SCHOOL-BASED HEALTH CENTER". A CLINIC LICENSED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW OR SPONSORED BY A FACILITY LICENSED UNDER THE PUBLIC HEALTH LAW WHICH PROVIDES PRIMARY HEALTH CARE SERVICES INCLUDING 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.

(W-1) "SPONSORING ORGANIZATION". A FACILITY LICENSED UNDER ARTICLE TWENTY-EIGHT OF THE PUBLIC HEALTH LAW WHICH ACTS AS THE SPONSOR FOR A SCHOOL-BASED HEALTH CENTER.

S 58. Subdivision 2 of section 364-j of the social services law is amended by adding a new paragraph (d) to read as follows:

(D) THE COMMISSIONER OF HEALTH SHALL BE AUTHORIZED TO INCLUDE THE SERVICES OF A SCHOOL-BASED HEALTH CENTER 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.

ON AND AFTER JULY FIRST, TWO THOUSAND SEVENTEEN, THE COMMISSIONER OF HEALTH IS AUTHORIZED TO INCLUDE THE SERVICES OF A SCHOOL-BASED HEALTH CENTER IN THE MANAGED CARE PROGRAM SUBJECT TO 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, SPONSORING ORGANIZATION AND THE MANAGED CARE PROVIDER. THE COMMISSIONER OF HEALTH SHALL TAKE INTO CONSIDERATION, ANY RELEVANT FINDINGS OF THE FINAL AND INTERIM REPORTS.

S 59. 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) 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 PURSUANT TO THIS SECTION, AND SHALL CONTINUE TO BE PROVIDED OUTSIDE OF MANAGED CARE PROGRAMS IN ACCORDANCE WITH APPLICABLE REIMBURSEMENT METHODOLOGIES. "APPLICABLE REIMBURSEMENT METHODOLOGIES" SHALL MEAN:

(I) 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

(II) 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 FEE FOR SERVICE RATE FOR SUCH SERVICES IN EFFECT PRIOR TO THE ENACTMENT OF THIS CHAPTER FOR THE AMBULATORY PATIENT GROUP RATE FOR THE APPLICABLE SERVICE.

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

S 60. Subdivision (c) of section 62 of chapter 165 of the laws of 1991, amending the public health law and other laws relating to establishing payments for medical assistance, as amended by section 26 of part D of chapter 59 of the laws of 2011, is amended to read as follows:

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

S 61. Subdivision 18-a of section 206 of the public health law, as amended by section 11 of part A of chapter 58 of the laws of 2010, paragraphs (b) and (d) as amended by section 16 of part A of chapter 60 of the laws of 2014, paragraph (c) as amended by chapter 132 of the laws of 2014, is amended to read as follows:

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

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

(A) efforts to incentivize electronic health record adoption;

(B) interconnection of physicians through regional collaborations;

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

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

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

(b) The commissioner shall:

(i) convene a workgroup to:

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

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

(ii) submit [a] AN INTERIM report to the governor [and], the temporary president of the senate and the speaker of the assembly, which shall [fully consider the evaluation and recommendations of the workgroup] DETAIL THE CONCERNS AND ISSUES ASSOCIATED WITH ESTABLISHING THE STATE'S HEALTH INFORMATION TECHNOLOGY INFRASTRUCTURE CONSIDERED BY THE WORKGROUP, on or before December first, two thousand fourteen[.]; AND

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

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

(d) The commissioner may make such rules and regulations as may be necessary to implement federal policies and disburse funds as required by the American Recovery and Reinvestment Act of 2009 and to promote the development of a self-sufficient SHIN-NY to enable widespread, non-duplicative interoperability among disparate health information systems, including electronic health records, personal health records, health care claims, payment and other administrative data, and public health information systems, while protecting privacy and security. Such rules and regulations shall include, but not be limited to, requirements for organizations covered by 42 U.S.C. 17938 or any other organizations that exchange health information through the SHIN-NY or any other statewide health information system recommended by the workgroup. The commissioner shall consider the FINAL REPORT AND recommendations of the workgroup. If

the commissioner acts in a manner inconsistent with the recommendations of the workgroup, he or she shall provide the reasons therefor.

S 62. Subdivision 4 of section 365-h of the social services law, as amended by section 20 of part B of chapter 109 of the laws of 2010, is amended to read as follows:

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

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

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

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

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

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

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

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

S 63. Section 2826 of the public health law, as added by section 27 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

S 2826. [Temporary] VITAL ACCESS PROVIDER; TEMPORARY adjustment to reimbursement rates. (a) Notwithstanding any provision of law to the contrary, within funds appropriated and subject to the availability of federal financial participation, the commissioner may grant approval of a temporary adjustment to the non-capital components of rates, or make temporary lump-sum Medicaid payments, to eligible general hospitals, skilled nursing facilities, clinics and home care providers, provided however, that should federal financial participation not be available for any eligible provider, then payments pursuant to this subdivision may be made as grants and shall not be deemed to be medical assistance payments.

(b) Eligible providers shall include:

(i) providers undergoing closure;

(ii) providers impacted by the closure of other health care providers;

(iii) providers subject to mergers, acquisitions, consolidations or restructuring; or

(iv) providers impacted by the merger, acquisition, consolidation or restructuring of other health care providers.

(c) Providers seeking temporary rate adjustments under this section shall demonstrate through submission of a written proposal to the commissioner that the additional resources provided by a temporary rate adjustment will achieve one or more of the following:

(i) protect or enhance access to care;

(ii) protect or enhance quality of care;

(iii) improve the cost effectiveness of the delivery of health care services; or

(iv) otherwise protect or enhance the health care delivery system[, as determined by the commissioner].

(d) (i) Such written proposal shall be submitted to the commissioner at least sixty days prior to the requested effective date of the temporary rate adjustment, and shall include a proposed budget to achieve the goals of the proposal. Any Medicaid payment issued pursuant to this section shall be in effect for a specified period of time as determined by the commissioner, of up to three years. At the end of the specified timeframe such payments or adjustments to the non-capital component of rates shall cease, and the provider shall be reimbursed in accordance with the otherwise applicable rate-setting methodology as set forth in applicable statutes and regulations. The commissioner may establish, as a condition of receiving such temporary rate adjustments or grants, benchmarks and goals to be achieved in conformity with the provider's written proposal as approved by the commissioner and may also require that the facility submit such periodic reports concerning the achievement of such benchmarks and goals as the commissioner deems necessary. Failure to achieve satisfactory progress, as determined by the commissioner, in accomplishing such benchmarks and goals shall be a basis for ending the facility's temporary rate adjustment or grant prior to the end of the specified timeframe. (ii) The commissioner [may] SHALL require that applications submitted pursuant to this section be submitted in response to and in accordance with a Request For Applications or a Request For Proposals issued by the commissioner.

(e) FOR THE PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, TO THE EXTENT PRACTICABLE BASED ON SUBMITTED RESPONSES TO THE COMMISSIONER'S REQUEST FOR APPLICATIONS OR REQUEST FOR PROPOSALS, THE COMMISSIONER SHALL MAKE TEMPORARY ADJUSTMENTS TO RATES OF ELIGIBLE PROVIDERS WITHIN

AMOUNTS MADE AVAILABLE EQUITABLY ACROSS THE STATE; PROVIDED, HOWEVER, THAT AT LEAST FORTY PERCENT OF FUNDS MADE AVAILABLE ANNUALLY SHALL BE AWARDED TO ELIGIBLE PROVIDERS WHO ARE LOCATED IN COUNTIES WHOSE POPULATION AT THE MOST RECENT CENSUS DOES NOT EXCEED NINE HUNDRED TWENTY-FIVE THOUSAND AND WHOSE POPULATION PER SQUARE MILE DOES NOT EXCEED ONE THOUSAND TWO HUNDRED.

(F) 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 million dollars annually pursuant to this section. The department [of health] shall provide a report to the governor and legislature no later than December first, two thousand fourteen providing recommendations on how to ensure the financial stability of, and preserve patient access to, critical access hospitals.

(G) FOR PERIODS ON AND AFTER APRIL FIRST, TWO THOUSAND FIFTEEN, 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 VITAL ACCESS PROVIDER (VAP) TEMPORARY RATE ADJUSTMENT PROGRAM. SUCH REPORTS SHALL BE SUBMITTED NO LATER THAN SIXTY DAYS AFTER THE CLOSE OF THE QUARTER, AND SHALL INCLUDE THE MOST CURRENT INFORMATION ON VITAL ACCESS PROVIDER TEMPORARY RATE ADJUSTMENTS OR GRANTS. THE REPORTS SHALL INCLUDE FOR ANY VAP TEMPORARY RATE ADJUSTMENT OR GRANT MADE:

(I) THE AMOUNT OF ANY RATE ADJUSTMENT OR GRANT FOR ALL YEARS OF THE AWARD;

(II) A DESCRIPTION OF HOW THE TEMPORARY RATE ADJUSTMENT OR GRANT RECIPIENT WILL ACHIEVE ANY OF THE GOALS OF THE VITAL ACCESS PROVIDER TEMPORARY RATE ADJUSTMENT PROGRAM PURSUANT TO SUBDIVISION (C) OF THIS SECTION AND ANY ADDITIONAL INFORMATION OR FACTORS TAKEN INTO CONSIDERATION BY THE COMMISSIONER IN APPROVING A TEMPORARY RATE ADJUSTMENT OR GRANT PURSUANT TO THIS SECTION;

(III) THE STATUS OF THE TEMPORARY RATE ADJUSTMENT OR GRANT RECIPIENT IN MEETING THE BENCHMARK OR GOALS ESTABLISHED BY THE COMMISSIONER;

(IV) A SUMMARY OF ANY PERIODIC REPORTS REQUIRED BY THE COMMISSIONER AS A CONDITION OF RECEIVING A TEMPORARY RATE ADJUSTMENT OR GRANT; AND

(V) INFORMATION ON PROJECT SPENDING AND BUDGET.

(H) THE COMMISSIONER SHALL PROVIDE ON AN ANNUAL BASIS TO THE CHAIRS OF THE SENATE FINANCE, ASSEMBLY WAYS AND MEANS, SENATE HEALTH AND ASSEMBLY HEALTH COMMITTEES A SUMMARY OF THE STATEWIDE GEOGRAPHIC DISTRIBUTION OF FUNDS.

S 64. The opening paragraph of subdivision 2 of section 363-a of the social services law is designated paragraph (a) and a new paragraph (b) is added to read as follows:

(B) NOTWITHSTANDING ANY INCONSISTENT PROVISION OF SECTION TWO HUNDRED ONE OF THE PUBLIC HEALTH LAW, THIS SECTION OR ANY OTHER PROVISION OF LAW, AMENDMENTS PROMULGATED BY THE DEPARTMENT OF HEALTH THAT WOULD ADD A NEW COVERED BENEFIT OR BENEFITS, OR EXPANSION OF BENEFIT COVERAGE, UNDER THE STATE'S MEDICAID PROGRAM SHALL REQUIRE LEGISLATIVE APPROVAL PRIOR TO THE EFFECTIVE DATE OF ANY CHANGE TO THE PLAN.

S 65. Paragraph 2 of subdivision (a) of section 90 of part H of chapter 59 of the laws of 2011, amending the public health law and other laws, relating to general hospital inpatient reimbursement for annual rates, as amended by section 38 of part C of chapter 60 of the laws of 2014, is amended and two new paragraphs 3 and 4 are added to read as follows:

(2) [Alternative] SUBJECT TO PARAGRAPH THREE OF THIS SUBDIVISION, ALTERNATIVE methods of cost containment as authorized and implemented pursuant to paragraph one of this subdivision shall continue to be applied and maintained for periods on and after April 1, 2014, provided, however, that the commissioner of health, in consultation with the director of the budget, is authorized to terminate such alternative methods upon a finding that they are no longer necessary to maintain essential cost savings; PROVIDED, FURTHER, HOWEVER, THAT ON AND AFTER APRIL FIRST, TWO THOUSAND FIFTEEN THIS PARAGRAPH SHALL NOT APPLY TO FACILITIES OPERATING PURSUANT TO ARTICLE SIXTEEN OF THE MENTAL HYGIENE LAW.

(3) NOTWITHSTANDING ANY PROVISION OF LAW OR REGULATION TO THE CONTRARY AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER SHALL INCREASE MEDICAID PAYMENTS TO NURSING HOMES AND ADULT DAY HEALTH CARE PROGRAMS BY ONE PERCENT FOR ALL PERIODS ON AND AFTER APRIL 1, 2015 DURING WHICH AN ALTERNATIVE METHOD OF COST CONTAINMENT IS APPLIED AND MAINTAINED PURSUANT TO PARAGRAPH TWO OF THIS SUBDIVISION. FOR THIS PURPOSE, RATES OF PAYMENT TO MEDICAID MANAGED CARE PLANS SHALL BE INCREASED BY ONE PERCENT FOR SUCH SERVICES, AND SUCH PLANS SHALL REFLECT SUCH RATE INCREASES IN THE RATES PAID TO THE PROVIDERS OF SUCH SERVICES. IF AND UNTIL SUCH TIME AS THE COMMISSIONER OF HEALTH RECEIVES FROM THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES FINAL APPROVAL OF THE REVISION IN RATES OF PAYMENT AUTHORIZED BY THIS PARAGRAPH AND FINAL APPROVAL OF THE UNIVERSAL SETTLEMENT OF NURSING HOME RATE APPEALS AND LAWSUITS, THE ALTERNATIVE METHOD OF COST CONTAINMENT APPLIED AND MAINTAINED TO NURSING HOMES AND ADULT DAY HEALTH ARE PROGRAMS PURSUANT TO PARAGRAPH TWO OF THIS SUBDIVISION SHALL BE SUSPENDED AND BE OF NO FORCE OR EFFECT UNTIL THE EFFECTIVE DATE OF SUCH APPROVALS.

(4) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, THE 0.8 PERCENT NON-REIMBURSABLE ASSESSMENT ALTERNATIVE METHOD OF COST CONTAINMENT IMPOSED UPON SKILLED NURSING FACILITIES PURSUANT TO THE PROVISIONS OF PARAGRAPH ONE OF THIS SUBDIVISION BEGINNING FOR THE STATE FISCAL YEAR APRIL 1, 2011 SHALL END ON MARCH 31, 2014. ASSESSMENT PAYMENTS MADE BY SKILLED NURSING PROVIDERS FOR THE PERIOD ON AND AFTER APRIL 1, 2014 THROUGH MARCH 31, 2015 SHALL BE REFUNDED TO SUCH PROVIDERS. THIS ASSESSMENT MAY BE REINSTITUTED PROSPECTIVELY IN FUTURE FISCAL YEARS UPON THE RATIFICATION OF A LEGALLY BINDING UNIVERSAL SETTLEMENT BETWEEN THE STATE AND ALL AFFECTED SKILLED NURSING PROVIDERS FOR CERTAIN RATE APPEALS AND LITIGATION BROUGHT BY CURRENT OR FORMER OWNERS RELATING TO THE STATE'S PRE-PRICING RATE METHODOLOGY.

S 66. Paragraph (d) of subdivision 2-a of section 2808 of the public health law, as added by chapter 483 of the laws of 1978, is amended to read as follows:

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

assets and shall not include amounts resulting from mortgage amortization where the payment therefor has been provided by real property cost reimbursement.

S 67. Subdivision 1 of section 206 of the public health law is amended by adding a new paragraph (v) to read as follows:

(V) ESTABLISH AN OFFICE OF ACCOUNTABILITY WITHIN THE DEPARTMENT. THE OFFICE OF ACCOUNTABILITY SHALL BE RESPONSIBLE FOR ENSURING ALL WORKGROUPS REQUIRED UNDER THIS CHAPTER ARE TIMELY CONVENED AND ALL REPORTS REQUIRED UNDER THIS CHAPTER ARE TIMELY DISTRIBUTED. THE OFFICE SHALL REVIEW AND REPORT TO THE LEGISLATURE BY JANUARY FIRST, TWO THOUSAND SIXTEEN, AND ANNUALLY THEREAFTER, ON THE FOLLOWING:

(1) THE DATE EACH STATUTORILY REQUIRED REPORT WAS DISTRIBUTED, AND TO WHOM IT WAS DISTRIBUTED;

(2) ANY REPORTS THAT WERE REQUIRED BY LAW AND NOT PROVIDED, WITH AN EXPLANATION OF WHY SUCH REPORT WAS NOT PROVIDED;

(3) RECOMMENDATIONS FOR STREAMLINING REPORTING REQUIREMENTS WHICH MAY INCLUDE RECOMMENDED STATUTORY AMENDMENTS TO MAKE REPORT DEADLINES AND RECIPIENTS MORE CONSISTENT, TO PROVIDE THE REPORTS IN ELECTRONIC FORMAT, TO CONSOLIDATE ANY RELATED REPORTING REQUIREMENTS, OR TO REPEAL REPORTING REQUIREMENTS NO LONGER DEEMED NECESSARY;

(4) ALL CURRENTLY ACTIVE WORKGROUPS, AD HOC WORKGROUPS, ADVISORY COMMITTEES OR TASKFORCES THE DEPARTMENT IS RUNNING OR ENGAGED IN EITHER DIRECTLY OR IN COMBINATION WITH OTHER AGENCIES OR DEPARTMENTS AND THE STATUS OF EACH SUCH GROUP; AND

(5) ANY STATUTORILY REQUIRED WORKGROUP THAT HAS NOT MET WITHIN THE LAST YEAR, WITH AN EXPLANATION OF WHY THIS GROUP IS INACTIVE, WHICH MAY INCLUDE A RECOMMENDATION TO REPEAL THE WORKGROUP IF THE PURPOSE OF THE GROUP HAVE BEEN FULFILLED.

THIS REPORT MAY BE PROVIDED ELECTRONICALLY AND SHALL BE PROVIDED TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE.

S 68. Paragraph (t) of subdivision 1 of section 206 of the public health law, as added by section 112 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

(t) [The department shall submit as part of its annual report prepared pursuant to] SUBMIT AN ANNUAL REPORT TO THE LEGISLATURE ON OR BEFORE THE FIFTEENTH DAY OF MAY, FOR THE PRECEDING CALENDAR YEAR, AS REQUIRED BY section one hundred sixty-four of the executive law[, which may be submitted in electronic format,]. THE ANNUAL REPORT SHALL BE A comprehensive [information including, but not limited to, a detailed description] REPORT of the department's mission, priorities and goals for the upcoming year, achievements of the past year, ONGOING INITIATIVES and any relevant data and statistics. THE ANNUAL REPORT SHALL PROVIDE A LIST OF ALL OTHER REPORTS ISSUED BY THE DEPARTMENT WITHIN THE PRECEDING YEAR, AND INFORMATION ON HOW SUCH REPORTS CAN BE OBTAINED. THIS REPORT MAY BE PROVIDED ELECTRONICALLY AND SHALL BE PROVIDED TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH, AND THE CHAIR OF THE ASSEMBLY HEALTH COMMITTEE.

S 69. The opening paragraph of subdivision 1 and subdivision 3 of section 367-s of the social services law, as amended by section 8 of part C of chapter 60 of the laws of 2014, are amended to read as follows:

Notwithstanding any provision of law to the contrary, a supplemental medical assistance payment shall be made on an annual basis to providers

of emergency medical transportation services in an aggregate amount not to exceed four million dollars for two thousand six, six million dollars for two thousand seven, six million dollars for two thousand eight, [and] six million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, AND SIX MILLION DOLLARS ANNUALLY BEGINNING WITH THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN pursuant to the following methodology:

3. If all necessary approvals under federal law and regulation are not obtained to receive federal financial participation in the payments authorized by this section, payments under this section shall be made in an aggregate amount not to exceed two million dollars for two thousand six, three million dollars for two thousand seven, three million dollars for two thousand eight [and], three million dollars for the period May first, two thousand fourteen through March thirty-first, two thousand fifteen, AND THREE MILLION DOLLARS ANNUALLY BEGINNING WITH THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN. In such case, the multiplier set forth in paragraph (b) of subdivision one of this section shall be deemed to be two million dollars or three million dollars as applicable to the annual period.

S 70. Paragraph (e) of subdivision 8 of section 2511 of the public health law is REPEALED.

S 71. Subparagraph (v) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as amended by section 67-a of part C of chapter 60 of the laws of 2014, is amended to read as follows:

(v) such regulations shall incorporate quality related measures, including, but not limited to, potentially preventable re-admissions (PPRs) and provide for rate adjustments or payment disallowances related to PPRs and other potentially preventable negative outcomes (PPNOs), which shall be calculated in accordance with methodologies as determined by the commissioner, provided, however, that such methodologies shall be based on a comparison of the actual and risk adjusted expected number of PPRs and other PPNOs in a given hospital and with benchmarks established by the commissioner and provided further that such rate adjustments or payment disallowances shall result in an aggregate reduction in Medicaid payments of no less than thirty-five million dollars for the period July first, two thousand ten through March thirty-first, two thousand eleven and no less than fifty-one million dollars for annual periods beginning April first, two thousand eleven through March thirty-first, two thousand [fifteen] SIXTEEN, provided further that such aggregate reductions shall be offset by Medicaid payment reductions occurring as a result of decreased PPRs during the period July first, two thousand ten through March thirty-first, two thousand eleven and the period April first, two thousand eleven through March thirty-first, two thousand [fifteen] SIXTEEN and as a result of decreased PPNOs during the period April first, two thousand eleven through March thirty-first, two thousand [fifteen] SIXTEEN; and provided further that for the period July first, two thousand ten through March thirty-first, two thousand [fifteen] SIXTEEN, such rate adjustments or payment disallowances shall not apply to behavioral health PPRs; or to readmissions that occur on or after fifteen days following an initial admission. By no later than July first, two thousand eleven the commissioner shall enter into consultations with representatives of the health care facilities subject to this section regarding potential prospective revisions to applicable methodologies and benchmarks set forth in regulations issued pursuant to this subparagraph;

S 72. Subdivision 18 of section 364-j of the social services law is amended by adding two new paragraphs (c) and (d) to read as follows:

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

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

S 73. 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 74. Notwithstanding any inconsistent provision of law, rule or regulation, the effectiveness of the provisions of sections 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h), as they relate to time frames for notice, approval or certification of rates of payment, are hereby suspended and without force or effect for purposes of implementing the provisions of this act.

S 75. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

S 76. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015, section eight of this act shall expire and be deemed repealed March 31, 2016:

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

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 financial services and any appropriate council may take steps necessary to implement this act prior to its effective date;

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

determines necessary to implement any provision of this act on its effective date;

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

7. sections fifty-three and fifty-four of this act shall take effect on the sixtieth day after it shall have become a law; provided that effective immediately, the commissioner of health may make regulations and take other actions necessary to implement such sections on such effective date; provided further that the amendments to section 364-j of the social services law made by section fifty-three of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

7-a. section fifty-six-a of this act shall apply to any coding of payment of claims for long term care on or after January 1, 2016;

8. sections fifty-seven, fifty-eight and fifty-nine of this act shall take effect June 30, 2015; provided, further, that the amendments to section 364-j of the social services law made by sections fifty-seven, fifty-eight and fifty-nine of this act shall not affect the repeal of such section as provided in section 11 of chapter 710 of the laws of 1988, as amended, and shall be deemed repealed therewith;

9. the amendments to paragraphs (b) and (d) of subdivision 18-a of section 206 of the public health law, made by section sixty-one of this act, shall not affect the expiration of such paragraphs and shall expire therewith;

10. the amendments to subdivision 4 of section 365-h of the social services law, made by section sixty-two of this act, shall not affect the repeal of such section and shall be deemed repealed therewith;

11. the amendments to subdivision 18 of section 364-j of the social services law made by section seventy-two of this act shall not affect the repeal of such section and shall be deemed to be repealed therewith; and

12. section seventy of this act shall take effect January 1, 2016.

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] 2018 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] DECEMBER 31, 2018 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] 2018 for all services provided to persons under the age of twenty-one; provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described above, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioner of alcoholism and substance abuse services and the commissioner of the office of mental health, promulgate regulations, including emergency regulations promulgated prior to October 1, 2015 to establish rates for ambulatory behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this section shall be included in the report required under section 45-c of part A of this chapter.

2. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, THE FEES PAID BY MANAGED CARE ORGANIZATIONS LICENSED UNDER ARTICLE 44 OF THE PUBLIC HEALTH LAW OR UNDER ARTICLE 43 OF THE INSURANCE LAW, TO PROVIDERS LICENSED PURSUANT TO ARTICLE 28 OF THE PUBLIC HEALTH LAW OR ARTICLE 31 OR 32 OF THE MENTAL HYGIENE LAW, FOR AMBULATORY BEHAVIORAL HEALTH SERVICES PROVIDED TO PATIENTS ENROLLED IN THE CHILD HEALTH INSURANCE PROGRAM PURSUANT TO TITLE ONE-A OF ARTICLE 25 OF THE PUBLIC HEALTH LAW, SHALL BE IN THE FORM OF FEES FOR SUCH SERVICES WHICH ARE EQUIVALENT TO THE PAYMENTS ESTABLISHED FOR SUCH SERVICES UNDER THE AMBULATORY PATIENT GROUP (APG) RATE-SETTING METHODOLOGY. THE COMMISSIONER OF HEALTH SHALL CONSULT WITH THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH IN DETERMINING SUCH SERVICES AND ESTABLISHING SUCH FEES. SUCH AMBULATORY BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2018 FOR PATIENTS IN THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2018 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED ABOVE, SUBJECT TO

THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED.

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

Section 1. A. Notwithstanding any contrary provision of law, the commissioners of mental health and alcoholism and substance abuse services are authorized, subject to the approval of the director of the budget, to transfer to the commissioner of health state funds to be utilized as the state share for the purpose of increasing payments under the medicaid program to managed care organizations licensed under article 44 of the public health law or under article 43 of the insurance law. Such managed care organizations shall utilize such funds for the purpose of reimbursing providers licensed pursuant to article 28 of the public health law, or pursuant to article 31 or article 32 of the mental hygiene law for ambulatory behavioral health services, as determined by the commissioner of health in consultation with the commissioner of mental health and commissioner of alcoholism and substance abuse services, provided to medicaid eligible outpatients. Such reimbursement shall be in the form of fees for such services which are equivalent to the payments established for such services under the ambulatory patient group (APG) rate-setting methodology as utilized by the department of health or by the office of mental health or office of alcoholism and substance abuse services for rate-setting purposes; provided, however, that the increase to such fees that shall result from the provisions of this section shall not, in the aggregate and as determined by the commissioner of health in consultation with the commissioners of mental health and alcoholism and substance abuse services, be greater than the increased funds made available pursuant to this section. The increase of such behavioral health fees to providers available under this section shall be for all rate periods on and after the effective date of [the] SECTION 15 OF PART C OF chapter 60 of the laws of 2014 [which amended this section] through December 31, [2016] 2018 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] DECEMBER 31, 2018 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] 2018 for all services provided to persons under the age of twenty-one; provided, however, that managed care organizations and providers may negotiate different rates and methods of payment during such periods described, subject to the approval of the department of health. The department of health shall consult with the office of alcoholism and substance abuse services and the office of mental health in determining whether such alternative rates shall be approved. The commissioner of health may, in consultation with the commissioners of mental health and alcoholism and substance abuse services, promulgate regulations, including emergency regulations promulgated prior to October 1, 2013 that establish rates for behavioral health services, as are necessary to implement the provisions of this section. Rates promulgated under this

section shall be included in the report required under section 45-c of part A of chapter 56 of the laws of 2013.

B. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, THE FEES PAID BY MANAGED CARE ORGANIZATIONS LICENSED UNDER ARTICLE 44 OF THE PUBLIC HEALTH LAW OR UNDER ARTICLE 43 OF THE INSURANCE LAW, TO PROVIDERS LICENSED PURSUANT TO ARTICLE 28 OF THE PUBLIC HEALTH LAW OR ARTICLE 31 OR 32 OF THE MENTAL HYGIENE LAW, FOR AMBULATORY BEHAVIORAL HEALTH SERVICES PROVIDED TO PATIENTS ENROLLED IN THE CHILD HEALTH INSURANCE PROGRAM PURSUANT TO TITLE ONE-A OF ARTICLE 25 OF THE PUBLIC HEALTH LAW, SHALL BE IN THE FORM OF FEES FOR SUCH SERVICES WHICH ARE EQUIVALENT TO THE PAYMENTS ESTABLISHED FOR SUCH SERVICES UNDER THE AMBULATORY PATIENT GROUP (APG) RATE-SETTING METHODOLOGY. THE COMMISSIONER OF HEALTH SHALL CONSULT WITH THE COMMISSIONER OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE COMMISSIONER OF THE OFFICE OF MENTAL HEALTH IN DETERMINING SUCH SERVICES AND ESTABLISHING SUCH FEES. SUCH AMBULATORY BEHAVIORAL HEALTH FEES TO PROVIDERS AVAILABLE UNDER THIS SECTION SHALL BE FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2018 FOR PATIENTS IN THE CITY OF NEW YORK, AND FOR ALL RATE PERIODS ON AND AFTER THE EFFECTIVE DATE OF THIS CHAPTER THROUGH DECEMBER 31, 2018 FOR PATIENTS OUTSIDE THE CITY OF NEW YORK, PROVIDED, HOWEVER, THAT MANAGED CARE ORGANIZATIONS AND PROVIDERS MAY NEGOTIATE DIFFERENT RATES AND METHODS OF PAYMENT DURING SUCH PERIODS DESCRIBED ABOVE, SUBJECT TO THE APPROVAL OF THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH SHALL CONSULT WITH THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES AND THE OFFICE OF MENTAL HEALTH IN DETERMINING WHETHER SUCH ALTERNATIVE RATES SHALL BE APPROVED.

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

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

S 5. Severability clause. If any clause, sentence, paragraph, subdivision, section or part of this act shall be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subdivision, section or part thereof directly involved in the controversy in which such judgment shall have been rendered. It is hereby declared to be the intent of the legislature that this act would have been enacted even if such invalid provisions had not been included herein.

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

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

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

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

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

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

6. the amendments to section 48-a of part A of chapter 56 of the laws of 2013 made by section one of this act 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] 2017, and

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

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

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

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

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

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

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

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

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

trend factor projections or adjustments for the period April 1, 1996, through March 31, 1997.

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

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

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

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

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

(ii) If the 1997, 1998, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014 [and], 2015, 2016 AND

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

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

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

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

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

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

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

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

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

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

(g) Target period. For purposes of this section, the 1996 target period shall mean August 1, 1996 through March 31, 1997, the 1997 target

period shall mean January 1, 1997 through November 30, 1997, the 1998 target period shall mean January 1, 1998 through November 30, 1998, the 1999 target period shall mean January 1, 1999 through November 30, 1999, the 2000 target period shall mean January 1, 2000 through November 30, 2000, the 2001 target period shall mean January 1, 2001 through November 30, 2001, the 2002 target period shall mean January 1, 2002 through November 30, 2002, the 2003 target period shall mean January 1, 2003 through November 30, 2003, the 2004 target period shall mean January 1, 2004 through November 30, 2004, and the 2005 target period shall mean January 1, 2005 through November 30, 2005, the 2006 target period shall mean January 1, 2006 through November 30, 2006, and the 2007 target period shall mean January 1, 2007 through November 30, 2007 and the 2008 target period shall mean January 1, 2008 through November 30, 2008, and the 2009 target period shall mean January 1, 2009 through November 30, 2009 and the 2010 target period shall mean January 1, 2010 through November 30, 2010 and the 2011 target period shall mean January 1, 2011 through November 30, 2011 and the 2012 target period shall mean January 1, 2012 through November 30, 2012 and the 2013 target period shall mean January 1, 2013 through November 30, 2013, and the 2014 target period shall mean January 1, 2014 through November 30, 2014 and the 2015 target period shall mean January 1, 2015 through November 30, 2015 AND THE 2016 TARGET PERIOD SHALL MEAN JANUARY 1, 2016 THROUGH NOVEMBER 30, 2016 AND THE 2017 TARGET PERIOD SHALL MEAN JANUARY 1, 2017 THROUGH NOVEMBER 30, 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

medicaid revenue percentage for that year, the reduction factor for that year shall be zero.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notwithstanding any inconsistent provision of law or regulation, for the purposes of establishing rates of payment by governmental agencies for long term home health care programs for the period April first, two thousand five, through December thirty-first, two thousand five, and for the period January first, two thousand six through March thirty-first, two thousand seven, and on and after April first, two thousand seven through March thirty-first, two thousand nine, and on and after April

first, two thousand nine through March thirty-first, two thousand eleven, and on and after April first, two thousand eleven through March thirty-first, two thousand thirteen and on and after April first, two thousand thirteen through March thirty-first, two thousand fifteen, AND ON AND AFTER APRIL 1ST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN the reimbursable base year administrative and general costs of a provider of services shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services.

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

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

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

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

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

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

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

3. Notwithstanding any law to the contrary, and in accordance with section four of the state finance law, the comptroller is hereby authorized and directed to transfer from the health care reform act (HCRA) resources fund (061) to the general fund, upon the request of the director of the budget, up to $6,500,000 on or before March 31, 2006, and the comptroller is further hereby authorized and directed to transfer from the healthcare reform act (HCRA); Resources fund (061) to the Capital Projects Fund, upon the request of the director of budget, up to $139,000,000 for the period April 1, 2006 through March 31, 2007, up to

$171,100,000 for the period April 1, 2007 through March 31, 2008, up to $208,100,000 for the period April 1, 2008 through March 31, 2009, up to $151,600,000 for the period April 1, 2009 through March 31, 2010, up to $215,743,000 for the period April 1, 2010 through March 31, 2011, up to $433,366,000 for the period April 1, 2011 through March 31, 2012, up to $150,806,000 for the period April 1, 2012 through March 31, 2013, up to $78,071,000 for the period April 1, 2013 through March 31, 2014, and up to $86,005,000 for the period April 1, 2014 through March 31, 2015, AND UP TO $86,005,000 FOR THE PERIOD APRIL 1, 2015 THROUGH DECEMBER 31, 2017.

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

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

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

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

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

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal [year] YEARS beginning April first, two thousand ten and ending March thirty-first, two thousand [fifteen] NINETEEN, the commissioner shall not be required to revise certified rates of payment established pursuant to this article for rate periods prior to April first, two thousand [fifteen] NINETEEN, based on consideration of rate appeals filed by residential health care facilities or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of an application for construction under section twenty-eight hundred two of this article, in excess of an aggregate annual amount of eighty million dollars for each such state fiscal year provided, however, that for the period April first, two thousand eleven through March thirty-first, two thousand twelve such aggregate annual amount shall be fifty million dollars. In revising such rates within such fiscal limit, the commissioner shall, in prioritizing such rate appeals, include consideration of which facilities the commissioner determines are facing significant financial hardship as well as such other considerations as the commissioner deems appropriate and, further,

the commissioner is authorized to enter into agreements with such facilities or any other facility to resolve multiple pending rate appeals based upon a negotiated aggregate amount and may offset such negotiated aggregate amounts against any amounts owed by the facility to the department, including, but not limited to, amounts owed pursuant to section twenty-eight hundred seven-d of this article; provided, however, that the commissioner's authority to negotiate such agreements resolving multiple pending rate appeals as hereinbefore described shall continue on and after April first, two thousand [fifteen] NINETEEN. Rate adjustments made pursuant to this paragraph remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision two of section twenty-eight hundred seven of this article.

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

(a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective April first, two thousand twelve through March thirty-first, two thousand [fifteen] NINETEEN, payments by government agencies for services provided by certified home health agencies, except for such services provided to children under eighteen years of age and other discreet groups as may be determined by the commissioner pursuant to regulations, shall be based on episodic payments. In establishing such payments, a statewide base price shall be established for each sixty day episode of care and adjusted by a regional wage index factor and an individual patient case mix index. Such episodic payments may be further adjusted for low utilization cases and to reflect a percentage limitation of the cost for high-utilization cases that exceed outlier thresholds of such payments.

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

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

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

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The

commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner. [Notwithstanding any inconsistent provision of sections one hundred twelve and one hundred sixty-three of the state finance law, or section one hundred forty-two of the economic development law, or any other law, the commissioner is authorized to enter into a contract or contracts under this subdivision without a competitive bid or request for proposal process, provided, however, that:

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

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

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

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

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

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

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

S 25. Intentionally omitted.

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

S 2. This act shall take effect immediately and shall expire and be deemed repealed July 1, [2015] 2018.

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

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

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

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

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

S 4-a. Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided on and after January 1, [2015] 2017 through March 31, [2015] 2017, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, except for residential health care facilities or units of such facilities providing services primarily to children under twenty-one years of age, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, and for personal care services provided pursuant to section 365-a of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to the [2015] 2017 calendar year in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors attributable to such [2015] 2017 calendar year shall also be applied to rates of payment provided on and after January 1, [2015] 2017 through March 31, [2015] 2017 for personal care services provided in those local social services districts, including New York city, whose rates of payment for such services are established by such local social services districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social services districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided on and after January 1, [2015] 2017 through March 31, [2015] 2017, such trend factors attributable to the [2015] 2017 calendar year shall be established at no greater than zero percent.

S 30. 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 31. 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 32. Section 32 of part A of chapter 58 of the laws of 2008, amending the elder law and other laws relating to reimbursement to participating provider pharmacies and prescription drug coverage, as amended by section 37 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

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

S 33. 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 34. 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 35. 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 36. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2015 provided, that:

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

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

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

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

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

PART E

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

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

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

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

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

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

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

(iii)(A) Such regulations shall establish transition adjustments to the distributions made pursuant to clauses (A) and (B) of subparagraph

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

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

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

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

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

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

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

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

S 2. Intentionally omitted

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. 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. Intentionally Omitted

S 2. Intentionally Omitted

S 3. Intentionally Omitted

S 4. Intentionally Omitted

S 5. Intentionally Omitted

S 6. Intentionally Omitted

S 7. Paragraph 1 of subsection (a) of section 3231 of the insurance law, as amended by section 69 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) No individual health insurance policy and no group health insurance policy covering between one and fifty employees or members of the group, EXCEPT AS SET FORTH IN SUBSECTION (H) OF THIS SECTION, or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen exclusive of spouses and dependents, hereinafter referred to as a small group, providing hospital and/or medical benefits, including medicare supplemental insurance, shall be issued in this state unless such policy is community rated and, notwithstanding any other provisions of law, the underwriting of such policy involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article.

S 8. Paragraph 1 of subsection (h) of section 3231 of the insurance law, as added by chapter 501 of the laws of 1992, is amended to read as follows:

(1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. FOR PURPOSES OF THIS SUBSECTION, "SMALL GROUP" SHALL MEAN A GROUP COMPRISED OF BETWEEN ONE AND FIFTY EMPLOYEES OR MEMBERS, EXCLUSIVE OF SPOUSES AND DEPENDENTS.

S 9. Paragraph 1 of subsection (a) of section 4317 of the insurance law, as amended by section 72 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) No individual health insurance contract and no group health insurance contract covering between one and fifty employees or members of the group, EXCEPT AS SET FORTH IN SUBSECTION (E) OF THIS SECTION, or between one and one hundred employees or members of the group for policies issued or renewed on or after January first, two thousand sixteen exclusive of spouses and dependents, including contracts for which the premiums are paid by a remitting agent for a group, hereinafter referred to as a small group, providing hospital and/or medical benefits, including Medicare supplemental insurance, shall be issued in this state unless such contract is community rated and, notwithstanding any other provisions of law, the underwriting of such contract involves no more than the imposition of a pre-existing condition limitation if otherwise permitted by this article.

S 10. Paragraph 1 of subsection (e) of section 4317 of the insurance law, as amended by section 72 of part D of chapter 56 of the laws of 2013, is amended to read as follows:

(1) Notwithstanding any other provision of this chapter, no insurer, subsidiary of an insurer, or controlled person of a holding company system may act as an administrator or claims paying agent, as opposed to an insurer, on behalf of small groups which, if they purchased insurance, would be subject to this section. No insurer, subsidiary of an insurer, or controlled person of a holding company may provide stop loss, catastrophic or reinsurance coverage to small groups which, if they purchased insurance, would be subject to this section. FOR PURPOSES OF THIS SUBSECTION, "SMALL GROUP" SHALL MEAN A GROUP COMPRISED OF BETWEEN ONE AND FIFTY EMPLOYEES OR MEMBERS, EXCLUSIVE OF SPOUSES AND DEPENDENTS.

S 11. This act shall take effect immediately.

PART H

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

17. (A) DIAGNOSTIC OR TREATMENT CENTERS ESTABLISHED TO PROVIDE HEALTH CARE SERVICES WITHIN THE SPACE OF A RETAIL BUSINESS OPERATION, SUCH AS A PHARMACY OR A STORE OPEN TO THE GENERAL PUBLIC, OR WITHIN SPACE USED BY AN EMPLOYER FOR PROVIDING HEALTH CARE SERVICES TO ITS EMPLOYEES, MAY BE OPERATED BY LEGAL ENTITIES FORMED UNDER THE LAWS OF THE STATE OF NEW YORK: (I) WHOSE STOCKHOLDERS OR MEMBERS, AS APPLICABLE, ARE NOT NATURAL

PERSONS; (II) WHOSE PRINCIPAL STOCKHOLDERS AND MEMBERS, AS APPLICABLE, AND CONTROLLING PERSONS COMPLY WITH ALL APPLICABLE REQUIREMENTS OF THIS SECTION; AND (III) THAT DEMONSTRATE, TO THE SATISFACTION OF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, SUFFICIENT EXPERIENCE AND EXPERTISE IN DELIVERING HIGH QUALITY HEALTH CARE SERVICES. SUCH DIAGNOSTIC AND TREATMENT CENTERS SHALL BE REFERRED TO IN THIS SECTION AS "LIMITED SERVICES CLINICS".

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

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

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

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

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

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

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

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

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

(IV) SETTING FORTH GUIDELINES FOR ADVERTISING AND SIGNAGE, DISCLOSURE OF OWNERSHIP INTERESTS, INFORMED CONSENT, RECORD KEEPING, REFERRAL FOR TREATMENT AND CONTINUITY OF CARE, CASE REPORTING TO THE PATIENT'S PRIMARY CARE OR OTHER HEALTH CARE PROVIDERS, DESIGN, CONSTRUCTION, FIXTURES,

AND EQUIPMENT. SIGNAGE SHALL ALSO BE REQUIRED TO INDICATE THAT PRESCRIPTIONS AND OVER-THE-COUNTER SUPPLIES MAY BE PURCHASED BY A PATIENT FROM ANY BUSINESS AND DO NOT NEED TO BE PURCHASED ON-SITE; AND

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

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

(G) A LIMITED SERVICES CLINIC SHALL PROVIDE TREATMENT WITHOUT DISCRIMINATION AS TO RACE, COLOR, RELIGION, SEX, NATIONAL ORIGIN, DISABILITY, SEXUAL ORIENTATION OR SOURCE OF PAYMENT.

(H) NOTWITHSTANDING THIS SUBDIVISION AND ANY OTHER LAW OR REGULATION TO THE CONTRARY AND SUBJECT TO THE PROVISIONS OF SECTION TWENTY-EIGHT HUNDRED TWO OF THIS ARTICLE, A DIAGNOSTIC AND TREATMENT CENTER, COMMUNITY HEALTH CENTER OR FEDERALLY QUALIFIED HEALTH CENTER MAY OPERATE A LIMITED SERVICES CLINIC WHICH MEETS THE REGULATION PROMULGATED PURSUANT TO PARAGRAPH (D) OF THIS SUBDIVISION REGARDING OPERATIONAL AND PHYSICAL PLANT STANDARDS FOR LIMITED SERVICES CLINICS.

S 1-a. Section 2802 of the public health law is amended by adding a new subdivision 8 to read as follows:

8. NOTWITHSTANDING ANY LAW, RULE OR REGULATION TO THE CONTRARY, A GENERAL HOSPITAL ESTABLISHED PURSUANT TO SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE MAY SUBMIT AN APPLICATION PURSUANT TO THIS SECTION TO OPERATE A LIMITED SERVICES CLINIC THAT MEETS THE REGULATIONS PROMULGATED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION SEVENTEEN OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE REGARDING OPERATIONAL AND PHYSICAL PLANT STANDARDS.

S 2. Intentionally omitted.

S 3. Intentionally omitted.

S 4. Intentionally omitted.

S 5. Intentionally omitted.

S 6. This act shall take effect immediately.

PART I

Intentionally omitted.

PART J

Intentionally Omitted

PART K

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

1. An application for such construction shall be filed with the department, together with such other forms and information as shall be prescribed by, or acceptable to, the department. Thereafter the department shall forward a copy of the application and accompanying documents

to the public health and health planning council, and the health systems agency, if any, having geographical jurisdiction of the area where the hospital is located.

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

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

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

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

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

(e) whether the facility is currently in substantial compliance with all applicable codes, rules and regulations, provided, however, that the commissioner shall not disapprove an application solely on the basis that the facility is not currently in substantial compliance, if the application is specifically:

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

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

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

(iv) for decertification of beds and services.

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

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

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

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

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

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

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

3. The public health and health planning council shall not approve a certificate of incorporation, articles of organization or application for establishment unless it is satisfied, insofar as applicable, as to (a) the public need for the existence of the institution at the time and place and under the circumstances proposed, provided, however, that in the case of an institution proposed to be established or operated by an organization defined in subdivision one of section one hundred seventy-two-a of the executive law, the needs of the members of the religious denomination concerned, for care or treatment in accordance with their

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

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

(b) [(i)] Any transfer, assignment or other disposition of ten percent or more of [an] DIRECT OR INDIRECT interest or voting rights in [a partnership or limited liability company, which is the] AN operator of a hospital to a new STOCKHOLDER, partner or member, OR ANY TRANSFER, ASSIGNMENT OR OTHER DISPOSITION OF A DIRECT OR INDIRECT INTEREST OR VOTING RIGHTS OF SUCH AN OPERATOR WHICH RESULTS IN THE OWNERSHIP OR CONTROL OF MORE THAN TEN PERCENT OF THE INTEREST OR VOTING RIGHTS OF SUCH OPERATOR BY ANY PERSON NOT PREVIOUSLY APPROVED BY THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL, OR ITS PREDECESSOR, FOR THAT OPERATOR shall be approved by the public health and health planning council, in accordance with the provisions of subdivisions two and three of this section, except that: (A) any such change shall be subject to the approval by the

public health and health planning council in accordance with paragraph (b) of subdivision three of this section only with respect to the new STOCKHOLDER, partner or member, and any remaining STOCKHOLDERS, partners or members who have not been previously approved for that facility in accordance with such paragraph, and (B) such change shall not be subject to paragraph (a) of subdivision three of this section. IN THE ABSENCE OF SUCH APPROVAL, THE OPERATING CERTIFICATE OF SUCH HOSPITAL SHALL BE SUBJECT TO REVOCATION OR SUSPENSION.

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

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

if the equity position of the partnership or limited liability company, determined in accordance with generally accepted accounting principles, would be reduced as a result of the transfer, assignment or disposition. The public health and health planning council shall state specific reasons for barring any transaction under this subparagraph and shall so notify each party to the proposed transaction.

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

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

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

1. Any change in the person who, or any transfer, assignment, or other disposition of an interest or voting rights of ten percent or more, or

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

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

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

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

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

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

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

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

S 7. Subdivision 5 of section 2801 of the public health law, as added by chapter 795 of the laws of 1965 and as renumbered by chapter 653 of the laws of 1975, is amended to read as follows:

5. "Construction" means the erection, building, [or] substantial [acquisition, alteration,] reconstruction, [improvement, extension or modification] OR SUBSTANTIAL CHANGE IN CLINICAL SERVICES of a hospital, including [its equipment;] the inspection and supervision thereof[; and the studies, surveys, designs, plans, working drawings, specifications, procedures and other actions necessary thereto].

S 8. Subdivisions 3 and 3-a 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:

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, stockholders, members or operators; with respect to any proposed incorporator, director, sponsor, stockholder, member or operator who is already or within the past [ten] FIVE 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] FINGER LAKES HEALTH SYSTEM AGENCY, 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, 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)] (A) threatened to directly affect the health, safety or welfare of any patient or resident, and [(ii)] (B) were recurrent or were not promptly corrected; [(c)] the financial resources of the proposed institution and its sources of future revenues; and [(d)] such other matters as it shall deem pertinent.

3-a. Notwithstanding any other provisions of this chapter, the public health council is hereby empowered to approve the establishment, for demonstration purposes, of not more than one existing hospital within the geographical jurisdiction of each health systems agency established under the provisions of subdivision (c) of section twenty-nine hundred four of this chapter. The purposes of such hospitals shall be to offer and provide nursing home services, board and lodging to persons requiring such services within one hospital. [The public health council may approve the establishment of such hospitals without regard to the requirement of public need as set forth in subdivision three of this section.]

S 9. Subparagraph (i) of paragraph (b) 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, is amended to read as follows:

(i) Any transfer, assignment or other disposition of ten percent or more of an interest or voting rights in a partnership or limited liability company, which is the operator of a hospital to a new partner or member, 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 partner or member, and any remaining 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].

S 10. Paragraph (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, is amended to read as follows:

(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. 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 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 owner of a hospital to any person previously approved by the public health and health planning council, or its predecessor, for that corporation. However, no such transaction shall be effective unless at least ninety days prior to the intended effective date thereof, the stockholder 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 to become the owner of ten percent or more of the stock of a corporation which is 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 11. Subparagraph (i) of paragraph (g) and subparagraph (i) of paragraph (h) 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:

(i) the character, competence and standing in the community of each proposed trustee operator pursuant to the provisions of [paragraph (b) of] subdivision three of this section; and

(i) the character, competence and standing in the community of the proposed conservator operator or committee operator pursuant to the provisions of [paragraph (b) of] subdivision three of this section; and

S 12. Paragraph (a) of subdivision 14 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:

(a) The public health and health planning council may approve the establishment of not-for-profit rural health networks as defined in article twenty-nine-A of this chapter, pursuant to the provisions of subdivisions two and three of this section, except that the public health and health planning council shall not consider the [public need for and] financial resources and sources of future revenues of such networks which do not seek approval to operate a hospital. In addition to character and competence, the public health and health planning council may take into consideration available network plans.

S 13. Paragraph (b) of subdivision 15 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:

(b) The following provisions of this section shall not apply to diagnostic or treatment centers operated pursuant to this subdivision: (i) [paragraph (b) of] subdivision three of this section, relating to stockholders and members; (ii) paragraph (c) of subdivision four of this section, relating to the disposition of stock or voting rights; and (iii) paragraph (e) of subdivision four of this section, relating to the ownership of stock or membership.

S 14. Subdivision 4 of section 2801-e of the public health law, as added by chapter 750 of the laws of 2004, is amended to read as follows:

4. Any reductions in the number of operational residential health care facility beds resulting from this demonstration shall not be considered to create additional public need for residential health care facility beds [under this article].

S 15. Paragraph (c) of subdivision 6 of section 2801-e of the public health law, as amended by chapter 257 of the laws of 2005, is amended to read as follows:

(c) The commissioner may, as necessary, waive existing methodologies for determining public need under [this article,] article thirty-six of this chapter and article seven of the social services law, as well as enrollment limitations under section forty-four hundred three-f of this chapter, to accommodate permanent conversions of beds to other programs or services on the basis that any such increases in capacity are linked to commensurate reductions in the number of residential health care facility beds.

S 16. Subdivision 2 of section 2802 of the public health law, as amended by section 58 of part A of chapter 58 of the laws of 2010, is amended to read as follows:

2. The commissioner shall not act upon an application for construction of a hospital until the public health and health planning council and the [health systems agency] FINGER LAKES HEALTH SYSTEM 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 appli-

cation 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].

S 17. Paragraph (a) of subdivision 6 of section 2806 of the public health law, as amended by chapter 77 of the laws of 1977, such subdivision as renumbered by chapter 896 of the laws of 1977, is amended to read as follows:

(a) Notwithstanding the provisions of subdivisions two through four of this section, the commissioner shall suspend, limit, modify, or revoke a hospital operating certificate, after taking into consideration [the total number of beds necessary to meet the public need,] the availability of facilities or services such as preadmission, ambulatory, home care or other services which may serve as alternatives or substitutes for the whole or any part of any such hospital facility, and, in the case of modification, the level of care and the nature and type of services provided or required by all or some of the patients in or seeking admission to such hospital facility, and whether such level of care is consistent with the operating certificate of the hospital, and after finding that suspending, limiting, modifying, or revoking the operating certificate of such facility would be within the public interest [in order to conserve health resources by restricting the number of beds and/or the level of services to those which are actually needed].

S 18. Paragraph (f) of subdivision 6 of section 2806 of the public health law, as added by chapter 769 of the laws of 1977, is amended to read as follows:

(f) In determining whether there is a [public need] NECESSITY for any services or facilities as required by this subdivision, the commissioner shall consider the advice of the state health planning and development agency designated pursuant to the provisions of the national health planning and resources development act of nineteen hundred seventy-four and any amendments thereto and the state health plan developed thereunder.

S 19. Subdivision 1 of section 2874-a of the public health law, as added by chapter 934 of the laws of 1985, is amended to read as follows:

1. The medical care facilities finance agency shall not make a mortgage loan to eligible secured hospital borrowers unless [the commissioner has recommended the project based on public need,] the hospital discloses the financial resources available to it, and the hospital complies with the provisions of article twenty-eight of this chapter. In considering the financial resources available to support a project, the commissioner shall take into account programs designed to offset eligible secured hospital borrowers' past and current unmet bad debt and charity care losses.

S 20. Section 2802 of the public health law is amended by adding two new subdivisions 8 and 9 to read as follows:

8. NOTWITHSTANDING ANY LAW, RULE, OR REGULATION TO THE CONTRARY, THIS SUBDIVISION SHALL APPLY TO ANY APPLICATION FOR CONSTRUCTION REQUIRED UNDER THIS SECTION WITH THE EXCEPTION OF THOSE FEDERALLY QUALIFIED

HEALTH CENTER CAPITAL PROJECTS SUBJECT TO SECTION TWENTY-EIGHT HUNDRED SEVEN-Z OF THIS ARTICLE.

(A) FOR AN APPLICATION REQUIRING A LIMITED OR ADMINISTRATIVE REVIEW, WITHIN NINETY CALENDAR DAYS OF THE DEPARTMENT DEEMING THE APPLICATION COMPLETE, THE COMMISSIONER SHALL MAKE A DECISION TO APPROVE OR DISAPPROVE THE APPLICATION. IF THE COMMISSIONER DETERMINES TO DISAPPROVE THE APPLICATION, THE BASIS FOR SUCH DISAPPROVAL SHALL BE PROVIDED IN WRITING; HOWEVER, DISAPPROVAL SHALL NOT BE BASED ON THE INCOMPLETENESS OF THE APPLICATION. IF THE COMMISSIONER FAILS TO TAKE ACTION TO APPROVE OR DISAPPROVE THE APPLICATION WITHIN NINETY CALENDAR DAYS OF THE APPLICATION BEING DEEMED COMPLETE, THE APPLICATION SHALL BE DEEMED APPROVED.

(B) FOR AN APPLICATION REQUIRING FULL REVIEW BY THE COUNCIL, THE APPLICATION SHALL BE PLACED ON THE NEXT COUNCIL AGENDA FOLLOWING THE DEPARTMENT DEEMING THE APPLICATION COMPLETE.

(C) WHERE THE COMMISSIONER OR DEPARTMENT REQUIRES THE APPLICANT TO SUBMIT INFORMATION TO SATISFY A CONTINGENCY FOR A CONSTRUCTION PROJECT, THE COMMISSIONER OR DEPARTMENT SHALL HAVE THIRTY CALENDAR DAYS TO REVIEW AND APPROVE OR DISAPPROVE THE SUBMITTED INFORMATION. IF THE COMMISSIONER OR DEPARTMENT DETERMINES THAT THE SUBMITTED INFORMATION IS INCOMPLETE, IT SHALL SO NOTIFY THE APPLICANT IN WRITING AND PROVIDE THE APPLICANT WITH TEN CALENDAR DAYS TO CORRECT THE DEFICIENCY OR PROVIDE ADDITIONAL INFORMATION. IF THE COMMISSIONER OR DEPARTMENT DETERMINES THAT THE SUBMITTED INFORMATION DOES NOT SATISFY THE CONTINGENCY, THE BASIS FOR SUCH DISAPPROVAL SHALL BE PROVIDED IN WRITING; HOWEVER, DISAPPROVAL SHALL NOT BE BASED ON THE INCOMPLETENESS OF THE APPLICATION. WITHIN FIFTEEN CALENDAR DAYS OF COMPLETE SATISFACTION OF A CONTINGENCY, THE COMMISSIONER OR DEPARTMENT SHALL TRANSMIT THE FINAL APPROVAL LETTER TO THE APPLICANT.

(D) THE DEPARTMENT SHALL DEVELOP EXPEDITED PRE-OPENING SURVEY PROCESSES FOR APPLICATIONS APPROVED UNDER THIS SECTION, BUT UNDER NO CIRCUMSTANCES SHALL PRE-OPENING SURVEY REVIEWS BE SCHEDULED LATER THAN THIRTY CALENDAR DAYS AFTER FINAL APPROVAL, CONSTRUCTION COMPLETION AND NOTIFICATION OF SUCH COMPLETION OF THE DEPARTMENT.

9. WITH REGARD TO ANY CONSTRUCTION PROJECT REQUIRING SUBMISSION OF AN APPLICATION PURSUANT TO THIS SECTION WHERE THE COMMISSIONER HAS DETERMINED THAT A WRITTEN CERTIFICATION BY AN ARCHITECT OR ENGINEER LICENSED PURSUANT TO ARTICLE ONE HUNDRED FORTY-FIVE OR ONE HUNDRED FORTY-SEVEN OF THE EDUCATION LAW THAT THE PROJECT MEETS APPLICABLE REGULATIONS OF THE DEPARTMENT CAN BE ACCEPTED, THE SUBMISSION BY THE APPLICANT OF SUCH COMPLETE AND FULLY EXECUTED CERTIFICATION BY CERTIFIED OR REGISTERED MAIL WITH A RETURN RECEIPT SIGNED BY THE DEPARTMENT SHALL CONSTITUTE A FULFILLMENT OF THE CERTIFICATION REQUIREMENT AND THE DEPARTMENT SHALL PROCEED WITH THE PROCESSING OF SUCH APPLICATION. NOTHING IN THIS SECTION SHALL BE CONSTRUED AS PROHIBITING THE DEPARTMENT UPON SURVEY FROM REQUIRING SUBSEQUENT CORRECTIONS TO THE PROJECT TO MEET THE APPLICABLE REGULATIONS.

S 21. Subdivision 1 of section 2806-a of the public health law is amended by adding a new paragraph (g) to read as follows:

(G) "IMPROPER DELEGATION OF AUTHORITY TO A MANAGEMENT CONSULTANT BY THE GOVERNING AUTHORITY OR OPERATOR" OF A GENERAL HOSPITAL SHALL INCLUDE, BUT NOT BE LIMITED TO, THE DELEGATION OF (I) AUTHORITY TO HIRE OR FIRE THE ADMINISTRATOR OR OTHER KEY MANAGEMENT EMPLOYEES; (II) MAINTENANCE AND CONTROL OF THE BOOKS AND RECORDS; (III) AUTHORITY OVER THE DISPOSITION OF ASSETS AND THE INCURRING OF LIABILITIES ON BEHALF OF THE FACILITY; AND (IV) THE ADOPTION AND ENFORCEMENT OF POLICIES REGARDING THE OPERATION OF THE FACILITY. THE CRITERIA SET FORTH IN THIS PARAGRAPH

SHALL NOT BE THE SOLE DETERMINING FACTORS, BUT INDICATORS TO BE CONSIDERED WITH SUCH OTHER FACTORS THAT MAY BE PERTINENT IN PARTICULAR INSTANCES. PROFESSIONAL EXPERTISE SHALL BE EXERCISED IN THE UTILIZATION OF THE CRITERIA. ALL OF THE LISTED INDICIA NEED NOT BE PRESENT IN A GIVEN INSTANCE FOR THERE TO BE AN IMPROPER DELEGATION OF AUTHORITY.

S 22. Paragraph (a) of subdivision 2 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

(a) In the event that: (i) a facility seeks extraordinary financial assistance and the commissioner finds that the facility is experiencing serious financial instability that is jeopardizing existing or continued access to essential services within the community, or (ii) the commissioner finds that there are conditions within the facility that seriously endanger the life, health or safety of residents or patients, the commissioner may appoint a temporary operator to assume sole control and sole responsibility for the operations of that facility, OR (III) THE COMMISSIONER FINDS THAT THERE HAS BEEN AN IMPROPER DELEGATION OF AUTHORITY TO A MANAGEMENT CONSULTANT BY THE GOVERNING AUTHORITY OR OPERATOR OF A GENERAL HOSPITAL, THE COMMISSIONER SHALL APPOINT A TEMPORARY OPERATOR TO ASSUME SOLE CONTROL AND SOLE RESPONSIBILITY FOR THE OPERATIONS OF THAT FACILITY. The appointment of the temporary operator shall be effectuated pursuant to this section and shall be in addition to any other remedies provided by law.

S 23. Subdivision 5 of section 2806-a of the public health law, as added by section 50 of part E of chapter 56 of the laws of 2013, is amended to read as follows:

5. (a) The initial term of the appointment of the temporary operator shall not exceed one hundred eighty days. After one hundred eighty days, if the commissioner determines that termination of the temporary operator would cause significant deterioration of the quality of, or access to, health care or residential care in the community or that reappointment is necessary to correct the conditions within the facility that seriously endanger the life, health or safety of residents or patients, or the financial instability that required the appointment of the temporary operator, the commissioner may authorize up to two additional ninety-day terms.

(b) Upon the completion of the two ninety-day terms referenced in paragraph (a) of this subdivision,

(i) if the established operator is the debtor in a bankruptcy proceeding, and the commissioner determines that the temporary operator requires additional terms to operate the facility during the pendency of the bankruptcy proceeding and to carry out any plan resulting from the proceeding, the commissioner may reappoint the temporary operator for additional ninety-day terms until the termination of the bankruptcy proceeding, provided that the commissioner shall provide for notice and a hearing as set forth in subdivision six of this section; [or]

(ii) if the established operator requests the reappointment of the temporary operator, the commissioner may reappoint the temporary operator for one additional ninety-day term, pursuant to an agreement between the established operator, the temporary operator and the department[.]; OR

(III) IF THE COMMISSIONER FINDS THAT CONDITIONS REGARDING THE IMPROPER DELEGATION OF AUTHORITY TO A MANAGEMENT CONSULTANT BY THE GOVERNING AUTHORITY OR OPERATOR OF A GENERAL HOSPITAL HAVE NOT BEEN REMEDIED, HE SHALL SUBMIT A RECOMMENDATION TO THE PUBLIC HEALTH AND HEALTH PLANNING

COUNCIL FOR REMEDIAL ACTION PURSUANT TO PARAGRAPH (I) OF SUBDIVISION FOUR OF SECTION TWENTY-EIGHT HUNDRED ONE-A OF THIS ARTICLE.

(c) Within fourteen days prior to the termination of each term of the appointment of the temporary operator, the temporary operator shall submit to the commissioner and to the established operator a report describing:

(i) the actions taken during the appointment to address such deficiencies and financial instability,

(ii) objectives for the continuation of the temporary operatorship if necessary and a schedule for satisfaction of such objectives,

(iii) recommended actions for the ongoing operation of the facility subsequent to the term of the temporary operator INCLUDING RECOMMENDATIONS REGARDING THE PROPER MANAGEMENT OF THE FACILITY AND ONGOING AGREEMENTS WITH MANAGEMENT CONSULTANTS; and

(iv) with respect to the first ninety-day term referenced in paragraph (a) of this subdivision, a plan for sustainable operation to avoid closure, or transformation of the facility which may include any option permissible under this chapter or the social services law and implementing regulations thereof. The report shall reflect best efforts to produce a full and complete accounting.

(d) The term of the initial appointment and of any subsequent reappointment may be terminated prior to the expiration of the designated term, if the established operator and the commissioner agree on a plan of correction and the implementation of such plan.

S 24. Subdivision 4 of section 2801-a of the public health law is amended by adding a new paragraph (i) to read as follows:

(I) UPON RECOMMENDATION BY THE COMMISSIONER, IF THE PUBLIC HEALTH AND HEALTH PLANNING COUNCIL FINDS BY SUBSTANTIAL EVIDENCE THAT AN IMPROPER DELEGATION OF AUTHORITY TO A MANAGEMENT CONSULTANT BY A GOVERNING AUTHORITY OR OPERATOR OF A GENERAL HOSPITAL HAS OCCURRED AS DEFINED BY PARAGRAPH (G) OF SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED SIX-A OF THIS ARTICLE, THE OPERATING CERTIFICATE OF SUCH HOSPITAL SHALL BE SUBJECT TO REVOCATION OR SUSPENSION.

S 25. This act shall take effect immediately; provided, however, that sections seven through twenty of this act shall take effect January 1, 2016; provided, further, that the amendments to subdivision 1 of section 2874-a of the public health law, made by section nineteen of this act, shall not affect the expiration of such section and shall be deemed to expire therewith; and provided, further, that the amendments to section 2806-a of the public health law, made by sections twenty-one, twenty-two and twenty-three of this act, shall not affect the expiration and repeal of such section, and shall be deemed repealed therewith.

PART L

Section 1. Section 230-d of the public health law is amended by adding two new subdivisions 6 and 7 to read as follows:

6. THE COMMISSIONER SHALL CONVENE AN OFFICE-BASED SURGERY WORKGROUP TO REVIEW THE SCOPE OF OFFICE-BASED SURGERY. THE WORKGROUP SHALL BE COMPRISED OF STAKEHOLDERS AND EXPERTS IN THE FIELD OF OFFICE-BASED SURGERY, WHICH SHALL AT A MINIMUM INCLUDE NO LESS THAN FIVE PHYSICIANS CURRENTLY ACCREDITED IN OFFICE-BASED SURGERY AND NO LESS THAN TWO LICENSED ANESTHESIOLOGISTS, TWO LICENSED CHIROPRACTORS, AND TWO LICENSED PODIATRISTS. THE WORKGROUP SHALL EXAMINE THE SCOPE OF OFFICE-BASED SURGERY IN NEW YORK AND WHETHER CERTAIN SURGICAL PROCEDURES NOT CURRENTLY PROVIDED IN THIS SETTING SHOULD BE, WHETHER CERTAIN SURGICAL PROCE-

DURES CURRENTLY PROVIDED SHOULD NOT BE PROVIDED IN THIS SETTING, AND WHETHER NON-SURGICAL PROCEDURES INVOLVING CERTAIN LEVELS OF ANESTHESIA SHOULD BE PROVIDED WITHIN THIS SETTING. IN EXAMINING THE SCOPE OF OFFICE-BASED SURGERY, THE WORKGROUP SHALL CONSIDER WHAT OTHER STATES COVER UNDER THIS ACCREDITATION AND WHAT MEDICARE COVERS IN THIS SETTING. THE WORKGROUP SHALL REPORT AND RECOMMEND ANY STATUTORY CHANGES THEY DEEM APPROPRIATE TO THE LEGISLATURE. SUCH REPORT SHALL BE SUBMITTED TO THE TEMPORARY PRESIDENT OF THE SENATE, SPEAKER OF THE ASSEMBLY, CHAIR OF THE SENATE STANDING COMMITTEE ON HEALTH AND CHAIR OF THE ASSEMBLY HEALTH COMMITTEE BY DECEMBER FIRST, TWO THOUSAND FIFTEEN.

7. EVERY OFFICE-BASED SURGERY PRACTICE WITH FULL ACCREDITED STATUS SHALL BE ELIGIBLE TO SEEK PAYMENT FROM A HEALTH PLAN FOR COSTS RELATED TO THE USE OF SUCH SURGERY LOCATION OR SETTING. SUCH FEE IS IN ADDITION TO THE FEE CHARGED BY THE LICENSEE FOR THE PERFORMANCE OF THE COVERED OFFICE-BASED SURGERY INVOLVING AN INSURED OR A HEALTH PLAN ENROLLEE; PROVIDED THAT THE HEALTH PLAN ALSO REIMBURSES FOR COSTS RELATED TO THE USE OF A SURGERY LOCATION OR SETTING CHARGED IN CONNECTION WITH THE SAME COVERED PROCEDURE PERFORMED AT A HOSPITAL OR AMBULATORY SURGERY CENTER ORGANIZED PURSUANT TO ARTICLE TWENTY-EIGHT OF THIS CHAPTER. WHEN CALCULATING THE APPROPRIATE RATE OF OFFICE-BASED SURGERY RELATED REIMBURSEMENT, A HEALTH PLAN MAY ALSO TAKE INTO CONSIDERATION CERTAIN COMPARABLE AND NON-COMPARABLE COSTS AND OBLIGATIONS OF AMBULATORY SURGERY CENTERS AND HOSPITALS AND ADJUST RATES ACCORDINGLY AND IN A REASONABLE MANNER.

S 2. Paragraph (b) of subdivision 1 of section 230-d of the public health law, as added by chapter 365 of the laws of 2007, is amended to read as follows:

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

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

Reporting [of adverse events] in office based surgery. 1. The commissioner shall enter into agreements with accrediting agencies pursuant to which the accrediting agencies shall REQUIRE ALL OFFICE-BASED SURGICAL PRACTICES TO CONDUCT QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES AND UTILIZE AMERICAN BOARD OF MEDICAL SPECIALTIES (ABMS) OR EQUIVALENT CERTIFICATION, HOSPITAL PRIVILEGING OR OTHER EQUIVALENT METHODS TO DETERMINE COMPETENCY OF PRACTITIONERS TO PERFORM OFFICE-BASED SURGERY. THE ACCREDITING AGENCY SHALL report[, at a minimum, aggregate] data [on adverse events] for all office-based surgical practices accredited by the accrediting agencies to the department. The department may disclose reports of aggregate data to the public.

2. The information required to be collected, maintained and reported directly to the department AND THE ACCREDITING AGENCIES, AND MAINTAINED BY OFFICE-BASED SURGERY PRACTICES UNDER QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES pursuant to section two hundred thirty-d of this chapter shall be kept confidential and shall not be released, except to the department and except as required or permitted under subdivision nine-a and subparagraph (v) of paragraph (a) of subdivision ten of section two hundred thirty of this chapter. Notwithstanding any other provision of law, none of [such information] THE INFORMATION COLLECTED, MAINTAINED AND REPORTED TO THE DEPARTMENT OR THE ACCREDITING AGENCIES,

AND MAINTAINED BY THE OFFICE-BASED SURGERY PRACTICES UNDER QUALITY IMPROVEMENT AND QUALITY ASSURANCE ACTIVITIES PURSUANT TO THIS SECTION shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules.

S 4. Section 2806 of the public health law is amended by adding a new subdivision 1-a to read as follows:

1-A. ANY AMBULATORY SURGERY CENTER THAT MAINTAINS AN ACCREDITATION STATUS IN ADDITION TO ITS LICENSURE UNDER THIS ARTICLE SHALL BE SUBJECT TO A HEARING PURSUANT TO THIS SECTION IN ORDER TO DETERMINE WHETHER ITS OPERATING CERTIFICATION SHOULD BE SUSPENDED OR REVOKED UPON THE REMOVAL OF ACCREDITATION BY ANY ACCREDITING BODY.

S 5. This act shall take effect immediately, except that section three of this act shall take effect on the ninetieth day 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

Intentionally Omitted

PART O

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

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

S 2. This act shall take effect immediately.

PART P

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

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

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

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

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

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

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

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

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

PART Q

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

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

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

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

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

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

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

(B) THE SHAREHOLDERS OF THE BUSINESS CORPORATION;

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

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

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

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

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

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

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

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

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

(2) INCORPORATES A REPRESENTATIVE GOVERNANCE MODEL THAT:

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

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

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

(4) COMMITS TO MAINTAINING OR ENHANCING EXISTING LEVELS OF SERVICES, CHARITY CARE AND CORE COMMUNITY BENEFITS;

(5) IDENTIFIES AN ACTIONABLE STRATEGY TO MONITOR AND MAINTAIN OR IMPROVE QUALITY OF CARE;

(6) EXPLAINS THE LEVEL OF CAPITAL COMMITMENT AND THE MECHANISM OR MECHANISMS FOR INFUSING CAPITAL INTO THE NOT-FOR-PROFIT HOSPITAL PARTNER;

(7) EXPLAINS HOW IT WILL RETAIN THE WORKFORCE, EITHER IN EXISTING JOBS OR THROUGH RETRAINING, AND ADDRESSES OBLIGATIONS OWED TO EMPLOYEE BENEFIT PLANS AND PENSIONS;

(8) WILL CREATE A FOUNDATION TO ADDRESS THE PUBLIC HEALTH NEEDS OF THE COMMUNITY; AND

(9) IDENTIFIES HOW PROFIT DISTRIBUTIONS SHALL BE MADE IN A WAY TO ENSURE THAT THE COMMUNITY'S ACCESS TO QUALITY CARE AND CORE COMMUNITY BENEFITS ARE NOT COMPROMISED AND ACCESS TO CAPITAL IS NOT COMPROMISED.

NONE OF THE FOREGOING FACTORS SHALL BE DISPOSITIVE IN THE APPROVAL OR DISAPPROVAL OF THE BUSINESS CORPORATION.

(G) NO BUSINESS CORPORATION SHALL BE APPROVED UNDER THIS SECTION THAT FAILS TO ATTEST THAT IT WILL PROVIDE THE NOT-FOR-PROFIT HOSPITAL PARTNER WITH THE EXCLUSIVE AUTHORITY OVER FUNCTIONS RELATING TO ITS EXEMPT STATUS.

(H) THE BOARD OF DIRECTORS OF A BUSINESS CORPORATION ESTABLISHED PURSUANT TO THIS SUBDIVISION SHALL BE DEEMED A "GOVERNING BODY" FOR THE PURPOSES OF SECTION TWENTY-EIGHT HUNDRED THREE-L OF THIS ARTICLE AND SHALL COMPLY WITH THE PROVISIONS OF SUCH SECTION, REGARDLESS OF THE CORPORATION'S PROFIT-MAKING STATUS.

(I) A SALE, LEASE, CONVEYANCE, EXCHANGE, TRANSFER, OR OTHER DISPOSITION OF ALL OR SUBSTANTIALLY ALL OF THE ASSETS OF THE BUSINESS CORPORATION SHALL NOT BE EFFECTIVE UNLESS THE TRANSACTION IS APPROVED BY THE COMMISSIONER.

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

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

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

(3) WILL MAINTAIN THE HOSPITAL GOVERNANCE STRUCTURE; AND

(4) IMPOSES MINIMUM CAPITALIZATION CRITERIA POST-TRANSACTION.

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

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

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

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

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

S 4. This act shall take effect immediately.

PART R

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

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

S 2. This act shall take effect immediately.

PART S

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

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

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

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

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

(III) BE ELIGIBLE FOR MEDICAID;

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

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

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

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

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

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 USING A VALID MEASURE.

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 COMMISSIONERS OF DEVELOPMENTAL DISABILITIES AND HEALTH SHALL PROMULGATE RULES AND REGULATIONS AS NECESSARY TO EFFECTUATE THE PROVISIONS OF THIS SECTION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S 5. 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) NOTWITHSTANDING ANY OTHER PROVISION OF LAW TO THE CONTRARY, THE PROVISION OF LICENSED NURSING SERVICES SHALL BE AUTHORIZED AS PART OF THE PROGRAMS CERTIFIED PURSUANT TO THIS ARTICLE.

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

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

(2) Application shall be made by the person or entity responsible for operation of the facility OR PROVISION OF SERVICES AS DESCRIBED IN SUBDIVISION FOUR OF SECTION 16.03 OF THIS ARTICLE. Applications shall be in writing, shall be verified and shall contain such information as required by the commissioner.

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

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

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

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

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

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

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

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

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

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

OVERSIGHT OF FACILITIES AND SERVICES. (A) THE COMMISSIONER SHALL PROVIDE FOR THE OVERSIGHT OF FACILITIES AND PROVIDERS OF SERVICES HOLDING OPERATING CERTIFICATES PURSUANT TO SECTION 16.03 OF THIS ARTICLE AND

SHALL PROVIDE FOR THE ANNUAL REVIEW OF SUCH FACILITIES AND PROVIDERS IN IMPLEMENTING THE REQUIREMENTS OF THE OFFICE AND IN PROVIDING QUALITY CARE AND PERSON CENTERED AND COMMUNITY BASED SERVICES.

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

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

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

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

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

(d) In conducting any inspection or investigation under this chapter, the commissioner or his OR HER authorized representative is empowered to subpoena witnesses, compel their attendance, administer oaths to witnesses, examine witnesses under oath, and require the production of any books or papers deemed relevant to the investigation, inspection, or hearing. A subpoena issued under this section shall be regulated by the civil practice law and rules.

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

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

laws of 2007, subdivision (g) as amended by chapter 24 of the laws of 2007, and subdivision (h) as amended by chapter 306 of the laws of 1995, is amended to read as follows:

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

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

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

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

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

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

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

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

shall not thereafter be required to [reinspect] REVIEW the facility OR PROVIDER OF SERVICES during the emergency period of suspension or limitation.

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

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

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

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

a. administer oaths and affirmations;

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

c. take testimony; or

d. control the conduct of the hearing.

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

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

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

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

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

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

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

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

of operation pursuant to subdivision (a) of section 16.05 of this article.

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

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

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

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

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

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

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

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

S 15. This act shall take effect immediately.

PART T

Section 1. Subdivision (a) of section 41.35 of the mental hygiene law, as amended by chapter 658 of the laws of 1977, is amended to read as follows:

(a) The commissioners of the offices in the department shall cause to be developed plans for three or more time-limited demonstration programs, the purpose of which shall be to test and evaluate new methods or arrangements for organizing, financing, staffing and providing services for the mentally disabled in order to determine the desirability of such methods or arrangements. Subject to regulations established by the commissioners and notwithstanding SECTIONS ONE HUNDRED TWELVE AND ONE HUNDRED SIXTY-THREE OF THE STATE FINANCE LAW, SECTION ONE HUNDRED FORTY-TWO OF THE ECONOMIC DEVELOPMENT LAW, OR any other provision of law, such programs may include but shall not be limited to comprehensive organizational structures to serve all mentally disabled persons within the purview of a local governmental unit, innovative financing and staffing arrangements and specific programs to serve the mentally disabled. Such demonstration programs shall be consistent with established statewide goals and objectives and local comprehensive plans, shall be developed in conjunction with the local comprehensive planning process, and shall be submitted to the single agent jointly designated by the commissioners of the department for review and approval by the commissioner or commissioners having jurisdiction of the services.

S 2. This act shall take effect immediately.

PART U

Section 1. Short title. This act shall be known and may be cited as the "employment first choice act".

S 2. Legislative intent. The legislature hereby supports increasing access to integrated employment settings for individuals with developmental disabilities. The legislature additionally finds, however, that the policy to increase integrated employment opportunities shall not preclude an individual's right to choose either an integrated or nonintegrated setting in accordance with such individual's personal wishes. Furthermore, the legislature supports an individual's wish to remain in a nonintegrated setting in order to, among other personal priorities, retain friendships, continue their participation in their community as they so choose, and, in some instances, maintain their ability to earn a paycheck.

The legislature, therefore, finds that individuals with developmental disabilities, who currently participate in a nonintegrated setting, should be allowed to choose to remain in such a setting. To require such individuals to transition out of this chosen environment undermines the guiding Supreme Court decision in Olmstead v. L.C., which held that the Americans with Disabilities Act of 1990 requires placement of individuals with developmental disabilities in integrated settings rather than nonintegrated settings, but only when such a transfer is not opposed by the affected individual. The legislature, therefore, declares this act to be a priority of the state's actions affecting individuals with developmental disabilities.

S 3. The mental hygiene law is amended by adding a new section 16.02 to read as follows:

S 16.02 INDIVIDUAL'S RIGHT OF CHOICE.

ANY INDIVIDUAL WITH A DEVELOPMENTAL DISABILITY WHO IS PARTICIPATING IN A NONINTEGRATED SETTING INCLUDING, BUT NOT LIMITED TO, A SHELTERED WORKSHOP, AND WHO CHOOSES TO REMAIN IN A NONINTEGRATED SETTING MAY SEEK

ACCOMMODATION FROM THE COMMISSIONER TO ALLOW SUCH PLACEMENT, PROVIDED THAT PENDING SUCH REQUEST THE INDIVIDUAL MAY REMAIN IN THE NONINTEGRATED SETTING.

(A) ACCOMMODATIONS SHALL BE GRANTED AT THE DISCRETION OF THE COMMISSIONER, WHO MAY ALSO REQUIRE THAT THE INDIVIDUAL HAS COMPLETED AT LEAST ONE OF THE FOLLOWING:

(1) PARTICIPATION IN AT LEAST ONE VOCATIONAL ASSESSMENT EVERY FIVE YEARS IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE COMMISSIONER. THE PRIMARY PURPOSE OF A VOCATIONAL ASSESSMENT SHALL BE TO DETERMINE AN INDIVIDUAL'S INTERESTS, STRENGTHS AND ABILITIES, IN ORDER TO IDENTIFY A SUITABLE MATCH BETWEEN THE INDIVIDUAL AND A COMPETITIVE INTEGRATED EMPLOYMENT SETTING;

(2) COMPLETION OF ONE TRIAL INTEGRATED WORK EXPERIENCE EVERY FIVE YEARS, WHICH CAN INCLUDE ANY WORK EXPERIENCE WITH OR WITHOUT PAY IN WHICH THE INDIVIDUAL WORKS ALONGSIDE NON-DISABLED COWORKERS, CUSTOMERS OR PEERS, WITH THE APPROPRIATE SERVICES AND SUPPORTS FOR A SUFFICIENT PERIOD OF TIME TO ESTABLISH WHETHER AN INDIVIDUAL'S INTERESTS, SKILLS AND ABILITIES ARE WELL-SUITED FOR THE PARTICULAR JOB. THE TRIAL INTEGRATED WORK EXPERIENCE SHALL BE SELECTED THROUGH A PERSON-CENTERED PLANNING PROCESS AND SHALL BE INDIVIDUALLY TAILORED TO EACH PERSON. ALTERNATIVELY, THE COMMISSIONER SHALL CONSIDER THE INDIVIDUAL'S DEMONSTRATION OF AN INABILITY TO PARTICIPATE IN AN INTEGRATED WORK SETTING DUE TO A DOCUMENTED MEDICAL CONDITION THAT POSES AN IMMEDIATE AND SERIOUS THREAT TO THE INDIVIDUAL'S HEALTH OR SAFETY, OR THE HEALTH OR SAFETY OF OTHERS IN AN INTEGRATED WORK SETTING;

(3) RECEIPT OF OUTREACH, EDUCATION AND SUPPORT SERVICES IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE COMMISSIONER. OUTREACH, EDUCATION AND SUPPORT SERVICES ARE SERVICES DESIGNED TO EXPLAIN THE BENEFITS OF SUPPORTED EMPLOYMENT, AS DEFINED IN SUBDIVISION ELEVEN OF SECTION ONE THOUSAND TWO OF THE EDUCATION LAW, THAT ADDRESS CONCERNS OF FAMILIES AND PERCEIVED OBSTACLES TO PARTICIPATION, AND ARE DESIGNED TO ENCOURAGE INDIVIDUALS IN DAY ACTIVITY SERVICE PROGRAMS, INCLUDING IN SHELTERED WORKSHOPS AND FACILITY-BASED DAY PROGRAMS, AND THEIR FAMILIES TO SEEK SUPPORTED EMPLOYMENT SERVICES, AS DEFINED UNDER SUBDIVISION TWELVE OF SECTION ONE THOUSAND TWO OF THE EDUCATION LAW; OR

(4) INVOLVEMENT IN A BENEFITS COUNSELING CONSULTATION IN ACCORDANCE WITH REGULATIONS PROMULGATED BY THE COMMISSIONER. A BENEFIT COUNSELING CONSULTATION SHALL PROVIDE INFORMATION TO THE INDIVIDUAL AND HIS OR HER FAMILY OR GUARDIAN ABOUT THE IMPACT OF EARNED INCOME ON THE INDIVIDUAL'S PUBLIC BENEFITS.

(B) THE OFFICE SHALL ENSURE THAT INDIVIDUALS WHO ARE GRANTED ACCOMMODATION TO PARTICIPATE IN A NONINTEGRATED SETTING SHALL CONTINUE TO RECEIVE SERVICES AND ANY ADDITIONAL SERVICES THE OFFICE DETERMINES ARE NECESSARY TO ENABLE THE INDIVIDUAL'S MEANINGFUL PARTICIPATION IN THE CHOSEN SETTING.

(C) THE PROCEDURES FOR OBTAINING ACCOMMODATION TO REMAIN IN A NONINTEGRATED SETTING SHALL NOT SUPERSEDE NOR BAR THE INDIVIDUAL'S CHOICE TO REMAIN IN A NONINTEGRATED SETTING.

(D) THE ACCOMMODATION TO REMAIN IN A NONINTEGRATED SETTING SHALL NOT DIMINISH THE INDIVIDUAL'S ELIGIBILITY FOR RECEIPT OF SERVICES UNDER TITLE ELEVEN OF ARTICLE FIVE OF THE SOCIAL SERVICES LAW, AND SUCH INDIVIDUAL'S ELIGIBILITY TO RECEIVE SUCH SERVICES SHALL BE SUBSTANTIALLY SIMILAR TO BENEFITS THAT WOULD HAVE BEEN RECEIVED HAD THE INDIVIDUAL CHOSEN TO PARTICIPATE IN AN INTEGRATED SETTING.

(E) THE COMMISSIONER IS AUTHORIZED TO ISSUE, AMEND OR REPEAL ANY REGULATIONS AS HE OR SHE SHALL DEEM NECESSARY TO IMPLEMENT THE PROVISIONS OF THIS SECTION.

S 4. The commissioner of developmental disabilities shall amend and resubmit to the Federal Centers for Medicare and Medicaid Services the final New York plan to increase competitive employment opportunities for people with developmental disabilities, as approved on May 1, 2014, in order to secure the continued federal financial participation for prevocational services and any other necessary federal funds for those individuals choosing a sheltered workshop setting pursuant to section 16.02 of the mental hygiene law. The plan, as amended according to this section, shall stipulate that facility-based prevocational services shall continue to be eligible for federal funding, as allowed by such centers' stated policy that its regulations do not prohibit individuals from receiving prevocational services in a facility-based setting, such as a sheltered workshop, as referenced in its Informational Bulletin on Employment Services dated September 16, 2011, and its related document titled "HCBS Final Regulations 42 C.F.R. Part 441: Questions and Answers Regarding Home and Community-Based Settings; Public Notice and Comments".

S 5. This act shall take effect immediately.

PART V

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 W

Section 1. Section 7.17 of the mental hygiene law is amended by adding a new subdivision (g) to read as follows:

(G) THE COMMISSIONER SHALL PROVIDE MONTHLY STATUS REPORTS ON COMMUNITY INVESTMENTS AND THE IMPACT ON INPATIENT CENSUS TO THE CHAIRS OF THE

SENATE FINANCE COMMITTEE AND THE ASSEMBLY WAYS AND MEANS COMMITTEE. SUCH REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) A STATE OPERATED PSYCHIATRIC FACILITY CENSUS;

(2) LOW TO HIGH CENSUS RANGE;

(3) AVERAGE DAILY CENSUS;

(4) ADMISSIONS AND DISCHARGES;

(5) PSYCHIATRIC READMISSIONS TO HOSPITALS AND EMERGENCY ROOMS FOR STATE PC DISCHARGES;

(6) PSYCHIATRIC READMISSIONS TO HOSPITALS AND EMERGENCY ROOMS FOR ARTICLE TWENTY-EIGHT AND ARTICLE THIRTY-ONE HOSPITALS PSYCHIATRIC UNIT DISCHARGES;

(7) MEDICAID EMERGENCY ROOM PSYCHIATRIC VISITS;

(8) DESCRIPTIONS OF NEW COMMUNITY SERVICE REINVESTMENTS;

(9) AN EXPLANATION OF ANY MATERIAL CENSUS REDUCTIONS;

(10) MEDIAN LENGTH OF STAY AT EACH FACILITY;

(11) THE NUMBER OF INDIVIDUALS WHO ARE LONG STAY AT EACH FACILITY;

(12) THE NUMBER OF INDIVIDUALS OUT OF THE CATCHMENT AREA ADMITTED INTO FACILITIES IN THE CATCHMENT AREA;

(13) THE NUMBER OF INDIVIDUALS IN THE CATCHMENT AREA ADMITTED INTO FACILITIES OUT OF THE CATCHMENT AREA;

(14) ARTICLE TWENTY-EIGHT AND THIRTY-ONE HOSPITAL REINVESTMENT SUMMARIES PURSUANT TO CHAPTER FIFTY-THREE OF THE LAWS OF TWO THOUSAND FOURTEEN FOR SERVICES AND EXPENSES OF THE MEDICAL ASSISTANCE PROGRAM TO ADDRESS COMMUNITY MENTAL HEALTH SERVICE NEEDS RESULTING FROM THE REDUCTION OF PSYCHIATRIC INPATIENT SERVICES; AND

(15) A GLOSSARY OF SERVICES.

S 2. Section 13.17 of the mental hygiene law, as amended by section 1 of part J of chapter 56 of the laws of 2012, is amended to read as follows:

S 13.17 Programs, services, and operations in the office for people with developmental disabilities.

(a) The commissioner shall establish policy and procedures for the organization, administration, and service delivery system under his or her jurisdiction and shall make provision for the effective rendition of supports and services to individuals with developmental disabilities.

(b) There shall be, within the state operations offices of the office, the developmental disabilities services offices named below serving the areas either currently or previously served by a school, for the care and treatment of persons with developmental disabilities and for research and teaching in the science and skills required for the care and treatment of such persons with developmental disabilities:

Bernard M. Fineson Developmental Disabilities Services Office

Brooklyn Developmental Disabilities Services Office

Broome Developmental Disabilities Services Office

Capital District Developmental Disabilities Services Office

Central New York Developmental Disabilities Services Office

Finger Lakes Developmental Disabilities Services Office

Institute for Basic Research in Developmental Disabilities

Hudson Valley Developmental Disabilities Services Office

Metro New York Developmental Disabilities Services Office

Long Island Developmental Disabilities Services Office

Sunmount Developmental Disabilities Services Office

Taconic Developmental Disabilities Services Office

Western New York Developmental Disabilities Services Office

Staten Island Developmental Disabilities Services Office

The New York State Institute for Basic Research in Developmental Disabilities is designated as an institute for the conduct of medical research and other scientific investigation directed towards furthering knowledge of the etiology, diagnosis, treatment and prevention of developmental disabilities.

(c) The commissioner shall establish, at his or her discretion, developmental disabilities regional offices and shall establish state operations offices that provide for the direct delivery of supports and services by the office for people with developmental disabilities.

[(c)] (D) The commissioner may authorize other offices of the department and any public or private non-profit organization or political subdivision of the state to deliver supports and services to individuals with developmental disabilities, not inconsistent with the programs and objectives of the office in any facility under his jurisdiction. The commissioner may permit any facility under his jurisdiction to operate programs for persons with mental disabilities, not inconsistent with programs and objectives of the department, under contracts or agreements with other offices within the department.

(E) THE COMMISSIONER SHALL PROVIDE MONTHLY STATUS REPORTS TO THE CHAIRS OF THE SENATE FINANCE COMMITTEE AND THE ASSEMBLY WAYS AND MEANS COMMITTEE. SUCH REPORT SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) CURRENT CENSUS BY FACILITY;

(2) ADMISSIONS AND DISCHARGES;

(3) THE NUMBER OF INDIVIDUALS WHO ARE LONG STAY AT EACH FACILITY;

(4) AN EXPLANATION OF ANY SIGNIFICANT CENSUS REDUCTIONS; AND

(5) COMMUNITY SERVICES PROVIDED TO INDIVIDUALS LEAVING FACILITIES, INCLUDING THOSE INDIVIDUALS WITH COMPLEX NEEDS.

S 3. This act shall take effect immediately.

PART X

Section 1. The commissioner of the office for people with developmental disabilities, in collaboration with the developmental disabilities advisory council established pursuant to section 13.05 of the mental hygiene law, shall develop a plan for implementing the front door process. Such commissioner shall submit the plan to the temporary president of the senate and the speaker of the assembly no later than January 1, 2016 and implement guidelines putting the plan into effect on or after April 1, 2016, but no later than July 1, 2016. The plan shall:

(a) Provide clear and specific guidelines outlining the criteria for when self-direction is and is not appropriate for individuals.

(b) Provide guidelines for a clear, expeditious and transparent process for allocating residential placements and other critical services to persons based on their individual needs. Such process shall be consistent across the state and where exceptions are made such exceptions shall be made in explicit recognition of clear and rational factors. Such guidelines shall:

(1) Ensure that critical needs are met in a timely fashion;

(2) Provide an expedited appeals process to review and finally determine authorized requests for critical services when the state has not granted such a request promptly considering the circumstances, provided, however, that such appeal must be authorized if the request has not been granted within ten business days;

(3) Provide linguistically and culturally appropriate information on services and access to services in a universally clear and transparent manner;

(4) Provide designated staff which may include a Medicaid service coordinator to assist prospective service recipients and their families with navigating the front door process;

(5) Provide a process to ensure that people in crisis are not subject to the front door process and receive immediate services;

(6) Report on the extent to which the front door policy, as it has been implemented, is consistent with applicable requirements for the home and community based waiver regarding timeliness of decisions, comprehensiveness of necessary services, choice, persons centered planning and other matters affecting the appropriateness and adequacy of services for people with developmental disabilities.

(7) Provide guidelines to facilitate and support the evaluation of post-secondary options for individuals with developmental disabilities consistent with subparagraph 5 of paragraph b of subdivision 1 of section 4402 of the education law.

S 2. This act shall take effect immediately.

PART Y

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

(C) (1) FOR PURPOSES OF THIS SUBDIVISION, THE FOLLOWING TERMS SHALL HAVE THE FOLLOWING MEANINGS:

(A) "DIRECT SUPPORT PROFESSIONALS" MEANS DIRECT SUPPORT WORKERS, DIRECT CARE WORKERS, PERSONAL ASSISTANTS, PERSONAL ATTENDANTS, AND PARA-PROFESSIONALS THAT PROVIDE ASSISTANCE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES IN THE FORM OF DAILY LIVING, AND PROVIDE THE HABILITATION, REHABILITATION, AND VOCATIONAL AND EDUCATIONAL NEEDS OF THESE INDIVIDUALS.

(B) "LICENSED PROFESSIONALS" MEANS PHYSICIANS, DENTISTS, DENTAL HYGIENISTS, DENTAL ASSISTANTS, NURSE PRACTITIONERS, LICENSED PRACTICAL NURSES, REGISTERED NURSES, PSYCHIATRISTS, PSYCHOLOGISTS, LICENSED MASTER SOCIAL WORKERS, OR LICENSED CLINICAL SOCIAL WORKERS, LICENSED TO PRACTICE PURSUANT TO THE EDUCATION LAW AND OTHER QUALIFIED MENTAL HEALTH PROFESSIONALS.

(C) "SUPPORTS AND SERVICES" MEANS DIRECT SUPPORT PROFESSIONALS, LICENSED PROFESSIONALS, EMPLOYMENT, TRANSPORTATION, DAY AND RESIDENTIAL SERVICES, INCLUDING, BUT NOT LIMITED TO, PRIVATE RESIDENCES, COMMUNITY-INTEGRATED LIVING ARRANGEMENTS, SUPPORTED RESIDENTIAL PROGRAMS, SUPERVISED RESIDENTIAL PROGRAMS, OR SUPPORTIVE HOUSING PROGRAMS.

(2) THE COMMISSIONER SHALL CONDUCT AN ANNUAL GEOGRAPHIC ANALYSIS OF SUPPORTS AND SERVICES IN COMMUNITY SETTINGS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES IN EACH COUNTY OF THE STATE IN ORDER TO IDENTIFY GAPS BETWEEN SUPPORTS AND SERVICES CURRENTLY PROVIDED AND SUPPORTS AND SERVICES BEING REQUESTED BY INDIVIDUALS IN EACH COUNTY OF THE STATE. THE ANALYSIS SHALL BE BASED UPON INFORMATION CURRENTLY MAINTAINED BY THE OFFICE.

(A) THE COMMISSIONER SHALL CATEGORIZE THE NEEDS FOR DEVELOPMENTAL DISABILITY SERVICES WITHIN A FRAMEWORK THAT ENCOMPASSES THREE LEVELS OF URGENCY OF NEEDS. THESE LEVEL OF SUPPORT NEEDS ARE: (I) EMERGENCY NEED, FOR THOSE PERSONS WITH DEVELOPMENTAL DISABILITIES IN NEED OF IMMEDIATE SUPPORT EITHER DAY SUPPORT OR IN-HOME OR OUT-OF-HOME PLACEMENT; (II) CRITICAL NEED FOR THOSE INDIVIDUALS WHO WILL HAVE A NEED FOR SUPPORTS OR SERVICES WITHIN ONE YEAR; AND (III) PLANNING FOR NEED, FOR THOSE INDIVIDUALS WHOSE SUPPORT NEEDS ARE ONE TO FIVE YEARS AWAY, OR WHERE THE CAREGIVER'S PHYSICAL AND MENTAL WELL-BEING OR ABILITY IS COMPROMISED.

(B) THE GEOGRAPHIC ANALYSIS SHALL INCLUDE:
(I) THE STATEWIDE NUMBER OF INDIVIDUALS SEEKING SERVICES;
(II) INDIVIDUALS WHO HAVE REGISTERED FOR RESIDENTIAL PLACEMENT, RESIDENTIAL SUPPORTS IN THE COMMUNITY, DAY SERVICE SUPPORT, HOME AND COMMUNITY-BASED WAIVER SUPPORT, EMPLOYMENT SUPPORT, BEHAVIORAL HEALTH SERVICES AND SUPPORTS, OR OTHER COMMUNITY-BASED SUPPORT;
(III) RESIDENTIAL REGISTRY DATA SUCH AS:
(I) THE TYPE OF SUPPORTS AND SERVICES SUCH INDIVIDUALS ARE SEEKING AND THE TYPES OF SUPPORTS AND SERVICES SUCH INDIVIDUAL IS EXPECTED TO REQUIRE BASED UPON INDIVIDUAL SERVICES PLANNING MODEL (ISPM) GROUPING SCORES 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 FAMILY 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 SUPPORTS AND SERVICES REQUESTED 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, WHO ARE AWAITING AN ALTERNATIVE PLACEMENT OR ALTERNATIVE SUPPORT AND SERVICE DELIVERY OPTIONS;
(VII) THE NUMBER OF INDIVIDUALS THE COMMISSIONER HAS IDENTIFIED AS HAVING AN EMERGENCY NEED, FOR THOSE PERSONS WITH DEVELOPMENTAL DISABILITIES IN NEED OF IMMEDIATE SUPPORT EITHER DAY SUPPORT OR IN-HOME OR OUT-OF-HOME PLACEMENT; CRITICAL NEED FOR THOSE INDIVIDUALS WHO WILL HAVE A NEED FOR SUPPORTS OR SERVICES WITHIN ONE YEAR; AND PLANNING FOR NEED, FOR THOSE INDIVIDUALS WHOSE SUPPORT NEEDS ARE ONE TO FIVE YEARS AWAY, OR WHERE THE CAREGIVER'S PHYSICAL AND MENTAL WELL-BEING OR ABILITY IS COMPROMISED; AND
(VIII) ANY OTHER INFORMATION DEEMED NECESSARY BY THE COMMISSIONER.
(3) 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.
(4) THE COMMISSIONER SHALL MAKE PUBLIC EACH ANNUAL ANALYSIS NO LATER THAN THE FIRST DAY OF THE FIRST MONTH FOLLOWING THE END OF THE PRECEDING YEAR, BY POSTING THE DATA ON THE OFFICE WEBSITE.
S 2. This act shall take effect immediately.

PART Z

Section 1. Section 6801-a of the education law, as added by chapter 21 of the laws of 2011, is amended to read as follows:
S 6801-a. Collaborative drug therapy management [demonstration program]. 1. As used in this section, the following terms shall have the following meanings:

a. "Collaborative drug therapy management" shall mean the performance of services by a pharmacist relating to the review, evaluation and management of drug therapy to a patient, who is being treated by a physician OR NURSE PRACTITIONER for a specific disease or disease state, in accordance with a written agreement or protocol with a voluntarily participating physician OR NURSE PRACTITIONER and in accordance with the policies, procedures, and protocols of the facility. Such agreement or protocol as entered into by the physician OR NURSE PRACTITIONER and a pharmacist, may include, and shall be limited to:

(i) [adjusting or managing] PRESCRIBING IN ORDER TO ADJUST OR MANAGE a drug regimen of a patient, pursuant to a patient specific written order or protocol made by the patient's physician OR NURSE PRACTITIONER, which may include adjusting drug strength, frequency of administration or route of administration. Adjusting the drug regimen shall not include substituting or selecting a different drug which differs from that initially prescribed by the patient's physician OR NURSE PRACTITIONER unless such substitution is expressly authorized in the written order or protocol. The pharmacist shall be required to immediately enter into the patient record any change or changes made to the patient's drug therapy and shall use any reasonable means or method established by the facility or the department to notify any of the patient's other treating physicians OR NURSE PRACTITIONERS with whom he or she does not have a written agreement or protocol regarding such changes. The patient's physician OR NURSE PRACTITIONER may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the pharmacist;

(ii) evaluating and, only if specifically authorized by the protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering clinical laboratory tests related to the drug therapy management for the specific disease or disease state specified within the protocol; and

(iii) only if specifically authorized by the protocol and only to the extent necessary to discharge the responsibilities set forth in this section, ordering or performing routine patient monitoring functions as may be necessary in the drug therapy management, including the collecting and reviewing of patient histories, and ordering or checking patient vital signs, including pulse, temperature, blood pressure and respiration.

b. "Written agreement or protocol" shall mean a written document, pursuant to and consistent with any applicable state or federal requirements, that addresses a specific disease or disease state and that describes the nature and scope of collaborative drug therapy management to be undertaken by the pharmacist, in collaboration with the participating physician OR NURSE PRACTITIONER, in accordance with the provisions of this section.

c. "Physician OR NURSE PRACTITIONER" shall mean the physician OR NURSE PRACTITIONER, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient for the disease or disease state that is the subject of the collaborative drug therapy management.

d. "Facility" shall mean a [teaching] hospital, [including any diagnostic center, treatment center, or hospital-based outpatient department, however, for the purposes of this section, residential health care facilities and nursing homes shall be excluded] AS DEFINED BY SUBDIVISION ONE OF SECTION TWENTY-EIGHT HUNDRED ONE OF THE PUBLIC HEALTH LAW. [For the purposes of this section, a "teaching hospital" shall mean a hospital licensed pursuant to article twenty-eight of the public health

law that is eligible to receive direct or indirect graduate medical education payments pursuant to article twenty-eight of the public health law.] IN ADDITION, A FACILITY MAY ALSO INCLUDE UP TO FIFTEEN COMMUNITY-PRACTICE SITES, SELECTED BY THE DEPARTMENT IN CONSULTATION WITH THE DEPARTMENT OF HEALTH, WHERE PHARMACISTS AND PHYSICIANS OR NURSE PRACTITIONERS MAY PROPOSE TO ENTER INTO COLLABORATIVE ARRANGEMENTS, PURSUANT TO THE PROVISIONS OF THIS SECTION. SUCH SITES SHALL BE SELECTED BASED UPON A REVIEW OF APPLICATIONS SUBMITTED TO THE DEPARTMENT BY SUCH PHARMACISTS AND PHYSICIANS OR NURSE PRACTITIONERS, WHICH DEMONSTRATE THAT THE APPLICANTS CAN SATISFY THE REQUIREMENTS OF THIS SECTION.

2. a. A pharmacist who meets the experience requirements of paragraph b of this subdivision and who is EITHER employed by or otherwise affiliated with a facility OR IS PARTICIPATING WITH A COMMUNITY-PRACTICE SITE SELECTED PURSUANT TO PARAGRAPH D OF SUBDIVISION ONE OF THIS SECTION shall be permitted to enter into a written agreement or protocol with a physician OR NURSE PRACTITIONER authorizing collaborative drug therapy management, subject to the limitations set forth in this section, within the scope of such employment [or], affiliation OR PARTICIPATION.

b. A participating pharmacist must:

(i)(A) have been awarded either a master of science in clinical pharmacy or a doctor of pharmacy degree;

(B) maintain a current unrestricted license; and

(C) have a minimum of two years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians OR NURSE PRACTITIONERS with respect to drug therapy and may include a residency at a facility involving such consultation; or

(ii)(A) have been awarded a bachelor of science in pharmacy;

(B) maintain a current unrestricted license; and

(C) within the last seven years, have a minimum of three years experience, of which at least one year of such experience shall include clinical experience in a health facility, which involves consultation with physicians OR NURSE PRACTITIONERS with respect to drug therapy and may include a residency at a facility involving such consultation.

c. Notwithstanding any provision of this section, nothing herein shall authorize the pharmacist to diagnose disease. In the event that a treating physician OR NURSE PRACTITIONER may disagree with the exercise of professional judgment by the pharmacist, the judgment of the treating physician OR NURSE PRACTITIONER shall prevail.

3. The physician OR NURSE PRACTITIONER who is a party to a written agreement or protocol authorizing collaborative drug therapy management IN A FACILITY SETTING shall be employed by or otherwise affiliated with the same facility with which the pharmacist is also employed or affiliated.

4. The existence of a written agreement or protocol on collaborative drug therapy management and the patient's right to choose to not participate in collaborative drug therapy management shall be disclosed to any patient who is eligible to receive collaborative drug therapy management. Collaborative drug therapy management shall not be utilized unless the patient or the patient's authorized representative consents, in writing, to such management. If the patient or the patient's authorized representative consents, it shall be noted on the patient's medical record. If the patient or the patient's authorized representative who consented to collaborative drug therapy management chooses to no longer participate in such management, at any time, it shall be noted on the patient's medical record. In addition, the existence of the written

agreement or protocol and the patient's consent to such management shall be disclosed to the patient's primary physician OR NURSE PRACTITIONER and any other treating physician OR NURSE PRACTITIONER or healthcare provider.

5. Participation in a written agreement or protocol authorizing collaborative drug therapy management shall be voluntary, and no patient, physician, NURSE PRACTITIONER, pharmacist, or facility shall be required to participate.

6. Nothing in this section shall be deemed to limit the scope of practice of pharmacy nor be deemed to limit the authority of pharmacists and physicians OR NURSE PRACTITIONERS to engage in medication management prior to the effective date of this section and to the extent authorized by law.

S 2. 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 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 3. This act shall take effect immediately; provided, however, that section two of this act shall take effect on the one hundred twentieth day after it shall have become a law; provided 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.

PART AA

Section 1. Section 7.17 of the mental hygiene law is amended by adding a new subdivision (g) to read as follows:

(G) THE COMMISSIONER SHALL ESTABLISH THE SINGLE POINT OF ACCESS WAIT LIST FOR INDIVIDUALS SEEKING HOUSING AND RELATED SERVICES WITHIN THE OFFICE OF MENTAL HEALTH SERVICES SYSTEM.

(1) THE COMMISSIONER SHALL USE THE DATA REPORTED TO THE OFFICE BY COUNTIES AND THIRD PARTY ENTITIES CONTRACTED TO PROVIDE SINGLE POINT OF ACCESS SUPPORT SERVICES AS REQUIRED BY PARAGRAPH SEVENTEEN OF SUBDIVISION (A) OF SECTION 41.13 OF THIS CHAPTER, TO GENERATE THE SINGLE POINT OF ACCESS WAIT LIST FOR INDIVIDUALS SEEKING HOUSING AND RELATED SERVICES WITHIN THE OFFICE OF MENTAL HEALTH SERVICES SYSTEM.

(2) THE INFORMATION PROVIDED IN THE SINGLE POINT OF ACCESS WAIT LIST SHALL INCLUDE BUT NOT BE LIMITED TO:

(I) THE NAME OF EACH PERSON WHO IS REFERRED TO, APPLIES FOR, IS ADMITTED TO, WITHDRAWS AN APPLICATION FOR OR IS DENIED ACCESS TO HOUSING PROGRAMS OR RELATED SERVICES THROUGH EACH COUNTY'S SINGLE POINT OF ACCESS PROGRAM;

(II) THE NAMES OF PERSONS REFERRED TO A HOUSING SERVICES PROVIDER BY THE COUNTY OR THIRD PARTY ENTITY CONTRACTED TO PROVIDE SINGLE POINT OF ACCESS SUPPORT SERVICES VIA THE SINGLE POINT OF ACCESS PROGRAM;

(III) THE NAME OF EACH PERSON RECEIVING MENTAL HEALTH RESIDENTIAL SERVICES OR PLACED IN HOUSING VIA THE SINGLE POINT OF ACCESS PROGRAM; AND

(IV) ANY OTHER INFORMATION AS THE COMMISSIONER MAY REQUIRE.

(3) THE COMMISSIONER SHALL MAKE PUBLIC THE SINGLE POINT OF ACCESS WAIT LIST BY POSTING THE DATA, ABSENT PERSONAL IDENTIFICATION INFORMATION ON THE OFFICE OF MENTAL HEALTH WEBSITE. THE COMMISSIONER SHALL REGULARLY UPDATE THE OFFICE OF MENTAL HEALTH WEBSITE TO ACCURATELY REFLECT CHANGES TO THE SINGLE POINT OF ACCESS WAIT LIST AS NEW DATA IS REPORTED BUT SHALL NOT EXCEED A PERIOD LONGER THAN SEVENTY DAYS BETWEEN UPDATES.

(4) THE COMMISSIONER SHALL ESTABLISH POLICIES, PROCEDURES AND FORMS FOR THE SINGLE POINT OF ACCESS WAIT LIST IN ORDER TO ENSURE COUNTIES AND THIRD PARTY ENTITIES CONTRACTED TO PROVIDE SINGLE POINT OF ACCESS SUPPORT SERVICES ARE ABLE TO SUBMIT WAIT LIST INFORMATION, AS OUTLINED BY PARAGRAPHS SEVENTEEN, EIGHTEEN AND NINETEEN OF SUBDIVISION (A) OF SECTION 41.13 OF THIS CHAPTER, DIRECTLY TO THE OFFICE VIA ELECTRONIC MEANS. SUCH POLICIES, PROCEDURES AND FORMS SHALL SAFEGUARD THE CONFIDENTIALITY OF INFORMATION CONCERNING PERSONS SEEKING HOUSING, AND ACCORD EACH PERSON ON THE WAIT LIST AN OPPORTUNITY TO RECEIVE A WRITTEN COPY OF HIS OR HER PERSONAL INFORMATION MAINTAINED ON THE WAIT LIST. SUCH POLICIES AND PROCEDURES SHALL PROVIDE FOR THE SINGLE POINT OF ACCESS WAIT LIST TO INCLUDE ALL PERSONS ON ANY LOCAL WAIT LIST FOR HOUSING BEFORE THE EFFECTIVE DATE OF THIS SUBDIVISION AND THE DATE UPON WHICH EACH SUCH PERSON WAS FIRST PLACED ON SUCH WAIT LIST. SUCH LIST SHALL ALSO INCLUDE PERSONS WHO ARE PLACED ON ANY SUCH LOCAL WAIT LIST ON OR AFTER THE EFFECTIVE DATE OF THIS SUBDIVISION.

(5) THE COMMISSIONER SHALL PREPARE A REPORT ON THE SINGLE POINT OF ACCESS WAIT LIST OF PERSONS SEEKING HOUSING WITHIN THE MENTAL HEALTH SYSTEM. THE REPORT SHALL INCLUDE BUT NOT BE LIMITED TO: (I) THE NUMBER OF ADULTS REFERRED TO THE SINGLE POINT OF ACCESS WAIT LIST; (II) THE NUMBER OF ADULTS THAT APPLIED FOR EACH CATEGORY OF RESIDENTIAL SERVICE; (III) THE NUMBER OF ADULTS ADMITTED TO EACH CATEGORY OF RESIDENTIAL SERVICE; (IV) THE NUMBER OF ADULTS DENIED ADMISSION FOR EACH CATEGORY OF RESIDENTIAL SERVICE; (V) THE NUMBER OF ADULTS WHO WITHDREW APPLICATIONS FOR EACH CATEGORY OF RESIDENTIAL SERVICE; AND (VI) THE NUMBER OF ADULTS ON THE SINGLE POINT OF ACCESS WAIT LIST FOR EACH CATEGORY OF RESIDENTIAL SERVICE. SUCH REPORT SHALL INCLUDE FOR EACH CATEGORY AND COUNTY, THE NUMBER OF MONTHS ON THE SINGLE POINT OF ACCESS WAIT LIST FOR EACH PERSON. SUCH REPORT SHALL INCLUDE THE TYPES, CAPACITIES AND VACANCY RATES OF RESIDENTIAL SERVICES OFFERED IN EACH COUNTY. THE REPORTS SHALL INCLUDE ANY ACTIONS TAKEN BY THE OFFICE TO REDUCE THE LENGTH OF THE SINGLE POINT OF ACCESS WAIT LIST FOR EACH CATEGORY OF RESIDENTIAL SERVICES, INCLUDING THE METHODS BY WHICH THE OFFICE PRIORITIZES THE PROVISIONS OF SERVICES TO PERSONS ON THE SINGLE POINT OF ACCESS WAIT LIST AND THE ACTIONS OF THE OFFICE TO INFORM THE PUBLIC ABOUT THE SINGLE POINT OF ACCESS WAIT LIST AND THE AVAILABILITY OF COMMUNITY HOUSING AND SERVICES FOR ADULTS WITH A DOCUMENTED MENTAL ILLNESS. THE OFFICE SHALL SUBMIT THE REPORT TO THE GOVERNOR, THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY ON OR BEFORE JANUARY FIRST, TWO THOUSAND SEVENTEEN AND QUARTERLY THEREAFTER.

S 2. Subdivision (a) of section 41.13 of the mental hygiene law is amended by adding three new paragraphs 17, 18 and 19 to read as follows:

17. USING DATA CONTAINED IN THE SINGLE POINT OF ACCESS DATABASE, REPORT EVERY SIXTY DAYS TO THE OFFICE THE NAME OF EACH PERSON WHO IS REFERRED TO, APPLIES FOR, IS ADMITTED TO, WITHDRAWS AN APPLICATION FOR OR IS DENIED ACCESS TO HOUSING PROGRAMS OR RELATED SERVICES THROUGH THE COUNTY'S SINGLE POINT OF ACCESS PROGRAM, ALONG WITH SUCH OTHER INFORMATION AS THE COMMISSIONER MAY REQUIRE.

18. USING DATA CONTAINED IN THE SINGLE POINT OF ACCESS DATABASE, REPORT THE NAMES OF PERSONS REFERRED TO A HOUSING SERVICES PROVIDER BY THE COUNTY OR THIRD PARTY ENTITY CONTRACTED TO PROVIDE SINGLE POINT OF ACCESS SUPPORT SERVICES VIA THE SINGLE POINT OF ACCESS PROGRAM TO THE OFFICE, ALONG WITH SUCH OTHER INFORMATION AS THE COMMISSIONER MAY REQUIRE.

19. USING DATA CONTAINED IN THE SINGLE POINT OF ACCESS DATABASE, REPORT THE NAME OF EACH PERSON RECEIVING MENTAL HEALTH RESIDENTIAL SERVICES OR PLACED IN HOUSING, ALONG WITH SUCH OTHER INFORMATION AS THE COMMISSIONER MAY REQUIRE.

S 3. This act shall take effect on the one hundred twentieth day after it shall have become a law; provided, however, 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 are authorized and directed to be made and completed on or before such effective date.

PART BB

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

(iv) "Opioid antagonist recipient" or "recipient" means a person at risk of experiencing an opioid-related overdose, or a family member, friend or other person in a position to assist a person experiencing or at risk of experiencing an opioid-related overdose, or an organization registered as an opioid overdose prevention program pursuant to this section, OR A SCHOOL DISTRICT, BOARD OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARD, CHARTER SCHOOL, NON-PUBLIC ELEMENTARY AND/OR SECONDARY SCHOOL IN THE STATE OR ANY PERSON EMPLOYED BY SUCH DISTRICT, BOARD OR SCHOOL.

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

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

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

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

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

S 922. OPIOID OVERDOSE PREVENTION. 1. SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTEN-

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

2. SCHOOL DISTRICTS, BOARDS OF COOPERATIVE EDUCATIONAL SERVICES, COUNTY VOCATIONAL EDUCATION AND EXTENSION BOARDS, CHARTER SCHOOLS, AND NON-PUBLIC ELEMENTARY AND SECONDARY SCHOOLS IN THIS STATE OR ANY PERSON EMPLOYED BY ANY SUCH ENTITY MAY ADMINISTER AN OPIOID ANTAGONIST IN THE EVENT OF AN EMERGENCY PURSUANT TO THE REQUIREMENTS OF SECTION THREE THOUSAND THREE HUNDRED NINE OF THE PUBLIC HEALTH LAW.

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

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

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

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

S 7. This act shall take effect immediately.

PART CC

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. 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 chapter of the laws of [2014] 2015 which amended this section through [December 31, 2016] JUNE 30, 2018 for patients in the city of New York, for all rate periods on and after the effective date of the chapter of the laws of [2014] 2015 which amended this section through [June 30, 2017] SEPTEMBER 30, 2018 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] 2015 which amended this section through December 31, [2017] 2018 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.

S 2. Subdivision 8 of section 84 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 14 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

8. section forty-eight-a of this act shall expire and be deemed repealed January 1, [2018] 2019;

S 3. 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. 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 chapter of the laws of [2014] 2015 which amended this section through [December 31, 2016] JUNE 30, 2018 for patients in the city of New York, for all rate periods on and after the effective date of the chapter of the laws of [2014] 2015 which amended this section through [June 30, 2017] SEPTEMBER 30, 2018 for patients outside the city of New York, and for all rate periods on and after the effective date of the chapter of the laws of [2014] 2015 which amended this section through December 31, [2017] 2018 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.

S 4. Section 2 of part H of chapter 111 of the laws of 2010, relating to increasing Medicaid payments to providers through managed care organizations and providing equivalent fees through an ambulatory patient group methodology, as amended by section 16 of part C of chapter 60 of the laws of 2014, is amended to read as follows:

S 2. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2010, and shall expire on January 1, [2018] 2019.

S 5. Subdivision 7-a of section 84 of part A of chapter 56 of the laws of 2013, amending the public health law and other laws relating to state health mental hygiene budget for the 2013-14 state fiscal year, as added by section 16-b of part C of chapter 60 of the laws of 2014, is amended to read as follows:

7-a. section forty-five-c of this act shall expire and be deemed repealed January 1, [2018] 2019;

S 6. This act shall take effect immediately.

PART DD

Section 1. The mental hygiene law is amended by adding a new section 13.43 to read as follows:

S 13.43 INTEGRATED HOUSING PLAN.

(A) THE COMMISSIONER, IN CONSULTATION WITH THE DEVELOPMENTAL DISABILITIES ADVISORY COUNCIL, THE DEPARTMENT OF HEALTH, THE DIVISION OF HOUSING AND COMMUNITY RENEWAL, THE MOST INTEGRATED SETTINGS COORDINATING COUNCIL AND OTHER AGENCIES AS DETERMINED APPROPRIATE BY THE COMMISSIONER, SHALL ESTABLISH A PLAN TO INCREASE HOUSING OPPORTUNITIES FOR PEOPLE WITH

DEVELOPMENTAL DISABILITIES. THE PLAN SHALL INCLUDE, BUT NOT BE LIMITED TO:

(1) THE CREATION AND MAINTENANCE OF A LIST OF AFFORDABLE AND ACCESSIBLE RENTAL UNITS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES; AND

(2) IDENTIFICATION OF STRATEGIES TO FACILITATE INDIVIDUALS RECEIVING OR ELIGIBLE FOR HOME AND COMMUNITY BASED (HCBS) WAIVERS TO LIVE IN THEIR OWN HOME, LEASED APARTMENT OR FAMILY'S HOME, WHEN SUCH A PLACEMENT IS THEIR INFORMED CHOICE AND THE MOST INTEGRATED SETTING APPROPRIATE TO THEIR NEEDS. ANY SUCH STRATEGIES AT A MINIMUM SHALL ADDRESS:

(I) FACILITATING OPPORTUNITIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, INCLUDING STUDENTS TRANSITIONING FROM EDUCATIONAL PROGRAMS TO LIVE INDEPENDENTLY IN THEIR OWN HOME OR APARTMENT AND AWAY FROM THEIR PARENTAL HOME;

(II) INCREASING AFFORDABLE AND ACCESSIBLE RENTAL UNITS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES;

(III) INCREASING AND EXPANDING ACCESS TO RENTAL SUBSIDIES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES;

(IV) DEVELOPING AN EDUCATIONAL PROGRAM ABOUT INDIVIDUAL LIVING OPTIONS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, FAMILIES, PUBLIC AND PRIVATE ORGANIZATIONS, DEVELOPERS AND MEDICAID SERVICE COORDINATORS;

(V) ANALYZING POTENTIAL FEDERAL AND STATE POLICY CHANGES THAT WILL FACILITATE INCREASED ACCESS AND AVAILABILITY OF SERVICES AND SUPPORTS THAT PERMIT INDIVIDUALS TO CHOOSE MORE INDEPENDENT LIVING OPTIONS; AND

(VI) ASSESSING AND ADVANCING COORDINATED PLAN IMPLEMENTATION.

(B) THE COMMISSIONER, IN CONSULTATION WITH THE DEVELOPMENTAL DISABILITIES ADVISORY COUNCIL, THE DEPARTMENT OF HEALTH, THE DIVISION OF HOUSING AND COMMUNITY RENEWAL, THE MOST INTEGRATED SETTINGS COORDINATING COUNCIL AND OTHER AGENCIES AS DETERMINED APPROPRIATE BY THE COMMISSIONER, SHALL DEVELOP THE PLAN WITH INPUT FROM STAKEHOLDERS, INCLUDING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, PARENTS AND GUARDIANS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, ADVOCATES AND PROVIDERS OF SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

(C) THE PLAN REQUIRED PURSUANT TO THIS SECTION SHALL BE DEVELOPED AND SUBMITTED TO THE TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY AND POSTED ON THE WEBSITE OF THE OFFICE ON OR BEFORE APRIL FIRST, TWO THOUSAND SIXTEEN. SUCH PLAN SHALL BE REASSESSED AND UPDATED AT LEAST ANNUALLY THEREAFTER, ON OR BEFORE THE THIRTY-FIRST DAY OF JANUARY, TO ENSURE RESPONSIVENESS TO CHANGING NEEDS AND GOALS, TO REFLECT THE DEVELOPMENT OF NEW INFORMATION, AND TO REFLECT ACHIEVEMENT OF HOUSING TRANSFORMATION GOALS, EVALUATION OF SUCCESSFUL INTEGRATED HOUSING STRATEGIES AND MILESTONES TO MEET INTEGRATED HOUSING GOALS. SUCH UPDATED PLAN SHALL BE POSTED ON THE WEBSITE OF THE OFFICE, AND SUBMITTED TO THE TEMPORARY PRESIDENT OF THE SENATE AND SPEAKER OF THE ASSEMBLY.

S 2. This act shall take effect immediately.

PART EE

Section 1. The mental hygiene law is amended by adding a new section 31.38 to read as follows:

S 31.38 TEMPORARY ADJUSTMENT TO REIMBURSEMENT RATES FOR BEHAVIORAL HEALTH.

(A) NOTWITHSTANDING ANY PROVISION OF LAW TO THE CONTRARY, WITHIN FUNDS APPROPRIATED AND SUBJECT TO THE AVAILABILITY OF FEDERAL FINANCIAL PARTICIPATION, THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, MAY GRANT APPROVAL OF A TEMPORARY ADJUSTMENT TO THE

NON-CAPITAL COMPONENTS OF RATES, OR MAKE TEMPORARY LUMP-SUM MEDICAID PAYMENTS, TO ELIGIBLE PROVIDERS LICENSED UNDER THIS ARTICLE OR ARTICLE THIRTY-TWO OF THIS CHAPTER, PROVIDED HOWEVER, THAT SHOULD FEDERAL FINANCIAL PARTICIPATION NOT BE AVAILABLE FOR ANY ELIGIBLE PROVIDER, THEN PAYMENTS PURSUANT TO THIS SUBDIVISION MAY BE MADE AS GRANTS AND SHALL NOT BE DEEMED TO BE MEDICAL ASSISTANCE PAYMENTS.

(B) ELIGIBLE PROVIDERS SHALL INCLUDE:

(I) PROVIDERS UNDERGOING CLOSURE;

(II) PROVIDERS IMPACTED BY THE CLOSURE OF OTHER HEALTH CARE PROVIDERS;

(III) PROVIDERS SUBJECT TO MERGERS, ACQUISITIONS, CONSOLIDATIONS OR RESTRUCTURING; OR

(IV) PROVIDERS IMPACTED BY THE MERGER, ACQUISITION, CONSOLIDATION OR RESTRUCTURING OF OTHER HEALTH CARE PROVIDERS.

(C) PROVIDERS SEEKING TEMPORARY RATE ADJUSTMENTS UNDER THIS SECTION SHALL DEMONSTRATE THROUGH SUBMISSION OF A WRITTEN PROPOSAL TO THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, THAT THE ADDITIONAL RESOURCES PROVIDED BY A TEMPORARY RATE ADJUSTMENT WILL ACHIEVE ONE OR MORE OF THE FOLLOWING:

(I) PROTECT OR ENHANCE ACCESS TO CARE;

(II) PROTECT OR ENHANCE QUALITY OF CARE;

(III) IMPROVE THE COST EFFECTIVENESS OF THE DELIVERY OF HEALTH CARE SERVICES; OR

(IV) OTHERWISE PROTECT OR ENHANCE THE HEALTH CARE DELIVERY SYSTEM, AS DETERMINED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

(D) (I) SUCH WRITTEN PROPOSAL SHALL BE SUBMITTED TO THE COMMISSIONER, THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AT LEAST SIXTY DAYS PRIOR TO THE REQUESTED EFFECTIVE DATE OF THE TEMPORARY RATE ADJUSTMENT, AND SHALL INCLUDE A PROPOSED BUDGET TO ACHIEVE THE GOALS OF THE PROPOSAL. ANY MEDICAID PAYMENT ISSUED PURSUANT TO THIS SECTION SHALL BE IN EFFECT FOR A SPECIFIED PERIOD OF TIME AS DETERMINED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, OF UP TO THREE YEARS. AT THE END OF THE SPECIFIED TIMEFRAME SUCH PAYMENTS OR ADJUSTMENTS TO THE NON-CAPITAL COMPONENT OF RATES SHALL CEASE, AND THE PROVIDER SHALL BE REIMBURSED IN ACCORDANCE WITH THE OTHERWISE APPLICABLE RATE-SETTING METHODOLOGY AS SET FORTH IN APPLICABLE STATUTES AND REGULATIONS. THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, MAY ESTABLISH, AS A CONDITION OF RECEIVING SUCH TEMPORARY RATE ADJUSTMENTS OR GRANTS, BENCHMARKS AND GOALS TO BE ACHIEVED IN CONFORMITY WITH THE PROVIDER'S WRITTEN PROPOSAL AS APPROVED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, AND MAY ALSO REQUIRE THAT THE FACILITY SUBMIT SUCH PERIODIC REPORTS CONCERNING THE ACHIEVEMENT OF SUCH BENCHMARKS AND GOALS AS THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, DEEMS NECESSARY. FAILURE TO ACHIEVE SATISFACTORY PROGRESS, AS DETERMINED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, IN ACCOMPLISHING SUCH BENCHMARKS AND GOALS SHALL BE A BASIS FOR ENDING THE FACILITY'S TEMPORARY RATE ADJUSTMENT OR GRANT PRIOR TO THE END OF THE SPECIFIED TIME-

FRAME. (II) THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, MAY REQUIRE THAT APPLICATIONS SUBMITTED PURSUANT TO THIS SECTION BE SUBMITTED IN RESPONSE TO AND IN ACCORDANCE WITH A REQUEST FOR APPLICATIONS OR A REQUEST FOR PROPOSALS ISSUED BY THE COMMISSIONER, IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES.

(E) NOTWITHSTANDING ANY LAW TO THE CONTRARY, ANY PROGRAMS AND FACILITIES ISSUED OPERATING CERTIFICATES UNDER THIS ARTICLE OR ARTICLE THIRTY-TWO OF THIS CHAPTER SHALL BE ALLOCATED NO LESS THAN THIRTY MILLION DOLLARS ANNUALLY PURSUANT TO THIS SECTION.

S 2. This act shall take effect immediately.

PART FF

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

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

S 2. HCRA modernization task force: The commissioner of health shall convene a task force to evaluate and make recommendations related to increasing the transparency and accountability of the health care reform act resources fund (HCRA fund), to evaluate and modernize the provisions of law related to the health care reform act (HCRA), and to restore integrity and purpose to the HCRA program. The task force shall: be provided a detailed accounting of revenues and disbursements made through HCRA and the HCRA fund; assess the extent to which HCRA revenues are expended toward their originally intended purpose; evaluate and recommend a timeframe by which any state costs associated with Medicaid shall be wholly funded by the general fund; assess the impact any federal law enacted since 2009 has had on indigent care costs in the state, and make recommendations for updating and modernizing the HCRA statute. The task force shall be composed of the commissioner of health, and stakeholders with institutional knowledge regarding the provisions of HCRA and the disbursements from the HCRA fund, including but not limited to representatives of health plans, managed care plans, hospitals, physicians, other health care providers, the HCRA pool administrator, and the office of the state comptroller. At least one such stakeholder shall be appointed to the task force by the temporary president of the senate and one by the speaker of the assembly. The task force shall be convened not later than June 30, 2015 and shall submit its report to the governor, the temporary president of the senate and the speaker of the assembly no later than December 31, 2015.

S 3. Subdivision 10 of section 2807-m of the public health law is amended by adding two new paragraphs (g) and (h) to read as follows:

(G) NO LATER THAN JULY FIRST, TWO THOUSAND FIFTEEN, THE COMMISSIONER SHALL ISSUE A NEW REQUEST FOR APPLICATIONS FOR PHYSICIAN LOAN REPAYMENT AWARDS, AND NO LATER THAN JULY FIRST, TWO THOUSAND SIXTEEN, THE COMMISSIONER SHALL ISSUE ANOTHER REQUEST FOR SUCH APPLICATIONS.

(H) THE COMMISSIONER SHALL APPOINT A WORK GROUP OF INTERESTED PARTIES BY SEPTEMBER FIRST, TWO THOUSAND FIFTEEN, TO EVALUATE WHETHER CHANGES ARE NECESSARY IN ORDER TO ENHANCE THE PROGRAM, AND TO MAKE RECOMMENDATIONS FOR ANY CHANGES. A REPORT, CONTAINING THE RECOMMENDATIONS OF THE WORK GROUP, SHALL BE SUBMITTED TO THE GOVERNOR, THE CHAIRS OF THE SENATE HEALTH AND FINANCE COMMITTEES, AND THE CHAIRS OF THE ASSEMBLY HEALTH AND WAYS AND MEANS COMMITTEES BY OCTOBER FIRST, TWO THOUSAND SIXTEEN.

S 4. Subdivision 1 of section 2807-v of the public health law is amended by adding a new paragraph (iii) to read as follows:

(III) NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW, AND IN ADDITION TO FUNDS PROVIDED PURSUANT TO PARAGRAPH (D) OF SUBDIVISION FIVE-A OF SECTION TWENTY-EIGHT HUNDRED SEVEN-M OF THIS ARTICLE, FUNDS SHALL BE RESERVED AND ACCUMULATED FROM YEAR TO YEAR AND SHALL BE AVAILABLE FOR THE PURPOSE OF FUNDING THE PHYSICIAN LOAN REPAYMENT PROGRAM PURSUANT TO SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-M OF THIS ARTICLE IN THE FOLLOWING AMOUNTS:

(I) TWO MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN; AND

(II) FOUR MILLION FIVE HUNDRED THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND SIXTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN.

THE ADDITIONAL FUNDS OF TWO MILLION DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND FIFTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SIXTEEN SHALL FUND THE FIRST YEAR LOAN REPAYMENT FOR ONE HUNDRED NEW AWARDS, AND THE ADDITIONAL FUNDS OF FOUR MILLION FIVE HUNDRED THOUSAND DOLLARS FOR THE PERIOD APRIL FIRST, TWO THOUSAND SIXTEEN THROUGH MARCH THIRTY-FIRST, TWO THOUSAND SEVENTEEN SHALL FUND THE FIRST YEAR LOAN REPAYMENT FOR ANOTHER ONE HUNDRED NEW AWARDS AND THE SECOND YEAR LOAN REPAYMENT FOR THE PRIOR YEAR AWARDS. NOTWITHSTANDING ANY CONTRARY PROVISION OF LAW AND SUBJECT TO THE EXTENSION OF THE HEALTH CARE REFORM ACT OF 1996, SUFFICIENT FUNDS SHALL BE SET ASIDE AND RESERVED BY THE COMMISSIONER FOR STATE FISCAL YEARS ON AND AFTER APRIL FIRST, TWO THOUSAND SEVENTEEN, AND SHALL BE AVAILABLE FOR PURPOSES OF PHYSICIAN LOAN REPAYMENT IN ACCORDANCE WITH SUBDIVISION TEN OF SECTION TWENTY-EIGHT HUNDRED SEVEN-M OF THIS ARTICLE IN AMOUNTS SUFFICIENT TO AT LEAST FUND THE REMAINING YEAR COMMITMENTS FOR AWARDS MADE PRIOR TO APRIL FIRST, TWO THOUSAND SEVENTEEN.

S 5. Subdivision 2 of section 2807-g of the public health law, as added by chapter 1 of the laws of 1999, is amended to read as follows:

2. Grants shall be made on a competitive basis by region, in accordance with the amount raised in the region, PROVIDED THAT NO LESS THAN TWO AND ONE-HALF PERCENT OF THE TOTAL FUNDS MADE AVAILABLE IN ANY REQUEST FOR PROPOSALS SHALL BE MADE AVAILABLE IN ANY REGION, with preference within regions given to areas and eligible organizations that have experienced or are likely to experience job loss because of changes in the health care system. If, at the conclusion of the regional competitive contract award process, there are excess funds available within any regional allocation, such funds shall be redistributed to regions where there is a shortage of funds available for programs which otherwise qualify for funding pursuant to this section. IF A GRANT RECIPIENT HAS RECEIVED GRANT AWARDS FOR THE SAME WORKFORCE RETRAINING PROJECT IN MULTIPLE REGIONS, SUCH GRANT RECIPIENT, WITH THE APPROVAL OF THE COMMISSIONER, MAY REDISTRIBUTE FUNDS AMONG SAID REGIONS.

S 6. 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 7. 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 8. This act shall take effect immediately; provided, however, that the amendments made to section 2807-s of the public health law made by sections six and seven of this act shall not affect the expiration of such section and shall be deemed to expire therewith.

PART GG

Section 1. Section 2825 of the public health law, as added by section 8 of part A of chapter 60 of the laws of 2014, is amended to read as follows:

S 2825. Capital restructuring financing program. 1. A capital restructuring financing program is hereby established under the joint administration of the commissioner and the president of the dormitory authority of the state of New York, SUBJECT TO AN APPROPRIATION, for the purpose of enhancing the quality, financial viability and efficiency of New York's health care delivery system by transforming the system into a more rational patient-centered care system that promotes population health and improved well-being for all New Yorkers. The issuance of any bonds or notes hereunder shall further be subject to the approval of the director of the division of the budget, and any projects funded through the issuance of bonds or notes hereunder shall be approved by the New York state public authorities control board, as required under section fifty-one of the public authorities law.

2. For the period April first, two thousand [fourteen] FIFTEEN through March thirty-first, two thousand twenty-one, funds made available [for expenditure] pursuant to this section [may] SHALL be distributed by the commissioner and the president of the authority, in consultation with the commissioners of the office of mental health, office for people with developmental disabilities and office for alcoholism and substance abuse services, as applicable, [for:

(a) capital grants to general hospitals, residential health care facilities, diagnostics and treatment centers, and clinics licensed pursuant to this chapter or the mental hygiene law, assisted living programs, primary care providers, and home care providers certified or licensed pursuant to article thirty-six of this chapter (collectively "applicants") that qualify for payments under the delivery system reform incentive payment program (DSRIP), in which case funding under this paragraph shall be requested in such applicant's DSRIP application. Such capital grant projects include, but are not limited to; closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects as determined by the commissioner and the president of the authority.

(b) capital grants to general hospitals, residential health care facilities, diagnostic and treatment centers, and clinics licensed pursuant to this chapter or the mental hygiene law, assisted living programs, primary care providers, home care providers, certified or licensed pursuant to article thirty-six of this chapter (collectively

"applicants") that are non-qualifying and non-participating applicants under paragraph (a) of this subdivision, for capital non-operational works or purposes that support the purposes set forth in this section. Such capital grant projects include, but are not limited to;] PURSUANT TO A PROCESS AND PLAN APPROVED BY THE GOVERNOR, TEMPORARY PRESIDENT OF THE SENATE AND THE SPEAKER OF THE ASSEMBLY.

(A) I. UPON APPROVAL OF A PROCESS AND PLAN, FUNDS SHALL BE DISTRIBUTED TO SUPPORT DEBT RETIREMENT, NON-OPERATIONAL CAPITAL PROJECTS AND NON-CAPITAL PROJECTS, INCLUDING BUT NOT LIMITED TO PROJECTS RELATED TO closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, [the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services] ESTABLISHMENT OR EXPANSION OF HEALTH INFORMATION TECHNOLOGY, ESTABLISHMENT OF THE STATEWIDE HEALTH INFORMATION NETWORK OF NEW YORK, AND THE ESTABLISHMENT OF AN ALL PAYER DATABASE WITH THE DEPARTMENT.

II. CRITERIA ESTABLISHED FOR APPLICANTS INTENDING TO RETIRE DEBT MUST INCLUDE REQUIREMENTS TO DEMONSTRATE A REASONABLE RESTRUCTURING PLAN, WHICH DEMONSTRATES LONG TERM SUSTAINABILITY OF THE APPLICANT.

(B) ELIGIBLE FUNDING RECIPIENTS SHALL INCLUDE GENERAL HOSPITALS, RESIDENTIAL HEALTH CARE FACILITIES, DIAGNOSTIC AND TREATMENT CENTERS, CLINICS LICENSED PURSUANT TO THIS CHAPTER OR THE MENTAL HYGIENE LAW, ASSISTED LIVING PROGRAMS, PRIMARY CARE PROVIDERS, HOME CARE PROVIDERS CERTIFIED OR LICENSED PURSUANT TO ARTICLE THIRTY-SIX OF THIS CHAPTER, COMMUNITY HEALTH CARE PROVIDERS, AND FACILITIES AND PROVIDERS THAT ARE AFFILIATED WITH OR LEADS OF A PERFORMING PROVIDER SYSTEM (PPS) IN THE DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP), AND REGIONAL HEALTH INFORMATION ORGANIZATIONS.

3. The commissioner and the president of the authority shall enter into an agreement, subject to approval by the director of the budget and subject to section sixteen hundred eighty-r of the public authorities law, as added by [a] chapter FIFTY-FIVE of the laws of two thousand fourteen, for the purposes of awarding, distributing, and administering the funds made available pursuant to this section.

[(a) For capital grant projects under paragraph (a) of subdivision two of this section, the evaluation of applications shall be submitted pursuant to the process described in paragraph (b) of subdivision twenty of section twenty-eight hundred seven of this article; provided, however, that such capital grant projects shall not be subject to review by the federal Centers for Medicare and Medicaid services.

(b)] For monies allocated under [paragraph (b) of] subdivision two of this section:

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

[(A)] (I) the process by which such applications shall be reviewed;

[(B)] (II) the criteria by which such applications shall be judged; and

[(C)] (III) a list of approved and denied applications subsequent to such determination.

[(ii)] (B) the evaluation of applications shall be reviewed by the department, pursuant to a process to be determined by the department[. Applications shall then be subject to review by the panel established pursuant to paragraph (b) of subdivision twenty of section twenty-eight hundred seven of this article, which shall submit its recommendations to the commissioner for final determination. Determination of awards for funds allocated under paragraph (b) of subdivision two of this section,

shall include] INCLUDING, but not [be] limited to the following criteria:

[(A)] (I) eligibility requirements for applicants;

[(B)] (II) statewide geographic distribution of funds;

[(C)] (III) minimum and maximum amounts of funding to be awarded under the program;

[(D)] (IV) the relationship between the project proposed by an applicant and identified community need;

[(E)] (V) the extent to which the applicant has access to alternative financing;

[(F)] (VI) the extent to which the proposed project furthers the purposes set forth [in this section;

(G) the extent that the proposed project furthers the development of primary care;

(H) the extent to which the proposed project benefits Medicaid enrollees and uninsured individuals;

(I) the extent to which the proposed project addresses potential risk to patient safety and welfare;

(J) the extent that the proposed project involves an applicant that receives or has applied for a temporary rate adjustment pursuant to applicable regulations; and

(K) the extent to which the proposed project will contribute to the long term sustainability of the applicant] BY THE PLAN APPROVED TO ALLOCATE FUNDS.

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. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall conform to the reporting requirements of subdivision twenty of section twenty-eight hundred seven of this article, as applicable.

S 2. Paragraphs (b) 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 amended to read as follows:

(b) The commissioner shall establish an advisory panel to provide assistance with regard to the DSRIP program. The panel shall be charged with reviewing recommendations for DSRIP funding made by the state's contracted DSRIP assessor and advising the commissioner regarding the results of such review. [Such panel shall also review applications under paragraph (b) of subdivision two of section twenty-eight hundred twenty-five of this article.] Panel membership shall be comprised of individuals with significant health care system experience. Members may not be elected officials or employed by providers that would benefit from DSRIP funding, and must not have any conflict of interest that would prevent them from providing an impartial review of DSRIP assessor recommendations. The panel shall consist of members appointed by the commissioner and shall in addition consist of one member appointed by the [majority leader] TEMPORARY PRESIDENT of the New York state senate, and one member appointed by the speaker of the New York state assembly. The panel shall carry out the review of DSRIP recommendations in strict accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions. The panel shall submit its recommendations to the commissioner for final determination, in accordance with all requirements set forth in the state's federal 1115 Medicaid waiver standard terms and conditions. The commissioner may modify the requirements of this paragraph and paragraph (c) of this subdivision if such modifications are required by the federal CMS.

(e) 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) of this subdivision.

S 3. 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.