§ 2807. Hospital reimbursement provisions; generally. 1. Valid operating certificate requirement. No government agency and no corporation organized and operating in accordance with article forty-three of the insurance law and no health maintenance organization organized and operating in accordance with article forty-four of this chapter, shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service, unless, at the time the service was provided, the hospital possessed a valid operating certificate authorizing such service. No government agency shall purchase, pay for or make reimbursement or grants-in-aid for any hospital or health-related service that has been determined by the commissioner of health to be unauthorized for payment under the medical assistance program pursuant to section twenty-eight hundred three of this article.

2. (a) Rate approvals. Payments for hospital service and health-related service made by government agencies or for services provided prior to January first, nineteen hundred ninety-seven by organizations operating in accordance with the provisions of article forty-four of this chapter shall be at rates approved by the state director of the budget in the case of government agencies and approved by the commissioner in the case of plans, organized and operating under the provisions of article forty-four of this chapter, under which such payments are made by agencies other than government agencies or corporations organized and operating in accordance with article forty-three of the insurance law. Payments for hospital service and health-related service by corporations organized and operating in accordance with article forty-three of the insurance law for services provided prior to January first, nineteen hundred ninety-seven shall be at rates approved by the commissioner of health.

(a-1) Notwithstanding any inconsistent provision of law, rates of payment by governmental agencies for the operating cost component of general hospital out-patient and emergency services, and for the operating cost component of treatment or diagnostic center services shall not require a certification by the commissioner that they are reasonably related to the costs of efficient production of such services nor that they are reasonable and adequate to meet the costs which must

be incurred by efficiently and economically operated facilities.

(b) During the period October first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-five and for each twelve month rate period commencing on October first thereafter, rates of payment by governmental agencies for the operating cost component of treatment or diagnostic center services shall be based on operating costs in the base year cost report adjusted by a trend factor determined in accordance with rules and regulations promulgated pursuant to paragraph (b) of subdivision two of section twenty-eight hundred three of this article; provided, however, that prior to such adjustment, allowable operating costs shall be established by the commissioner after taking into account the cost of services provided in facilities offering similar services and regional economic factors, plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures, incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the rate period commencing on October first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent rate period.

(c) Notwithstanding any other provision of law to the contrary, for a diagnostic and treatment center licensed pursuant to this article that provides, as its principal mission, services to individuals with developmental disabilities, the commissioner may fully or partially waive or modify recoupment of medical assistance payments based on retroactive changes to the applicable formula for capital costs for the period of September first, two thousand nine to December thirty-first, two thousand twelve.

* (e) Notwithstanding any inconsistent provisions of this subdivision or any other law, payments made by governmental agencies for ambulatory surgical services provided by a hospital, including general hospitals and diagnostic and treatment centers, during the period June first, nineteen hundred eighty-nine through December thirty-first, nineteen hundred eighty-nine and the period January first, nineteen hundred ninety through December thirty-first, nineteen hundred ninety and every

twelve month rate period thereafter shall be at case based rates of reimbursement established by the commissioner and approved by the state director of the budget. Ambulatory surgical services case based rates of payment shall be established prospectively and shall include operating costs and capital costs. Factors considered in establishing such case based rates shall include, but not be limited to: a classification of procedures with individual or combined rates established for each services classification; operating and capital costs of ambulatory surgical services efficiently and economically provided, considering regional economic factors, trended to the rate period; and the need for incentives to improve services and institute economies.

* NB Expired April 1, 2011

* (f) (i) During the period July first, nineteen hundred ninety through March thirty-first, nineteen hundred ninety-one, the rate periods during the period April first, nineteen hundred ninety-one through September thirtieth, nineteen hundred ninety-four and for each fiscal year period commencing on October first thereafter, comprehensive clinic rates of payment by governmental agencies established in accordance with paragraph (b) of this subdivision, applicable for services provided to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law for voluntary non-profit or publicly sponsored diagnostic and treatment centers providing a comprehensive range of primary health care services which can demonstrate, on forms provided by the commissioner, losses from a disproportionate share of bad debt and charity care during a base year period established by regulation may include an allowance determined in accordance with this paragraph to reflect the needs of the diagnostic and treatment center for the financing of losses resulting from bad debt and the costs of charity care. Losses resulting from bad debt and the costs of charity care shall be determined by the commissioner considering, but not limited to, such factors as the losses resulting from bad debt and the costs of charity care provided by the diagnostic and treatment center and the availability of other financial support, including state and local assistance public health aid, to meet the losses resulting from bad debt and the costs of charity care of the diagnostic and treatment center. The bad debt and charity care allowance for a diagnostic and treatment center for a rate period shall be

determined by the commissioner in accordance with rules and regulations adopted by the council and approved by the commissioner, and shall be consistent with the purposes for which such allowances are authorized for general hospitals pursuant to the provisions of article twenty-eight of this chapter and rules and regulations promulgated by the commissioner. A diagnostic and treatment center applying for a bad debt and charity care allowance pursuant to this paragraph shall provide assurances satisfactory to the commissioner that it shall undertake reasonable efforts to maintain financial support from community and public funding sources and reasonable efforts to collect payments for services from third party insurance payors, governmental payors and self-paying patients. To be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must provide a comprehensive range of primary health care services and must demonstrate that a minimum of fifteen percent of total clinic visits reported during the applicable base year period were to uninsured individuals. The commissioner may retrospectively reduce the bad debt and charity care allowance of a diagnostic and treatment center if it is determined that provider management actions or decisions have caused a significant reduction for the rate period in the delivery of comprehensive primary health care services to bad debt and charity care residents of the community.

(ii) The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible voluntary and nonprofit diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual aggregate amount of seven million three hundred thousand dollars. The total amount of funds to be allocated and distributed for bad debt and charity care allowances to eligible publicly sponsored diagnostic and treatment centers for a rate period in accordance with this paragraph shall be limited to an annual aggregate amount of seven million seven hundred thousand dollars; provided, however, that twenty percent of the amount of funds allocated for distribution to eligible publicly sponsored diagnostic and treatment centers shall be available for clinics operating under the auspices of the Health and Hospitals Corporation. Notwithstanding the foregoing and any other provision of this chapter municipalities which received state aid, pursuant to article two of the public health law and prior to the

effective date of this chapter, in support of non-hospital based free-standing or local health department operated general medical clinics, shall receive a bad debt and charity care allowance of not less than the amount received in the nineteen hundred eighty-nine--nineteen hundred ninety state fiscal year for general medical clinics, plus the applicable local share for medical assistance expenditures under title XIX of the federal social security act. Funds to be distributed pursuant to this subparagraph shall be based on losses associated with the delivery of bad debt and charity care excluding the amount of such losses determined in accordance with subparagraph (ix) of this paragraph as the incremental loss basis for a supplemental allowance for a diagnostic and treatment center designated as a preferred primary care provider.

(iii) No diagnostic and treatment center may receive a bad debt and charity care allowance in accordance with this paragraph in an amount which exceeds its need for the financing of losses associated with the delivery of bad debt and charity care.

(iv) A nominal payment amount for the financing of losses associated with the delivery of bad debt and charity care will be established for each eligible diagnostic and treatment center. The nominal payment amount shall be calculated as the sum of the dollars attributable to the application of an incrementally increasing nominal coverage percentage of base year period losses associated with the delivery of bad debt and charity care for percentage increases in the relationship between base year period eligible bad debt and charity care clinic visits and base year period total clinic visits according to the following scale:

% of eligible bad debt and charity care clinic visits to total visits	% of nominal financial loss coverage
up to 15%	50%
15 - 30%	75%
30%+	100%

If the sum of the nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers or for all eligible public diagnostic and treatment centers is less than the amount allocated for bad debt and charity care allowances pursuant to subparagraph (ii) or (ix) respectively of this paragraph for such diagnostic and treatment

centers respectively, the nominal coverage percentages of base year period losses associated with the delivery of bad debt and charity care pursuant to this scale may be increased to not more than one hundred percent for voluntary non-profit diagnostic and treatment centers or for public diagnostic and treatment centers in accordance with rules and regulations adopted by the council and approved by the commissioner.

(v) The bad debt and charity care allowance for each eligible voluntary non-profit diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for voluntary non-profit diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible voluntary non-profit diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vi) The bad debt and charity care allowance for each eligible public diagnostic and treatment center shall be based on the dollar value of the result of the ratio of total funds allocated for bad debt and charity care allowances for public diagnostic and treatment centers pursuant to subparagraph (ii) of this paragraph to the total statewide nominal payment amounts for all eligible public diagnostic and treatment centers determined in accordance with subparagraph (iv) of this paragraph applied to the nominal payment amount for each such diagnostic and treatment center.

(vii) Diagnostic and treatment centers shall furnish to the department such reports and information as may be required by the commissioner to assess the cost, quality, access to, effectiveness and efficiency of bad debt and charity care provided. The council shall adopt rules and regulations, subject to the approval of the commissioner, to establish uniform reporting and accounting principles designed to enable diagnostic and treatment centers to fairly and accurately determine and report bad debt and charity care visits and the costs of bad debt and charity care. In order to be eligible for an allowance pursuant to this paragraph, a diagnostic and treatment center must be in compliance with bad debt and charity care reporting requirements.

(viii) Of the funds allocated and distributed for bad debt and charity care allowances to eligible voluntary and non-profit diagnostic and

treatment centers for a rate period in accordance with subparagraph (ii) of this paragraph, an annual aggregate amount not to exceed three million eight hundred thousand dollars within a rate period shall be paid by or on behalf of diagnostic and treatment centers into a primary care initiative pool established by the commissioner. Such funds shall be distributed to diagnostic and treatment centers in accordance with the provisions of subdivisions one through six of section twenty-eight hundred seven-b of this article.

(ix) During the period January first, nineteen hundred ninety-four through September thirtieth, nineteen hundred ninety-four and for each twelve month rate period commencing on October first thereafter, to the extent of funds available therefor, a diagnostic and treatment center which is approved as a preferred primary care provider pursuant to subdivision twelve of section twenty-eight hundred seven of this article and meets the requirements of this paragraph may be eligible for a supplemental allowance determined in accordance with this paragraph. The supplemental allowance shall be based on losses associated with the delivery of bad debt and charity care incurred by a preferred primary care provider to the extent such losses exceed any losses associated with the delivery of bad debt and charity care incurred for nineteen hundred ninety-three or, if later, the year immediately preceding the year in which the diagnostic and treatment center is first designated a preferred primary care provider.

(x) This paragraph shall be effective if, and as long as, federal financial participation is available for expenditures made for beneficiaries eligible for medical assistance under title XIX of the federal social security act based upon the allowances determined in accordance with this paragraph.

(xi) Notwithstanding any inconsistent provision of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with subparagraphs (i) through (x) of this paragraph shall apply only for services provided on or before December thirty-first, nineteen hundred ninety-six.

* NB Expired December 31, 1996

(g)(i) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates

of payment by governmental agencies for the operating cost component of general hospital outpatient services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided; provided, however, that the maximum payment for the operating cost component of outpatient services shall be sixty-seven dollars and fifty cents plus the addition of the capital cost per visit. The capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for major outpatient capital expenditures incurred subsequent to the reporting year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of the expenditures. The base year for the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply. The commissioner may waive the maximum allowable payment and limitations on the rate of payment as prescribed herein to provide for the reimbursement of offering and arranging services eligible for ninety percent federal funds as set forth in section nineteen hundred three of the federal social security act, and to provide for the reimbursement of specialized services having separately identifiable costs and statistics, including but not limited to hemodialysis services and surgical services provided on an outpatient basis. Such waiver shall be granted only when the commissioner finds that the services are being provided efficiently and at minimum cost. The commissioner shall promptly promulgate rules and regulations necessary to identify such services. Among the criteria which the commissioner shall consider in the case of specialized services are whether the services require highly specialized staff, equipment or facilities, thereby generating a cost that substantially exceeds that of more routine diagnostic or treatment services; whether the facility in which the services are provided is presently providing the services to the population in need; and, whether the services may be provided safely and effectively on an outpatient basis at a lower cost than through inpatient admission. In addition the commissioner shall provide for a waiver of the maximum allowable payment

for those outpatient services medically necessary which include surgical procedures where delay in surgical intervention would substantially increase the medical risk associated with such surgical intervention. Where the commissioner waives the maximum allowable payment for any specified service he may, in accordance with the foregoing criteria and such other criteria as he deems appropriate, establish a maximum allowable payment for such specified service.

(ii) During the period April first, nineteen hundred ninety-four through December thirty-first, nineteen hundred ninety-four and for each calendar year rate period commencing on January first thereafter, rates of payment by governmental agencies for the operating cost component of general hospital emergency services shall be based on the operating costs reported in the base year cost report adjusted by the trend factor applicable to the general hospital in which the services were provided, and in addition shall include that portion of the reasonable incremental emergency service operating costs incurred by such hospital in excess of emergency service costs reported in the nineteen hundred eighty-eight cost report, after application of the trend factor, attributable to meeting additional quality of care standards for emergency services that became effective on or after January first, nineteen hundred eighty-nine; provided, however, that the maximum payment for the operating component shall be ninety-five dollars, provided further, however, that for the period January first, two thousand seven through December thirty-first, two thousand seven the maximum payment for the operating component shall be one hundred twenty-five dollars, and during the period January first, two thousand eight through December thirty-first, two thousand eight, the maximum payment for the operating component shall be one hundred forty dollars; and during the period January first, two thousand nine through December thirty-first, two thousand nine and for each calendar year thereafter, the maximum payment for the operating component shall be one hundred fifty dollars. A capital cost per visit shall be based on the base year cost report except that the capital cost per visit may be adjusted for the major outpatient capital expenditures incurred subsequent to the report year, when such expenditures have received the requisite approvals and the facility has provided the commissioner with a certified statement of expenditures. The base year for the period April first, nineteen hundred

ninety-four through December thirty-first, nineteen hundred ninety-four shall be nineteen hundred ninety-two and shall be advanced one year thereafter for each subsequent calendar year rate period. Further, the provisions of subdivision seven of this section shall not apply prior to January first, two thousand seven.

* (iii) (A) For purposes of this subparagraph:

(1) "Children with medical fragility" shall mean an individual who is under twenty-one years of age and has a chronic debilitating condition or conditions, who may or may not be hospitalized or institutionalized, and who meets one or more of the following criteria: (I) is technology-dependent for life or health sustaining functions; (II) requires complex medication regimens or medical interventions to maintain or to improve their health status; or (III) is in need of ongoing assessment or intervention to prevent serious deterioration of their health status or medical complications that place their life, health or development at risk.

(2) "Pediatric residential health care facility" shall mean a free-standing facility or discrete unit within a facility authorized by the commissioner to provide extensive nursing, medical, psychological, and counseling support services solely to children under the age of twenty-one.

(3) "Pediatric diagnostic and treatment center" shall mean a diagnostic and treatment center established pursuant to this article, which as of April first, two thousand twenty-four, has been participating in the demonstration program authorized under subdivision one of section twenty-eight hundred eight-e of this article, for which at least eighty percent of its total Medicaid fee-for-service reimbursements derive from the provision of services to children under the age of twenty-one with medical fragility and is affiliated with a pediatric residential health care facility.

(B) (1) Notwithstanding any law, rule, or regulation to the contrary, the commissioner shall establish rates of reimbursement for pediatric diagnostic and treatment centers for all services provided on or after April first, two thousand twenty-four, to children eligible for medical assistance that reflect the costs necessary to provide care and services to children with medical fragility being treated at such pediatric diagnostic and treatment center.

(2) For the period April first, two thousand twenty-four, to December thirty-first, two thousand twenty-four, and until such time as a certified annual cost report for such period is received and verified by the department, the operating component of such rate shall reflect budgeted costs for the period January first, two thousand twenty-four, through December thirty-first, two thousand twenty-four, as submitted to the department and adjusted as the commissioner deems appropriate. Upon submission and subsequent verification of the cost report, the operating component of the rate shall be reflective of actual costs for the period January first, two thousand twenty-four, through December thirty-first, two thousand twenty-four, subject to further adjustments as the commissioner deems appropriate. Thereafter, the base period reported operating costs used to establish rates pursuant to this subparagraph shall be updated no less frequently than every two years. In addition to required annual cost reports, pediatric diagnostic and treatment centers, as defined by this subparagraph, shall submit additional data as the commissioner requires.

(3) Notwithstanding any law, rule, or regulation to the contrary, pediatric diagnostic and treatment centers shall be reimbursed for services provided to children enrolled in Medicaid managed care plans at the rates of reimbursement promulgated pursuant to this subparagraph.

(4) The capital component of the rate shall reflect actual base year costs.

(5) All rates established under this subparagraph shall be subject to the availability of federal financial participation.

(6) The commissioner may promulgate or amend regulations as the commissioner determines appropriate and necessary to establish the rates provided for in this subparagraph and/or exempt pediatric diagnostic and treatment centers from the ambulatory payment group reimbursement methodology applicable to diagnostic and treatment centers.

* NB Repealed April 1, 2029

(h) Notwithstanding any inconsistent provisions of this subdivision or any other law, except as provided in section 43.02 of the mental hygiene law, the commissioner may, in accordance with rules and regulations adopted by the council and approved by the commissioner, establish rates of reimbursement for payments made by governmental agencies, subject to the approval of the state director of the budget, for services provided

on an outpatient basis by a general hospital or diagnostic and treatment center designated as a preferred primary care provider pursuant to subdivision twelve of this section or providing specialty services including hemo and peritoneal dialysis, outpatient rehabilitative and psychiatric services, methadone maintenance, and other organized outpatient or clinic services which are structured to address extensive and complex medical needs for patients with chronic or infectious medical conditions based on factors other than those prescribed by paragraph (b) or subparagraph (i) of paragraph (g) of this subdivision or subdivision three of this section provided, however, that the use of such an alternative approach will not result in any increase to other rates of reimbursement established pursuant to this article. During the initial rate period such rates of payment for preferred primary care providers shall be at least equal to the average rate of payment per visit which would otherwise be provided pursuant to subparagraph (i) of paragraph (g) or paragraph (b) of this subdivision. Factors used to establish rates shall include a reasonable classification of medical procedures with individual or combined rates established for each service classification group which will be prospectively determined based upon an estimate of the costs of such outpatient services efficiently and economically provided by general hospitals and diagnostic and treatment centers, considering regional economic factors and the need for incentives to improve services and institute economies. Notwithstanding any inconsistent provisions of law, rates of payment by governmental agencies for outpatient services provided by a general hospital or diagnostic and treatment center, shall not require a certification by the commissioner that they are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

2-a. Notwithstanding any provision of which is inconsistent with or contrary to the structure established by this subdivision and subdivision thirty-three of section twenty-eight hundred seven-c of this article, and subject to the availability of federal financial participation, rates of payment by governmental agencies, established pursuant to this article, for general hospital outpatient services, general hospital emergency services, ambulatory surgical services

provided by a hospital as defined by subdivision one of section twenty-eight hundred one of this article, and diagnostic and treatment center services, but excepting any facility whose reimbursement is governed by subdivision eight of this section or any payments made on behalf of persons enrolled in Medicaid managed care or in the family health plus program, shall be in accordance with the following:

(a)(i) for the period December first, two thousand eight through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for each general hospital's outpatient services shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility for the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(v) This paragraph shall be effective the later of: (i) December first, two thousand eight, or (ii) after the commissioner receives final approval of federal financial participation in payments made for beneficiaries eligible for medical assistance under title XIX of the federal social security act for the rate methodology established pursuant to subparagraph (i) of paragraph (a) of subdivision thirty-three of section twenty-eight hundred seven-c of this article.

(b) (i) for the period September first, two thousand nine through November thirtieth, two thousand nine, seventy-five percent of such rates of payment for services provided by each diagnostic and treatment center and each free-standing ambulatory surgery center shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and twenty-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(ii) for the period December first, two thousand nine through December thirty-first, two thousand ten, fifty percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and fifty percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision;

(iii) for the period January first, two thousand eleven through December thirty-first, two thousand eleven, twenty-five percent of such rates for each facility shall reflect the average Medicaid payment per claim, as determined by the commissioner, for services provided by that

facility in the two thousand seven calendar year, but excluding any payments for services covered by the facility's licensure, if any, under the mental hygiene law, and seventy-five percent of such rates of payment shall, for the operating cost component, reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision; and

(iv) for periods on and after January first, two thousand twelve, one hundred percent of such rates of payment shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision.

(c) for periods on and after December first, two thousand eight, such rates of payment for ambulatory surgical services provided by general hospitals shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision, provided however, that the capital cost component for such rates shall be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision.

(d) for periods on and after January first, two thousand nine, the operating cost component of such rates of payment for general hospital emergency services shall reflect the utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision and shall not reflect any maximum payment amount as otherwise provided for in subparagraph (ii) of paragraph (g) of subdivision two of this section.

(e) (i) notwithstanding any inconsistent provisions of this subdivision, the commissioner shall promulgate regulations establishing, subject to the approval of the state director of the budget, methodologies for determining rates of payment for the services described in this subdivision. Such regulations shall reflect utilization of the ambulatory patient group (APG) methodology, in which patients are grouped based on their diagnosis, the intensity of the services provided and the medical procedures performed, and with each APG assigned a weight reflecting the projected utilization of resources. Such regulations shall provide for the development of one or more base rates and the multiplication of such base rates by the assigned weight for each APG to establish the appropriate payment level for each such APG. Such regulations may also utilize bundling, packaging and

discounting mechanisms.

If the commissioner determines that the use of the APG methodology is not, or is not yet, appropriate or practical for specified services, the commissioner may utilize existing payment methodologies for such services or may promulgate regulations, and may promulgate emergency regulations, establishing alternative payment methodologies for such services.

(ii) Notwithstanding this subdivision and any other contrary provision of law, the commissioner may incorporate within the payment methodology described in subparagraph (i) of this paragraph payment for services provided by facilities pursuant to licensure under the mental hygiene law, provided, however, that such APG payment methodology may be phased into effect in accordance with a schedule or schedules as jointly determined by the commissioner, the commissioner of mental health, the commissioner of alcoholism and substance abuse services, and the commissioner of the office for people with developmental disabilities.

(iii) Regulations issued pursuant to this paragraph may incorporate quality related measures limiting or excluding reimbursement related to potentially preventable conditions and complications; provided however, such quality related measures shall not include any preventable conditions and complications not identified for Medicare nonpayment or limited payment.

* (iv) Effective April first, two thousand twenty, regulations issued pursuant to this paragraph for public general hospitals or public health systems, other than those operated by the state of New York or the state university of New York, located in a city having a population of one million or more shall reflect additional reimbursement for costs, to the extent permitted under 42 CFR 447.321(b)(1) and based on actual utilization of services. Such rate add-on shall be contingent upon federal financial participation and approval, and subject to the terms of a binding memorandum of understanding executed between the department of health and the public general hospital or public health system receiving the rate add-on. If payment of such rate add-on is projected to cause Medicaid disbursements for such period to exceed the projected department of health Medicaid state funds in the enacted budget financial plan pursuant to subdivision three of section twenty-three of

the state finance law, as determined by the director of the budget, or the memorandum of understanding is not executed or is breached, the commissioner, in consultation with the director of the budget, may either cancel or reduce payment of such rate add-on to achieve compliance with the enacted budget financial plan.

* NB Repealed March 31, 2029

(f)(i) The commissioner shall periodically measure the utilization and intensity of services provided to medical assistance recipients in ambulatory settings. Such analysis shall include, but not be limited to: measurement of the shift of surgical procedures from the inpatient hospital setting to the ambulatory setting including measurement of the impact of any such shift on quality of care and outcomes; changes in the utilization and intensity of services provided in the outpatient hospital department and in diagnostic and treatment centers; and the change in the utilization and intensity of services provided in the emergency department.

(ii) notwithstanding the provisions of paragraphs (a) and (b) of this subdivision, for periods on and after January first, two thousand nine, the following services provided by general hospital outpatient departments and diagnostic and treatment centers shall be reimbursed with rates of payment based entirely upon the ambulatory patient group methodology as described in paragraph (e) of this subdivision, provided, however, that the commissioner may utilize existing payment methodologies or may promulgate regulations establishing alternative payment methodologies for one or more of the services specified in this subparagraph, effective for periods on and after March first, two thousand nine:

(A) services provided in accordance with the provisions of paragraphs (q), (r), and (ll) of subdivision two of section three hundred sixty-five-a of the social services law; and

(B) all services, but only with regard to additional payment amounts, as determined in accordance with regulations issued in accordance with paragraph (e) of this subdivision, for the provision of such services during times outside the facility's normal hours of operation, as determined in accordance with criteria set forth in such regulations; and

(C) services provided by licensed social workers, licensed mental

health counselors, and licensed marriage and family therapists, in accordance with licensing criteria set forth in applicable regulations; and

(D) individual psychotherapy services provided by licensed social workers, in accordance with licensing criteria set forth in applicable regulations, at diagnostic and treatment centers that provided, billed for, and received payment for these services between January first, two thousand seven and December thirty-first, two thousand seven;

(E) services provided to pregnant women pursuant to paragraph (s) of subdivision two of section three hundred sixty-five-a of the social services law and, for periods on and after January first, two thousand ten, all other services provided pursuant to such paragraph (s) and services provided pursuant to paragraph (t) of subdivision two of section three hundred sixty-five-a of the social services law;

(F) wheelchair evaluation services and eyeglass dispensing services; and

(G) immunization services, effective for services rendered on and after June tenth, two thousand nine.

(f-1) Notwithstanding any inconsistent provision of this section or any other contrary provision of law, the commissioner may with the approval of the director of the budget, for periods prior to two thousand twelve, establish rates of payments for selected patient service categories that are based entirely upon the ambulatory patient groups methodology as authorized pursuant to paragraph (e) of this subdivision.

(g) for the purposes set forth in paragraphs (a) and (b) of this subdivision, rates described as in effect for the two thousand seven calendar year shall mean those rates which are in effect for that year on the date this subdivision becomes effective and such rates shall not thereafter, for the purposes set forth in such paragraphs (a) and (b), be subject to further adjustment.

(h)(i) To the degree that rates of payment computed in accordance with paragraphs (a) and (d) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall remain subject to the provisions of

subparagraphs (i) and (ii) of paragraph (g) of subdivision two of this section, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment computed pursuant to paragraph (a) of this subdivision which are based on average Medicaid payments per claim.

(ii) To the degree that rates of payment computed in accordance with paragraph (b) of this subdivision reflect utilization of the ambulatory patient groups reimbursement methodology described in paragraph (e) of this subdivision for purposes of computing the operating component of such rates, the computation of the capital cost component of such rates shall, for diagnostic and treatment centers, remain subject to the provisions of paragraph (b) of subdivision two of this section and shall, for free-standing ambulatory surgery centers, be separately computed in accordance with regulations promulgated in accordance with paragraph (e) of this subdivision, provided, however, that this subparagraph shall not be understood as applying to those portions of rates of payment which are based on average Medicaid payments per claim.

(i) Notwithstanding any provision of law to the contrary, rates of payment by governmental agencies for general hospital outpatient services, general hospital emergency services and ambulatory surgical services provided by a general hospital established pursuant to paragraphs (a), (c) and (d) of this subdivision shall result in an aggregate increase in such rates of payment of fifty-six million dollars for the period December first, two thousand eight through March thirty-first, two thousand nine and one hundred seventy-eight million dollars for periods after April first, two thousand nine, through March thirty-first, two thousand thirteen, and one hundred fifty-three million dollars for state fiscal year periods on and after April first, two thousand thirteen, provided, however, that for periods on and after April first, two thousand nine, such amounts may be adjusted to reflect projected decreases in fee-for-service Medicaid utilization and changes in case-mix with regard to such services from the two thousand seven calendar year to the applicable rate year, and provided further, however, that funds made available as a result of any such decreases may be utilized by the commissioner to increase capitation rates paid to Medicaid managed care plans and family health plus plans to cover increased payments to health care providers for ambulatory care services

and to increase such other ambulatory care payment rates as the commissioner determines necessary to facilitate access to quality ambulatory care services.

3. Commissioner rate certification, governmental payments. Prior to the approval of such rates, as provided in subdivision two of this section, the commissioner shall determine, and in the case of approvals by the state director of the budget, certify to such official that the proposed rate schedules for payments to hospitals for hospital and health-related services are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. In making such certification, the commissioner shall take into consideration the elements of cost, geographical differentials in the elements of cost considered, economic factors in the area in which the hospital is located, the rate of increase or decrease of the economy in the area in which the hospital is located, costs of hospitals of comparable size, and the need for incentives to improve services and institute economies. The commissioner shall also take into consideration the economies and improvements in service to be anticipated from the operation of joint central service or use of facilities or services which may serve as alternatives or substitutes for the whole or any part of in-hospital service, including, but not limited to, obstetrical, pediatric, laboratory, training, radiology, pharmacy, laundry, purchasing, preadmission, nursing home, ambulatory or home care services. The commissioner shall exclude costs for research and those parts of the costs for educational salaries which the commissioner shall determine to be not directly related to hospital service, and allowances for costs which are not specifically identified except for allowances authorized under section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article. In determining and certifying to the state director of the budget rates of payment, including rates of payment for residential health care facilities, the commissioner shall take into consideration the different levels of care authorized to be provided in such hospital or health-related service and determine and certify distinct rates of payment for each such level of care. If the modification of an operating certificate of a hospital pursuant to subdivision six of section twenty-eight hundred six of this

article requires the establishment of a rate for a level of service not previously provided in such hospital during the rate period existing at the time of such modification, a new rate period for that portion of the hospital reclassified as a result of such modification may be established upon sixty days' prior notice.

4. Commissioner rate certifications, payments pursuant to the provisions of the workers' compensation law, the volunteer firefighters' benefit law, the volunteer ambulance workers' benefit law and the comprehensive motor vehicle insurance reparations act. For the rate years commencing January first, nineteen hundred eighty-six and January first, nineteen hundred eighty-seven the commissioner shall submit to the chairman of the workers' compensation board a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision two of section twenty-eight hundred seven-a of this article or as revised pursuant to subdivisions eleven and fourteen of section twenty-eight hundred seven-a of this article. Beginning with the rate period commencing January first, nineteen hundred eighty-eight the commissioner shall submit, and beginning with the rate period January first, nineteen hundred ninety-seven and certify, to the chairman of the workers' compensation board for an established rate period a schedule of hospital inpatient reimbursement rates computed in accordance with subdivision one of section twenty-eight hundred seven-c of this article for payments pursuant to the workers' compensation law, the volunteer firefighters' benefit law and the comprehensive motor vehicle insurance reparations act and beginning with the rate year commencing January first, nineteen hundred ninety-one including payments pursuant to the volunteer ambulance workers' benefit law.

5. Audit authority. The commissioner shall make available to the commissioner of social services, in a mutually satisfactory manner, all information necessary to conduct or have conducted, on a cost sharing basis among payors, an appropriate review or audit of the fiscal and statistical records of a hospital necessary to implement the provisions of this article.

6. Consideration of economic status in certain cases. Notwithstanding

the provisions of this section, the commissioner, in determining and certifying rates of payment for services provided by a party to a contract entered into pursuant to the provisions of subdivision three of section twenty-eight hundred three of this article, shall take into consideration the economic status of the patients receiving such services.

7. Reimbursement rate promulgation. The commissioner shall notify each residential health care facility and health-related service of its approved rates of payment which shall be used in reimbursing for services provided to persons eligible for payments made by state governmental agencies at least sixty days prior to the beginning of an established rate period for which the rate is to become effective and for general hospitals at least thirty days prior to the beginning of an established rate period for which the rate is to become effective. Notification shall be made only after approval of rate schedules by the state director of the budget. The sixty and thirty day notice provisions, herein, shall not apply to rates issued following judicial annulment or invalidation of any previously issued rates, or rates issued pursuant to changes in the methodology used to compute rates which changes are promulgated following the judicial annulment or invalidation of previously issued rates. Notwithstanding any provision of law to the contrary, nothing in this subdivision shall prohibit the recalculation and payment of rates, including both positive and negative adjustments, based on a reconciliation of amounts paid by residential health care facilities beginning April first, nineteen hundred ninety-seven for additional assessments or further additional assessments pursuant to section twenty-eight hundred seven-d of this article with the amounts originally recognized for reimbursement purposes.

7-a. Notwithstanding any inconsistent provision of law, with regard to a general hospital the provisions of subdivisions four and seven of this section and the provisions of section eighteen of chapter two of the laws of nineteen hundred eighty-eight relating to the requirement of prior notice and the time frames for notice, approval or certification of rates of payment, maximum rates of payment or maximum charges where

not otherwise waived pursuant to law shall be applicable only to such rates of payment or maximum charges prospectively established for an annual rate period and such provisions shall not be applicable to a general hospital with regard to prospective adjustments or retrospective adjustments of established rates of payment or maximum charges for or during an annual rate period based on correction of errors or omissions of data or in computation, rate appeals, audits or other rate adjustments authorized by law or regulations adopted pursuant to section twenty-eight hundred three of this article.

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

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

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

(d) Notwithstanding any provision of the law to the contrary, rates of

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

8. Rates for federally qualified health centers and rural health centers. Notwithstanding section four of chapter eighty-one of the laws of nineteen hundred ninety-five, as amended by section twenty-seven of chapter one of the laws of nineteen hundred ninety-nine, and any other law, rule or regulation to the contrary, for periods on and after January first, two thousand one, rates of payment made by governmental agencies for services provided by diagnostic and treatment centers or general hospital outpatient clinics licensed under this article to individuals eligible for medical assistance pursuant to title eleven of article five of the social services law which are also designated, in accordance with 42 USC § 1396a(aa), as federally qualified health centers or rural health centers shall be established in accordance with the following:

(a) For periods on and after January first, two thousand one, and prior to October first, two thousand one, such rates of payment shall be computed in accordance with paragraph (b) of subdivision two of this section, provided, however, that the operating and capital cost components of such rates and the applicable ceilings on allowable operating costs shall reflect an average of nineteen hundred ninety-nine and two thousand base year costs as reported to the department.

(b) For each twelve month period following September thirtieth, two thousand one, the operating cost component of such rates of payment shall reflect the operating cost component in effect on September thirtieth of the prior period as increased by the percentage increase in the Medicare Economic Index as computed in accordance with the requirements of 42 USC § 1396a(aa)(3) and as adjusted pursuant to applicable regulations to take into account any increase or decrease in the scope of services furnished by the facility.

(c) Rates of payments to facilities which first qualify as federally

qualified health centers or rural health centers on or after October first, two thousand shall be computed in accordance with the provisions of paragraph (b) of subdivision two of this section, provided, however, that the operating cost component of such rates shall reflect an average of the operating cost component of rates of payments issued to other facilities subject to this subdivision during the same rate period, located in the same geographic region and with a similar case load, and further provided that the capital cost component of such rates shall reflect the most recently available capital cost data as reported to the department. For each twelve month period following the rate period in which such facilities commence operation, the operating cost component of rates of payment for such facilities shall be computed in accordance with paragraph (b) of this subdivision. In calculating the operating cost component of such rates for facilities which first qualify as federally qualified health care centers on or after October first, two thousand, the counties comprising the geographic region known as downstate shall be the same as the counties comprising the downstate region for purposes of reimbursing diagnostic and treatment centers under ambulatory patient groups, which counties are specified in the regulations adopted by the commissioner implementing section 18 of part C of chapter fifty-eight of the laws of two thousand eight.

(d) Subject to receipt of all necessary federal approvals, rates of payment computed in accordance with this subdivision may be further adjusted in accordance with the provisions of subdivision seventeen of this section, provided, however, that such adjustments shall not be subject to trend adjustments as provided in paragraph (b) of this subdivision.

(e) Diagnostic and treatment centers eligible for rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision, which were, on December thirty-first, two thousand, receiving rates of payment as preferred primary care providers computed pursuant to paragraph (h) of subdivision two of this section, may elect to continue to receive rates of payment computed in accordance with such paragraph (h), provided that in no event shall such rates of payment be less than the rates of payment computed pursuant to paragraphs (a) and (b) of this subdivision.

(f) For any rate periods after March thirty-first, two thousand eight,

subject to the availability of federal financial participation, the commissioner may prospectively adjust rates of payment for facilities otherwise subject to this subdivision to reflect alternative rate-setting methodologies, provided, however, that such alternative rate-setting methodologies must: (i) be authorized by applicable state law, (ii) be agreed to by the commissioner and each facility to which they are applied and (iii) in no event result in rates that are, in aggregate, less than the rates of payment otherwise provided for in this subdivision.

9. Payments under this section not to preclude other lawful payments. Any payments made under the authority of this section or section twenty-eight hundred seven-c of this article shall not preclude payments under any other section of law.

10. Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provisions of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development and/or continuation of limited pilot reimbursement programs to provide additional knowledge and experience in different types of reimbursement mechanisms for general hospitals.

* 11. Notwithstanding the provisions of this article, the commissioner may waive, subject to the approval of the state director of the budget, the requirements of any provision of this section, section twenty-eight hundred seven-a or twenty-eight hundred seven-c of this article to permit the development, implementation and operation of limited pilot reimbursement programs for general hospital outpatient services and diagnostic and treatment center services that would be prospective and associated to the resource use patterns in rendering ambulatory care services.

* NB Expired April 1, 2020

12. (a) Notwithstanding any inconsistent provision of this article or any other law, for the purpose of improving access to and availability of comprehensive primary health care to persons receiving medical assistance pursuant to title eleven of article five of the social

services law, the commissioner, upon application by a health care provider, may designate such provider as a preferred primary care provider in accordance with the provisions of this subdivision.

(b) Health care providers designated as preferred primary care providers pursuant to this subdivision shall meet such requirements as may be established by the commissioner in regulation, including, but not limited to:

(i) access by the medically indigent and medicaid eligible to ambulatory services;

(ii) provision, to the maximum extent practicable, of continuity of care;

(iii) arrangements for specialty physician care and necessary ancillary services;

(iv) reasonably accessible hours of operation;

(v) services which are accessible to medically underserved populations and communities including, to the maximum extent feasible, offering such services within the medically underserved community; and

(vi) participation in local social services district managed care programs established pursuant to section three hundred sixty-four-j of the social services law, provided that the commissioner, in consultation with the commissioner of social services, may exempt a health care provider from such participation for good cause. Good cause shall include but not be limited to geographic inaccessibility to managed care programs, inability to coordinate services of managed care programs, or that participation in the managed care program would significantly affect the provider's financial ability to provide services.

(c) For the purposes of this subdivision, a health care provider eligible to be designated as a preferred primary care provider shall mean a general hospital, a diagnostic and treatment center, a private physician, a nurse practitioner, a midwife, a professional corporation or a group of physicians or nurse practitioners. The designation of any general hospital or a diagnostic and treatment center as a preferred primary care provider shall apply only to the specific site where the entity provides comprehensive primary health care services.

* 13. Subject to the availability of funds, the commissioner shall authorize health occupation development and workplace demonstration programs pursuant to the provisions of section two thousand eight

hundred seven-h of this article for diagnostic and treatment centers, and the commissioner is hereby directed to make rate adjustments to cover the cost of such programs.

* NB Expired July 1, 2017

* 14. Notwithstanding any inconsistent provision of law or regulation, for purposes of establishing rates of payment by governmental agencies for diagnostic and treatment centers for services provided on or after April first, nineteen hundred ninety-five, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this subdivision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses provided by this subdivision shall be expressed as a percentage reduction of the operating cost component of the rate promulgated by the commissioner for each diagnostic and treatment center with base year administrative and general costs exceeding the average.

* NB Expired March 31, 2011

15. Notwithstanding any inconsistent provision of law, including subdivision fourteen of this section, the facility-specific impact of eliminating the statewide cap on administrative and general costs, as imposed pursuant to subdivision fourteen of this section, for the period April first, nineteen hundred ninety-nine through June thirtieth, nineteen hundred ninety-nine pursuant to a chapter of the laws of nineteen hundred ninety-nine, shall be included in rates of payment for facilities affected by such elimination for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine. In addition, rates for diagnostic and treatment centers for the period October first, nineteen hundred ninety-nine through December thirty-first, nineteen hundred ninety-nine shall include, in the aggregate, the sum of fourteen million dollars which shall be added to rates of payment established in accordance with

paragraphs (b) and (h) of subdivision two of this section based on an apportionment of such amount using a ratio of each individual provider's estimated medicaid expenditures to total estimated medicaid expenditures for diagnostic and treatment centers, as determined by the commissioner, for the October first, nineteen hundred ninety-nine through September thirtieth, two thousand rate period.

16. Notwithstanding any inconsistent provision of law, payment for drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law provided to persons receiving medical assistance pursuant to title eleven of article five of the social services law by any non-hospital based diagnostic and treatment center licensed under this article in existence on the effective date of this subdivision providing comprehensive primary medical care services and registered by the state board of pharmacy pursuant to section sixty-eight hundred eight of the education law shall be on a fee-for-service basis and shall not be included in any comprehensive clinic rate paid to such facility by governmental agencies established in accordance with paragraph (b) of subdivision two of this section.

17. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the availability of federal financial participation, adjust medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for free-standing diagnostic and treatment centers licensed pursuant to this article and which are: a "covered provider" as defined in subdivision one of section three hundred sixty-four-j-two of the social services law; or eligible for an allocation under paragraph (a-1) of subdivision two of section three hundred sixty-four-j-two of the social services law; or which provides services to individuals with developmental disabilities as their principal mission, in accordance with paragraphs (b) and (c) of this subdivision for purposes of improving recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility in the following aggregate amounts for the following periods:

(i) for the period April first, two thousand two through December

thirty-first, two thousand two, thirteen million dollars;

(ii) for the period January first, two thousand three through December thirty-first, two thousand three, thirteen million dollars;

(iii) for the period January first, two thousand four through December thirty-first, two thousand four, thirteen million dollars;

(iv) for the period January first, two thousand five through December thirty-first, two thousand five, thirteen million dollars;

(v) for the period January first, two thousand six through December thirty-first, two thousand six, thirteen million dollars;

(vi) for the period January first, two thousand seven through June thirtieth, two thousand seven, six million five hundred thousand dollars;

(vii) for the period July first, two thousand seven through March thirty-first, two thousand eight, nine million seven hundred fifty thousand dollars; and

(viii) thirteen million dollars for the period April first, two thousand eight through March thirty-first, two thousand nine;

(ix) thirteen million dollars for the period April first, two thousand nine through March thirty-first, two thousand ten; and

(x) thirteen million dollars for the period April first, two thousand ten through March thirty-first, two thousand eleven.

(b) Such adjustments to rates of payments shall be allocated proportionally based on each diagnostic and treatment center's total annual gross salary and fringe benefit costs, as reported in each such diagnostic and treatment center's nineteen hundred ninety-nine cost report as submitted to the department prior to November first, two thousand one, provided, however, that for periods on and after July first, two thousand seven, such adjustments to rates of payment shall be allocated proportionally, based on each such diagnostic and treatment center's total reported medicaid visits, as reported in each such diagnostic and treatment center's two thousand four cost report as submitted to the department prior to January thirty-first, two thousand seven, to the total of such medicaid visits for all diagnostic and treatment centers.

(c) Rate adjustments made pursuant to this subdivision shall not be subject to subsequent adjustment or reconciliation.

(d) Diagnostic and treatment centers which have their rates adjusted

pursuant to this subdivision shall use such funds for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers at health care facilities or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

18. (a) Notwithstanding any contrary provision of law or regulation, the commissioner shall, subject to the provisions of paragraph (c) of this subdivision and to the availability of federal financial participation, increase medical assistance rates of payment established pursuant to paragraph (b) of subdivision two of this section for eligible diagnostic and treatment centers by three percent for services provided on and after December first, two thousand two for purposes of improving recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility.

(b) For the purposes of this subdivision, "eligible diagnostic and treatment center" shall mean a voluntary, not-for-profit diagnostic and treatment center licensed under this article that received medical assistance rates of payment reflecting assignment to limited primary care or drug free peer groups as established pursuant to applicable rate-setting regulations and that provides primary health care services to a patient population primarily comprised of substance abuse patients and that is ineligible for an adjustment to medical assistance rates of payment under subdivision seventeen of this section.

(c) Diagnostic and treatment centers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of non-supervisory workers or any worker

with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such diagnostic and treatment center shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. The commissioner is authorized to audit each such diagnostic and treatment center to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

19. (a) Notwithstanding any provision of law, rule or regulation to the contrary and subject to the provisions of paragraph (b) of this subdivision and to the availability of federal financial participation, the commissioner shall increase medical assistance rates of payment by three percent for services provided on and after December first, two thousand two by freestanding methadone maintenance service and program providers issued operating certificates pursuant to this article and section 32.09 of the mental hygiene law for the purposes of improving recruitment and retention of methadone maintenance workers.

(b) Freestanding methadone maintenance services and program providers which are eligible for rate adjustments pursuant to this subdivision and which are also eligible for rate adjustments pursuant to subdivision seventeen of this section, shall, on or before July first, two thousand two, submit, in a form and manner determined by the commissioner, amendments to designated sections of their AHCF-1 cost report segregating wages and fringe benefit costs associated with methadone maintenance services from all other services for the purposes of determining awards made pursuant to subdivision seventeen of this section for rate periods ending in two thousand three and in two thousand four.

(c) Freestanding methadone maintenance service and program providers which have their rates adjusted pursuant to this subdivision shall use such funds solely for the purpose of recruitment and retention of

non-supervisory workers or any worker with direct patient care responsibility and are prohibited from using such funds for any other purpose. Each such methadone maintenance service and program provider shall submit, at a time and in a manner to be determined by the commissioner, a written certification attesting that such funds will be used solely for the purpose of recruitment and retention of non-supervisory workers at such programs or any worker with direct patient care responsibility. The commissioner is authorized to audit each such methadone maintenance service and program provider to ensure compliance with the written certification required by this paragraph and shall recoup any funds determined to have been used for purposes other than recruitment and retention of non-supervisory workers or any worker with direct patient care responsibility. Such recoupment shall be in addition to any other penalties provided by law.

20. (a) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for Delivery System Reform Incentive Payments ("DSRIP") to such facilities. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the DSRIP funds. The commissioner shall, to the maximum degree practicable, and to the extent permitted by the federal Centers for Medicare and Medicaid Services ("CMS"), ensure that the DSRIP program is implemented throughout the entire state.

(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 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.

(c)(i) Project advisory committees. 1. Lead entities of systems established under the Medicaid delivery system reform incentive payment ("DSRIP") program shall establish a project advisory committee. The committee shall consider and advise the entity on matters concerning system operations, service delivery issues, elimination of health care disparities, measurement of project outcomes, the degree to which project goals are being reached and the development of any plans or programs. The entity may establish rules with respect to its project advisory committee.

(ii) The members of the committee shall be representatives of the community, or geographic service areas, served by the system, including Medicaid consumers attributed to that system, and any other members required by the terms and conditions of the DSRIP program. The lead entity shall file with the commissioner, and from time to time update, an up-to-date list of the members of the committee, which shall be made available to the public by the department on its website.

(iii) Notwithstanding any inconsistent provision of law, no officer or

employee of the state or of any civil division thereof, shall be deemed to have forfeited or shall forfeit his or her office or employment by reason of his or her acceptance of membership on a project advisory committee. No member of a project advisory committee shall receive compensation or allowance for services rendered on the committee, except, however, that members of a committee may be reimbursed by the entity or system for necessary expenses incurred in relation to service on a project advisory committee.

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

(i) analysis of progress made toward DSRIP goals;

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

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

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

(v) a status update on project milestone progress;

(vi) information on project spending and budget;

(vii) analysis of impact on Medicaid beneficiaries served;

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

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

(x) a description of all regulation waivers issued pursuant to paragraph (f) of this subdivision; and

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

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

the opportunities for public comment on the DSRIP program.

(f) Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office for people with developmental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary, consistent with applicable law, to allow applicants under this subdivision and paragraph (a) of subdivision two of section twenty-eight hundred twenty-five of this article to avoid duplication of requirements and to allow the efficient implementation of the proposed project; provided, however, that regulations pertaining to patient safety may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time periods as the authorizing commissioner may determine. Any regulatory relief granted pursuant to this subdivision shall be described, including each regulation waived and the project it relates to, in the report provided pursuant to paragraph (d) of this subdivision.

* 20-a. Notwithstanding any provision of law to the contrary, the commissioners of the department of health, the office of mental health, the office of 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 providers that are involved in DSRIP projects or replication and scaling activities, as approved by the authorizing commissioner, to avoid duplication of requirements and to allow the efficient scaling and replication of DSRIP promising practices, as determined by the authorizing commissioner; provided however, that regulations pertaining to patient safety, patient autonomy, patient privacy, patient rights, due process, scope of practice, professional licensure, environmental protections, provider reimbursement methodologies, or occupational standards and employee rights may not be waived, nor shall any regulations be waived if such waiver would risk patient safety. Any regulatory action under this subdivision shall be published on the applicable website of the authorizing commissioner and shall include a description of each waiver, including a citation of each regulation waived, and a description of the project of which such relief was granted.

* NB Expires April 1, 2028

21. (a) Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals and the availability of federal financial participation, the commissioner is authorized to enter into agreements with SUNY downstate medical center, other public general hospitals, and/or with the sponsoring local governments of such other public general hospitals, under which such facilities and/or such local government shall, by intergovernmental transfer, fund the non-federal share of Medicaid funds made available for implementation of Medicaid Redesign Team initiatives. Such non-federal share payments shall be deemed voluntary and, further, such payments shall be excluded from computations made pursuant to section one of part C of chapter fifty-eight of the laws of two thousand five, as amended. In addition, the facilities, and/or the sponsoring local governments of such facilities or the state may, by written notification to the other parties to the agreement, cancel such agreement at any time prior to the payment of the Medicaid Redesign Team initiatives funds.

(b) Applications by eligible applicants for Medicaid Redesign Team initiatives funded by monies made available pursuant to paragraph (a) of this subdivision shall be submitted for review to the advisory panel established pursuant to paragraph (b) of subdivision twenty of this section and such panel shall submit their recommendations to the commissioner for final determination. For periods on and after April first, two thousand fourteen, the commissioner shall provide a report on a quarterly basis to the majority leader of the New York state senate and to the speaker of the New York state assembly with regard to the status of such applications and approved projects. Such reports shall be submitted no later than sixty days after the close of the quarter, and shall include the most current information submitted by applicants to the state. The reports shall be submitted in conjunction with and as a part of the reports submitted pursuant to paragraph (c) of subdivision twenty of this section and shall include:

(i) analysis of progress made toward project goals;

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

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

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

(v) a status update on project milestone progress;

(vi) information on project spending and budget;

(vii) analysis of impact on Medicaid beneficiaries served;

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

(ix) a description of applications that were denied;

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

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

(c) The commissioner shall make all reports prepared pursuant to paragraph (b) of this subdivision and all supporting attachments and materials available on the department's website.

(d) Notwithstanding any inconsistent law to the contrary, and subject to federal financial participation, and subject to amounts appropriated for purposes herein, the department may distribute funds to make rate adjustments for health home providers as described in section three hundred sixty-five-l of the social services law for member engagement, staff training and retraining, health information technology implementation, joint governance technical assistance, and other such purposes as the commissioner, in consultation with the commissioners of the office of mental health and the office of alcoholism and substance abuse services determines.

(e) Notwithstanding any provisions 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, not shall any regulation be waived if such waiver would risk patient safety. Such waiver shall not exceed the life of the project or such shorter time period as the authorizing commissioner any determine. Any regulatory relief granted pursuant to this subdivision shall be described,

including each regulation waived and the project it relates to, in the report provided pursuant to paragraph (b) of this subdivision.