DRAFT LBDC

A BUDGET BILL submitted by the Governor
in accordance with Article VII of the Constitution

AN ACT to amend the public health law, in relation to general hospital inpatient reimbursement for annual rates; to amend chapter 1 of the laws of 1999 amending the public health law and other laws relating to enacting the New York Health Care Reform Act of 2000, in relation to rates of payment for residential health care facilities; to amend the public health law, in relation to establishing ceiling limitations for certain rates of payment; to repeal certain provisions of the social services law relating to prescription drug payments; to amend the social services law, in relation to a study to determine costs incurred by public school districts for certain medical care, services and supplies; to amend the public health law, in relation to calculation of capital costs and to repeal certain provisions of such law relating thereto; to amend the education law, in relation to immunizations; to amend the public health law, in relation to the pharmacy and therapeutics committee and the preferred drug program; and to repeal certain provisions of such law relating thereto; to amend the social services law and the public health law, in relation to covered part D drugs, limited coverage for formula therapy, prescription footwear, speech therapy, physical therapy and occupational therapy, payment for home health care nursing services, and coverage for smoking cessation counseling services, the furnishing of medical assistance to applicants with responsible relatives, and the commissioner of health's authority to negotiate agreements resolving multiple pending rate appeals; to repeal subdivision 12 of section 272 of the public health law relating to authorization under the preferred drug program for anti-psychotics, anti-depressants, anti-rejection drugs for transplants and anti-retrovirals used in the treatment of HIV and AIDS; to amend the public health law, in relation to temporary operator certificates for general hospitals or diagnostic and treatment centers; to amend the social services law, in relation to health home services; to amend the public health law, in relation to managed long term care plans; to amend the social services law, in relation to insurance co-payments; to amend the public health law, in relation to providing palliative care support for patients with advanced life limiting conditions and illnesses; to amend the social services law, in relation to provisions of home health care services, to establish a workgroup to develop a plan and draft legislation for the purpose of operating and managing public nursing homes; to amend the public health law, in relation to encouraging cooperative, collaborative and integrative arrangements between health care providers, payers, and others; to amend the social

services law, in relation to definition of estate; to amend the civil practice law and rules, in relation to damage awards and to repeal certain provisions of such law relating thereto; to amend the mental hygiene law, in relation to compliance with operational standards by hospitals and providers of services in hospitals; to amend the public health law, in relation to serious event reporting; to amend the general municipal law, in relation to including a hospital and continuing care retirement community within the definition of project and defining hospital; to amend chapter 66 of the laws of 1994, amending the public health law, the general municipal law and the insurance law relating to the financing of life care communities, in relation to repealing the application deadline for eligibility for assistance from an industrial development agency; to amend the social services law, in relation to limiting the reporting of death by the operator of an adult home or residence, to define certain terms as used in the social services law, and to require preclaim review for participating providers of medical assistance program items and services; to amend the public health law, and part B of chapter 58 of the laws of 2010, amending chapter 474 of the laws of 1996 amending the education law and other laws relating to rates for residential healthcare facilities and other laws relating to Medicaid payments, in relation to seeking federal approvals to establish payment methodologies with accountable care organizations, and to amend the mental hygiene law, in relation to entities subject to the visitation, examination, inspection, and investigation; to amend the social services law, in relation to medical assistance for needy persons and to repeal certain provisions of such law relating thereto; to amend the tax law, in relation to increasing credits for long-term care insurance; to amend the social services law, in relation to the character and adequacy of assistance; and providing for the repeal of certain provisions upon expiration thereof

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subparagraph 1 of paragraph (c) of subdivision 10 of section 2807-c of the public health law, as amended by chapter 419 of the laws of 2000, is amended to read as follows:

(1) For rate periods on and after April first, two thousand **through March thirty-first, two thousand eleven**, the commissioner shall estab-

lish trend factors for rates of payment for state governmental agencies to project for the effects of inflation except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. The factors shall be applied to the appropriate portion of reimbursable costs.

§ 2. Section 21 of chapter 1 of the laws of 1999 amending the public health law and other laws relating to enacting the New York Health Care Reform Act of 2000, as amended by section 18 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

§ 21. Notwithstanding any inconsistent provision of law, effective **for rate periods** April 1, 2000 **through March 31, 2011**, in determining rates of payment for residential health care facilities pursuant to section 2808 of the public health law, hospital outpatient services and diagnostic and treatment centers pursuant to section 2807 of the public health law, unless otherwise subject to the limits set forth in section 4 of chapter 81 of the laws of 1995, as amended by this act, certified home health agencies and long term home health care programs pursuant to section 3614-a of the public health law and personal care services pursuant to section 367-i of the social services law, and for periods on and after April 1, 2009, adult day health care services provided to patients diagnosed with AIDS as defined by applicable regulations, the commissioner of health shall apply trend factors using the methodology described in paragraph (c) of subdivision 10 of section 2807-c of the public health law, except that such trend factors shall not be applied to services for which rates of payment are established by the commissioners of the department of mental hygiene. Nothing in this section is

intended to reduce a change in any existing provision of law establishing maximum reimbursement rates.

§ 2-a. Notwithstanding any contrary provision of law, rule or regulation, for Medicaid rates of payment for services provided on and after April 1, 2011 the commissioner of health is authorized to promulgate regulations, including emergency regulations, with regard to trend factor adjustments for inflation which may be applied to such rates of payment with regard to hospice services provided pursuant to article 40 of the public health law, assisted living program services provided pursuant to section 461-1 of the social services law, foster care services provided pursuant to article 6 of the social services law, adult day health care services provided pursuant to article 28 of the public health law or personal care services provided in those local social services districts, including New York city, whose rates of payment for such services is established by such 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.

§ 3. Section 3614 of the public health law is amended by adding a new subdivision 12 to read as follows:

12. (a) Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, effective on and after April first, two thousand eleven through March thirty-first, two thousand twelve, rates of payment 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 discrete groups as may be determined by the commissioner pursuant to regulations, shall reflect ceiling limitations determined in accord-

ance with this subdivision, provided, however, that at the discretion of the commissioner such ceilings may, as an alternative, be applied to payments for services provided on and after April first, two thousand eleven, except for such services provided to children and other discrete groups as may be determined by the commissioner pursuant to regulations. In determining such payments or rates of payment, agency ceilings shall be established. Such ceilings shall be applied to payments or rates of payment for certified home health agency services as established pursuant to this section and applicable regulations. Ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and an agency patient case mix index, weighted at a percentage as determined by the commissioner. Such ceilings will be effective April first, two thousand eleven through March thirty-first, two thousand twelve. An interim payment or rate of payment adjustment effective April first, two thousand eleven, shall be applied to agencies with projected average per patient Medicaid claims, as determined by the commissioner, to be over their ceilings. Such agencies shall have their payments or rates of payment reduced to reflect the amount by which such claims exceed their ceilings.

(b) Ceiling limitations determined pursuant to paragraph (a) of this subdivision shall be subject to reconciliation. In determining payment or rate of payment adjustments based on such reconciliation, adjusted agency ceilings shall be established. Such adjusted ceilings shall be based on a blend of: (i) an agency's two thousand nine average per patient Medicaid claims adjusted by the percentage of increase or

decrease in such agency's patient case mix from the two thousand nine calendar year to the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner; and (ii) the two thousand nine statewide average per patient Medicaid claims adjusted by a regional wage index factor and the agency's patient case mix index for the annual period April first, two thousand eleven through March thirty-first, two thousand twelve, weighted at a percentage as determined by the commissioner. Such adjusted agency ceiling shall be compared to actual Medicaid paid claims for the period April first, two thousand eleven through March thirty-first, two thousand twelve. In those instances when an agency's actual per patient Medicaid claims are determined to exceed the agency's adjusted ceiling, the amount of such excess shall be due from each such agency to the state and may be recouped by the department in a lump sum amount or through reductions in the Medicaid payments due to the agency. In those instances where an interim payment or rate of payment adjustment was applied to an agency in accordance with paragraph (a) of this subdivision, and such agency's actual per patient Medicaid claims are determined to be less than the agency's adjusted ceiling, the amount by which such Medicaid claims are less than the agency's adjusted ceiling shall be remitted to each such agency by the department in a lump sum amount or through an increase in the Medicaid payments due to the agency.

(c) Interim payment or rate of payment adjustments pursuant to this subdivision shall be based on Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year two thousand nine. Amounts due from reconciling rate adjustments shall be based on Medicaid paid claims, as determined by the commissioner, for

services provided by agencies in the base year two thousand nine and Medicaid paid claims, as determined by the commissioner, for services provided by agencies in the reconciliation period April first, two thousand eleven through March thirty-first, two thousand twelve. In determining case mix, each patient shall be classified using a system based on measures which may include, but not be limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(d) The commissioner may require agencies to collect and submit any data required to implement the provisions of this subdivision. The commissioner may promulgate regulations, including emergency regulations, to implement the provisions of this subdivision.

(e) Payments or rate of payment adjustments determined pursuant to this subdivision shall, for the period April first, two thousand eleven through March thirty-first, two thousand twelve, be retroactively reconciled utilizing the methodology in paragraph (b) of this subdivision and utilizing actual paid claims from such period.

(f) Notwithstanding any inconsistent provision of this subdivision, payments or rate of payment adjustments made pursuant to this subdivision shall not result in an aggregate annual decrease in Medicaid payments to providers subject to this subdivision that is in excess of two hundred million dollars, as determined by the commissioner and not subject to subsequent adjustment, and the commissioner shall make such adjustments to such payments or rates of payment as are necessary to ensure that such aggregate limits on payment decreases are not exceeded.

§ 4. Section 3614 of the public health law is amended by adding a new subdivision 13 to read as follows:

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

(b) Initial base year episodic payments shall be based on Medicaid paid claims, as determined and adjusted by the commissioner to achieve savings comparable to the prior state fiscal year, for services provided by all certified home health agencies in the base year two thousand nine. Subsequent base year episodic payments may be based on Medicaid paid claims for services provided by all certified home health agencies in a base year subsequent to two thousand nine, as determined by the commissioner, provided, however, that such base year adjustment shall be made not less frequently than every three years. In determining case mix, each patient shall be classified using a system based on measures which may include, but not limited to, clinical and functional measures, as reported on the federal Outcome and Assessment Information Set (OASIS), as may be amended.

(c) The commissioner may require agencies to collect and submit any data required to implement this subdivision. The commissioner may

promulgate regulations, including emergency regulations, to implement the provisions of this subdivision.

§ 5. Sections 365-i and 369-dd of the social services law are REPEALED.

§ 5-a. Subparagraph (v) of paragraph (e) of subdivision 1 and subdivision 2-b of section 369-ee of the social services law, subparagraph (v) of paragraph (e) of subdivision 1 as amended by section 1 of part C and subdivision 2-b as added by section 2 of part C of chapter 58 of the laws of 2008, are amended to read as follows:

(v) prescription drugs [**as defined in section two hundred seventy of the public health law, which shall be provided pursuant to subdivision two-b of this section,**] and non-prescription smoking cessation products or devices;

2-b. Prescription drug payments. [**(a) Subject to paragraph (b) of this subdivision, payment for drugs, except for such drugs provided by medical practitioners, and for which payment is authorized pursuant to paragraph (e) of subdivision one of this section, shall be made pursuant to subdivision nine of section three hundred sixty-seven-a of this article and article two-A of the public health law and subdivision four of section three hundred sixty-five-a of this article. Payment for such drugs provided by medical practitioners shall be included in the capitation payment for services or supplies provided to persons eligible for health care services under this title.**

(b)] Payment for drugs for which payment is authorized pursuant to paragraph (e) of subdivision one of this section[**, and that are provided by an employer partnership for family health plus plan authorized by section three hundred sixty-nine-ff of this title,**] shall be included in the capitation payment for services or supplies provided to persons

eligible for health care services under [**such**] a family health insurance plan.

§ 6. Section 368-d of the social services law is amended by adding three new subdivisions 4, 5 and 6 to read as follows:

4. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by public school districts and state operated/state supported schools which operate pursuant to article eighty-five, eighty-seven or eighty-eight of the education law for medical care, services and supplies, including related special education services and special transportation, furnished to children with handicapping conditions.

5. 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 of health is authorized to enter into a contract or contracts under subdivision four of this section without a competitive bid or request for proposal process, provided, however, that:

(a) The department of health 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 of health; and

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

6. The commissioner shall evaluate the results of the study conducted pursuant to subdivision four of this section to determine, after identification of actual direct and indirect costs incurred by public school districts and state operated/state supported schools, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision five of section three hundred sixty-eight-e of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

§ 7. Section 368-e of the social services law is amended by adding three new subdivisions 3, 4 and 5 to read as follows:

3. The commissioner of health is authorized to contract with one or more entities to conduct a study to determine actual direct and indirect costs incurred by counties for medical care, services and supplies, including related special education services and special transportation, furnished to pre-school children with handicapping conditions.

4. 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 of health is authorized to enter into a contract or contracts under subdivision three of this section without a competitive bid or request for proposal process, provided, however, that:

(a) The department of health 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 of health; and

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

5. The commissioner shall evaluate the results of the study conducted pursuant to subdivision three of this section to determine, after identification of actual direct and indirect costs incurred by counties for medical care, services, and supplies furnished to pre-school children with handicapping conditions, whether it is advisable to claim federal reimbursement for expenditures under this section as certified public expenditures. In the event such claims are submitted, if federal reimbursement received for certified public expenditures on behalf of medical assistance recipients whose assistance and care are the responsibility of a social services district in a city with a population of over two million, results in a decrease in the state share of annual expenditures pursuant to this section for such recipients, then to the extent that the amount of any such decrease when combined with any decrease in the state share of annual expenditures described in subdivision six of section three hundred sixty-eight-d of this title exceeds fifty million dollars, the excess amount shall be transferred to such city. Any such excess amount transferred shall not be considered a revenue received by such social services district in determining the district's actual medical assistance expenditures for purposes of paragraph (b) of section one of part C of chapter fifty-eight of the laws of two thousand five.

§ 8. Paragraph d of subdivision 20 of section 2808 of the public health law is REPEALED and a new paragraph d is added 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, the capital cost component of Medicaid rates of payment for services

provided by residential health care facilities shall not include any payment factor for return on or return of equity.

§ 9. Paragraph (b) of subdivision 11 of section 272 of the public health law, as added by section 36 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(b) The commissioner may designate a pharmaceutical manufacturer as one with whom the commissioner is negotiating or has negotiated a manufacturer agreement, and all of the drugs it manufactures or markets shall be included in the preferred drug program. The commissioner may negotiate directly with a pharmaceutical manufacturer for rebates relating to any or all of the drugs it manufactures or markets. A manufacturer agreement shall designate any or all of the drugs manufactured or marketed by the pharmaceutical manufacturer as being preferred or non preferred drugs. When a pharmaceutical manufacturer has been designated by the commissioner under this paragraph but **the commissioner** has not reached a manufacturer agreement with the pharmaceutical manufacturer, then **the commissioner may designate some or** all of the drugs manufactured or marketed by the pharmaceutical manufacturer [**shall be**] **as** non preferred drugs. However, notwithstanding this paragraph, any drug that is selected to be on the preferred drug list under paragraph (b) of subdivision ten of this section on grounds that it is significantly more clinically effective and safer than other drugs in its therapeutic class shall be a preferred drug.

§ 10. Paragraphs (a), (b), (c), (d), (e) and (f) of subdivision 9 of section 367-a of the social services law are REPEALED, paragraphs (g), (h) and (i) are relettered paragraphs (b), (c) and (d) and the opening paragraph of subdivision 9, as amended by chapter 19 of the laws of 1998, is amended to read as follows:

(a) Notwithstanding any inconsistent provision of law or regulation to the contrary, for those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and for which payment is authorized pursuant to paragraph (g) of subdivision two of section three hundred sixty-five-a of this title, payments **for such drugs and dispensing fees** under this title shall be made at [**the following**] amounts[:] **established by the commissioner.**

§ 11. Intentionally Omitted.

§ 12. Subdivision 22 of section 6802 of the education law, as added by chapter 563 of the laws of 2008, is amended to read as follows:

22. "Administer", for the purpose of section sixty-eight hundred one of this article, means the direct application of an immunizing agent to [**adults**] **persons eleven years of age or older**, whether by injection, ingestion or any other means, pursuant to a patient specific order or non-patient specific regimen prescribed or ordered issued by a physician or certified nurse practitioner who has a practice site in the county in which the immunization is administered. However if the county where the immunization is to be administered has a population of seventy-five thousand or less, then the licensed physician or certified nurse practitioner may be in an adjoining county. Such administration shall be limited to immunizing agents [**to prevent influenza or pneumococcal disease**] **recommended by the federal Centers for Disease Control and Prevention for persons who are eleven years of age or older,** and medications required for emergency treatment of anaphylaxis.

§ 13. Subdivision 1 of section 271 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

1. There is hereby established in the department a pharmacy and therapeutics committee. The committee shall consist of [**seventeen**] **eighteen** members, who shall be appointed by the commissioner and who shall serve three year terms; except that for the initial appointments to the committee, five members shall serve one year terms, seven shall serve two year terms, and five shall serve three year terms. Committee members may be reappointed upon the completion of their terms. [**No**] **With the exception of the chairperson, no** member of the committee shall be an employee of the state or any 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.

§ 14. Paragraphs (d) and (e) of subdivision 2 of section 271 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended, and a new paragraph (f) is added to read as follows:

(d) one person with expertise in drug utilization review who is either a health care professional licensed under title eight of the education law, is a pharmacologist or has a doctorate in pharmacology; [**and**]

(e) 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, including issues affecting Medicaid or EPIC recipients[.]**; and**

(f) a chairperson designated pursuant to subdivision four of this section.

§ 15. Subdivision 4 of section 271 of the public health law is REPEALED and a new subdivision 4 is added to read as follows:

4. The commissioner shall designate a member of the department to serve as chairperson of the committee.

§ 16. Subdivision 3 of section 272 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, is amended to read as follows:

3. The commissioner shall establish performance standards for the program that, at a minimum, ensure that the preferred drug program and the clinical drug review program provide sufficient technical support and timely responses to consumers, prescribers and pharmacists. **The commissioner may designate a member of the department to perform any actions of the commissioner authorized or required by this section.**

§ 17. Subdivision 10 of section 272 of the public health law is amended by adding a new paragraph (d) to read as follows:

(d) Notwithstanding any provision of this section to the contrary, the commissioner may designate therapeutic classes of drugs or individual drugs as preferred prior to any review that may be conducted by the committee pursuant to this section.

§ 18. Paragraphs (b) and (c) of subdivision 3 of section 273 of the public health law, as added by section 10 of part C of chapter 58 of the laws of 2005, are amended to read as follows:

(b) In the event that the patient does not meet the criteria in paragraph (a) of this subdivision, the prescriber may provide additional information to the program to justify the use of a prescription drug that is not on the preferred drug list. The program shall provide a reasonable opportunity for a prescriber to reasonably present his or her justification of prior authorization. [**If, after consultation with the program, the prescriber, in his or her reasonable professional judgment, determines that the use of a prescription drug that is not on the**

preferred drug list is warranted, the prescriber's determination shall be final.]

(c) [**If a prescriber meets the requirements of paragraph (a) or (b) of this subdivision, the prescriber shall be granted prior authorization under this section**] **Prior authorization for the non-preferred drug shall be denied if the prescriber fails to meet the requirements of paragraph (a) of this subdivision or, if after consultation with the program as described in paragraph (b) of this subdivision, the program determines that the use of the prescribed drug that is not on the preferred drug list is not warranted**.

§ 19. Intentionally Omitted.

§ 20. Paragraph (g) of subdivision 4 of section 365-a of the social services law, as amended by section 61 of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(g) for eligible persons who are also beneficiaries under part D of title XVIII of the federal social security act, drugs which are denominated as "covered part D drugs" under section 1860D-2(e) of such act[; **provided however that, for purposes of this paragraph, "covered part D drugs" shall not mean atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, or anti-rejection drugs used for the treatment of organ and tissue transplants**].

§ 21. Subdivision 12 of section 272 of the public health law is REPEALED.

§ 22. Intentionally Omitted.

§ 23. Paragraph (g) of subdivision 2 of section 365-a of the social services law, as amended by section 1 of part F of chapter 497 of the laws of 2008, is amended to read as follows:

(g) sickroom supplies, eyeglasses, prosthetic appliances and dental prosthetic appliances furnished in accordance with the regulations of the department[,]; provided further that: (i) the commissioner of health is authorized to implement a preferred diabetic supply program wherein the department of health will receive enhanced rebates from preferred manufacturers of glucometers and test strips, and may subject non-preferred manufacturers' glucometers and test strips to prior authorization under section two hundred seventy-three of the public health law; (ii) enteral formula therapy is limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding or for treatment of an inborn error of metabolism; other nutritional or dietary supplements are not covered; (iii) prescription footwear and inserts are limited to coverage only when used as an integral part of a lower limb orthotic appliance, as part of a diabetic treatment plan, or to address growth and development problems in children; and (iv) compression and support stockings are limited to coverage only for pregnancy or treatment of venous stasis ulcers;

(g-1) drugs provided on an in-patient basis, those drugs contained on the list established by regulation of the commissioner of health pursuant to subdivision four of this section, and those drugs which may not be dispensed without a prescription as required by section sixty-eight hundred ten of the education law and which the commissioner of health shall determine to be reimbursable based upon such factors as the availability of such drugs or alternatives at low cost if purchased by a medicaid recipient, or the essential nature of such drugs as described by such commissioner in regulations, provided, however, that such drugs, exclusive of long-term maintenance drugs, shall be dispensed in quantities no greater than a thirty day supply or one hundred doses, whichever

is greater; provided further that the commissioner of health is authorized to require prior authorization for any refill of a prescription when less than seventy-five percent of the previously dispensed amount per fill should have been used were the product used as normally indicated; **provided further that the commissioner of health is authorized to require prior authorization of prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period;** medical assistance shall not include any drug provided on other than an in-patient basis for which a recipient is charged or a claim is made in the case of a prescription drug, in excess of the maximum reimbursable amounts to be established by department regulations in accordance with standards established by the secretary of the United States department of health and human services, or, in the case of a drug not requiring a prescription, in excess of the maximum reimbursable amount established by the commissioner of health pursuant to paragraph (a) of subdivision four of this section;

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

(a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative [**or**] **and** the refusal or failure of such **absent** relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from

such relative in accordance with title six of article three **of this chapter** and other applicable provisions of law.

§ 25. Paragraph (b) of subdivision 17 of section 2808 of the public health law, as added by section 30 of part B of chapter 109 of the laws of 2010, is amended and a new paragraph (c) is added to read as follows:

(b) Notwithstanding any inconsistent provision of law or regulation to the contrary, for the state fiscal year beginning April first, two thousand ten and ending March thirty-first, two thousand [**eleven**] **fifteen**, 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 [**eleven**] **fifteen**, 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. 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. 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.

(c) Notwithstanding any other contrary provision of law, rule or regulation, for periods on and after April first, two thousand eleven the commissioner shall promulgate regulations, and may promulgate emergency regulations, establishing priorities and time frames for processing rate appeals, including rate appeals filed prior to April first, two thousand eleven, within available administrative resources; provided, however, that such regulations shall not be inconsistent with the provisions of paragraph (b) of this subdivision.

§ 26. Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for periods on and after April 1, 2011, clinics certified pursuant to articles 16, 31 or 32 of the mental hygiene law shall be subject to targeted Medicaid reimbursement rate reductions in accordance with the provisions of this section. Such reductions shall be based on utilization thresholds which may be established either as provider-specific or patient-specific thresholds. Provider-specific thresholds shall be based on average patient utilization for a given provider in comparison to a peer based standard to be determined for each service. When applying a provider-specific threshold, rates will be reduced on a prospective basis based on the amount any provider is over the determined threshold level. Patient-specific thresholds will be based on annual thresholds determined for each service over which the per visit payment for each visit in excess of the standard during a twelve month period shall be reduced

by a pre-determined amount. The thresholds, peer based standards and the payment reductions shall be determined by the department of health, with the approval of the division of the budget, and in consultation with the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services, and any such resulting rates shall be subject to certification by the appropriate commissioners pursuant to subdivision (a) of section 43.02 of the mental hygiene law. The base period used to establish the thresholds shall be the 2009 calendar year. The total annualized reduction in payments shall be no less than $10,900,000 for Article 31 clinics, no less than $2,400,000 for Article 16 clinics, and no less than $13,250,000 for Article 32 clinics. The commissioner of health may promulgate regulations, including emergency regulations, to implement the provisions of this section.

§ 27. Paragraph (h) of subdivision 2 of section 365-a of the social services law, as amended by chapter 444 of the laws of 1979 and as relettered by chapter 478 of the laws of 1980, is amended to read as follows:

(h) **speech therapy, and when provided at the direction of a physician or nurse practitioner,** physical therapy [**and relative**] **including related** rehabilitative services [**when provided at the direction of a physician**] **and occupational therapy; provided, however, that speech therapy, physical therapy and occupational therapy each shall be limited to coverage of twenty visits per year; such limitation shall not apply to persons with developmental disabilities**;

§ 28. Section 3614 of the public health law is amended by adding a new subdivision 2-a to read as follows:

2-a. Notwithstanding any contrary law, rule or regulation, for rate periods on and after April first, two thousand eleven, Medicaid rates of payments for services provided by certified home health agencies, by long term home health care programs or by an AIDS home care program shall not reflect a separate payment for home care nursing services provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS).

§ 29. Paragraph (h) of subdivision 5-a of section 2807-m of the public health law is relettered paragraph (i) and a new paragraph (h) is added to read as follows:

(h) Public health services corps (PHSC). One million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve, and two million dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen shall be set aside and reserved by the commissioner from the regional pools established pursuant to subdivision two of this section and shall be available to fund awards made pursuant to a competitive request for proposal or request for application process to support well-trained, highly qualified non-physician health professionals dedicated to delivering public health and health care services to underserved communities outside their regularly scheduled employment in accordance with the following:

(i) PHSC members shall be non-physician clinical service providers who may include, but not be limited to, the following health care professionals: mental health specialists, including clinical psychologists and clinical social workers, dentists and dental hygienists, nurse practitioners and physician assistants, dieticians, public health nurses and other registered nurses, bachelor of science nurses, licensed practical

nurses, epidemiologists, public health educators and graduate students in public health who want to provide service to state and local health departments via an internship.

(ii) PHSC members granted awards pursuant to this paragraph shall receive up to fifteen thousand dollars annually on an individual basis to provide clinical, health promotion and disease prevention investigation, analysis and services to medically indigent populations and communities in New York state as determined by the commissioner and may include, but not be limited to, any number of the following activities:

(A) clinical treatment in underserved areas including vaccinations, physicals and dental checkups;

(B) public health emergency response as directed by the governor;

(C) public health education workshops including classes on nutrition, family planning, alcohol and drug abuse and elder care;

(D) community health evaluation studies including assistance with epidemiologic studies in a particular community;

(E) disease outbreak investigations; and

(F) career development instruction in designated schools.

(iii) PHSC members shall: provide up to three hundred hours of services; deliver services in existing venues such as hospitals, free-standing clinics, county health departments, schools, nursing homes, town halls and any other venue in a rural or inner-city area; and attend annual training provided in designated locations in New York state which shall address health system concerns such as preventable events, patient with multiple diagnoses and medical home models.

(iv) Up to fifteen percent of funding available pursuant to this paragraph shall be used for administration of the PHSC program, including PHSC member training, travel and placement.

§ 30. Subparagraphs (x), (xi), (xii), (xiii) and (xiv) of paragraph (a) of subdivision 7 of section 2807-s of the public health law, as amended by section 100 of part C of chapter 58 of the laws of 2009, are amended to read as follows:

(x) forty-seven million two hundred ten thousand dollars on an annual basis for the periods January first, two thousand nine through December thirty-first, two thousand ten; [**and**]

(xi) eleven million eight hundred thousand dollars for the period January first, two thousand eleven through March thirty-first, two thousand eleven;

(xii) **twenty-four million eight hundred thirty-six thousand dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve;**

(xiii) twenty-five million eight hundred thirty-six thousand dollars each state fiscal year for the period April first, two thousand twelve through March thirty-first, two thousand fourteen;

(xiv) provided, however, for periods prior to January first, two thousand nine, amounts set forth in this paragraph may be reduced by the commissioner in an amount to be approved by the director of the budget to reflect the amount received from the federal government under the state's 1115 waiver which is directed under its terms and conditions to the graduate medical education program established pursuant to section twenty-eight hundred seven-m of this article;

[**(xiii)**] **(xv)** provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the total actual distribution reductions for all facilities pursuant to paragraph (e) of subdivision three of section twenty-eight hundred seven-m of this article; and

[**(xiv)**] **(xvi)** provided further, however, for periods prior to July first, two thousand nine, amounts set forth in this paragraph shall be reduced by an amount equal to the actual distribution reductions for all facilities pursuant to paragraph (s) of subdivision one of section twenty-eight hundred seven-m of this article.

§ 31. Paragraph (s) of subdivision 2 of section 365-a of the social services law, as amended by section 46 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(s) smoking cessation counseling services [**for pregnant women on any day of pregnancy through the end of the month in which the one hundred eightieth day following the end of the pregnancy occurs, and children and adolescents ten to twenty years of age, during a medical visit when provided by a general hospital outpatient department or a free-standing clinic, or by a physician, registered physician's assistant, registered nurse practitioner or licensed midwife in office-based settings**]; provided, however, that the provisions of this paragraph [**relating to smoking cessation counseling services**] shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of such services.

§ 32. Subparagraph (i) of paragraph (b-1) of subdivision 1 of section 2807-c of the public health law, as amended by section 10 of part C of chapter 58 of the laws of 2010, is amended to read as follows:

(i) For patients discharged on and after January first, nineteen hundred ninety-seven and prior to January first, two thousand and on and after January first, two thousand, payments to general hospitals for reimbursement of inpatient hospital services provided to patients eligible for payments pursuant to the workers' compensation law, the volun-

teer firefighters' benefit law, the volunteer ambulance workers' benefit law, and the comprehensive motor vehicle insurance reparations act shall be at the rates of payment determined pursuant to this section for state governmental agencies, excluding adjustments pursuant to subdivision fourteen-f of this section and subdivision thirty-three of this section [**and**]**,** excluding such further reductions to such payments as are enacted as part of the state budget for the state fiscal year commencing April first, two thousand ten **and excluding such further reductions to such payments as are enacted as part of the state budget for state fiscal years commencing on and after April first, two thousand eleven**.

§ 33. The public health law is amended by adding a new section 3614-c to read as follows:

§ 3614-c. Home care worker wage parity. 1. As used in this section, the following terms shall have the following meaning:

(a) "Living wage law" means any law enacted by a municipal government in the state of New York which establishes a minimum wage for some or all employees who perform work on municipal government contracts.

(b) "Social services district" means any social services district recognized by the department on January first, two thousand eleven.

(c) "Municipal government" means any city or county government.

(d) "Total compensation" means all wages and other direct compensation paid to or provided on behalf of the employee including, but not limited to, wages, health, education or pension benefits, supplements in lieu of benefits and compensated time off, except that it does not include employer taxes or employer portion of payments for statutory benefits, including but not limited to FICA, disability insurance, unemployment insurance and workers' compensation.

(e) "Prevailing rate of total compensation" means the average hourly amount of total compensation paid to all home care aides covered by whatever collectively bargained agreement covers the greatest number of home care aides in a social services district. The prevailing rate shall be calculated separately for each social services district, provided that the social services district is coterminous with the geographic boundaries of a municipal government which has enacted a living wage law. For purposes of this definition, any set of collectively bargained agreements in a social services district with substantially the same terms and conditions relating to total compensation shall be considered as a single collectively bargained agreement.

(f) "Home care aide" means a home health aide, personal care aide, home attendant or other licensed or unlicensed person whose primary responsibility includes the provision of in-home assistance with activities of daily living instrumental activities of daily living or health-related tasks.

(g) "Managed care plan" means any managed care program, organization or demonstration covering personal care or home health aide services, and which receives premiums funded, in whole or in part, by the New York state medical assistance program, including but not limited to all Medicaid managed care, Medicaid managed long term care, Medicaid advantage, and Medicaid advantage plus plans and all programs of all-inclusive care for the elderly.

(h) "Episode of care" means any service unit reimbursed, in whole or in part, by the New York state medical assistance program, whether through direct reimbursement or covered by a premium payment, and which covers, in whole or in part, any service provided by a home care aide,

including but not limited to all service units defined as visits, hours, days, months or episodes.

2. Notwithstanding any inconsistent provision of law, rule or regulation, effective January first, two thousand twelve, no payments by government agencies shall be made to certified home health agencies, long term home health care programs or managed care plans for any episode of care furnished, in whole or in part, by any home care aide who is compensated at amounts less than the applicable minimum rate of home care aide total compensation established pursuant to this section, provided that the episode of care is provided in a social services district coterminous with the geographic boundaries of any municipal government which has enacted a living wage law.

3. The minimum rate of home care aide total compensation shall be:

(a) for the period March first, two thousand twelve through February twenty-eighth, two thousand thirteen, ninety percent of the total compensation mandated by the living wage law of the municipal government whose geographic boundaries are coterminous with the social services district in which the episode of care is provided;

(b) for the period March first, two thousand thirteen through February twenty-eighth, two thousand fourteen, ninety-five percent of the total compensation mandated by the living wage law of the municipal government whose geographic boundaries are coterminous with the social services district in which the episode of care is provided;

(c) for all periods on and after March first, two thousand fourteen, no less than the prevailing rate of total compensation as of January first, two thousand eleven, or the total compensation mandated by the living wage law of the municipal government whose geographic boundaries

are coterminous with the social services district in which the episode of care is provided, whichever is greater.

4. Any portion of the minimum rate of home care aide total compensation attributable to health benefit costs or payments in lieu of health benefits, and paid time off, as established pursuant to subdivision three of this section shall be superseded by the terms of any employer bona fide collective bargaining agreement in effect as of January first, two thousand eleven, or a successor to such agreement, which provides for home care aides' health benefits through payments to jointly administered labor-management funds.

5. The terms of this section shall apply equally to services provided by home care aides who work on episodes of care as direct employees of certified home health agencies, long term home health care programs, or managed care plans, or as employees of licensed home care services agencies, limited licensed home care services agencies, or under any other arrangement.

6. No payments by government agencies shall be made to certified home health agencies, long term home health care programs, or managed care plans for any episode of care without the certified home health agency, long term home health care program, or managed care plan having delivered prior written certification to the commissioner, on forms prepared by the department in consultation with the department of labor, that all services provided under each episode of care are in full compliance with the terms of this section and any regulations promulgated pursuant to this section.

7. If a certified home health agency or long term home health care program elects to provide home care aide services through contracts with licensed home care services agencies or through other third parties,

provided that the episode of care on which the home care aide works is covered under the terms of this section, the certified home health agency, long term home health care program, or managed care plan must obtain a written certification from the licensed home care services agency or other third party, on forms prepared by the department in consultation with the department of labor, which attests to the licensed home care services agency's or other third party's compliance with the terms of this section. Such certifications shall also obligate the certified home health agency, long term home health care program, or managed care plan to obtain, on no less than a quarterly basis, all information from the licensed home care services agency or other third parties necessary to verify compliance with the terms of this section. Such certifications and the information exchanged pursuant to them shall be retained by all certified home health agencies, long term home health care programs, or managed care plans, and all licensed home care services agencies, or other third parties for a period of no less than ten years, and made available to the department upon request.

8. The commissioner shall distribute to all certified home health agencies, long term home health care programs, and managed care plans official notice of the minimum rates of home care aide compensation at least one hundred twenty days prior to the effective date of each minimum rate for each social services district covered by the terms of this section.

9. The commissioner is authorized to promulgate regulations, and may promulgate emergency regulations, to implement the provisions of this section.

10. Nothing in this section should be construed as applicable to any service provided by certified home health agencies, long term home

health care programs, or managed care plans except for all episodes of care reimbursed in whole or in part by the New York Medicaid program.

11. No certified home health agency, managed care plan or long term home health care program shall be liable for recoupment of payments for services provided through a licensed home care services agency or other third party with which the certified home health agency, long term home health care program, or managed care plan has a contract because the licensed agency or other third party failed to comply with the provisions of this section if the certified home health agency, long term home health care program, or managed care plan has reasonably and in good faith collected certifications and all information required pursuant to subdivisions six and seven of this section.

§ 33-a. The social services law is amended by adding a new section 364-J-3 to read as follows:

§ 364-J-3. Provision of home care services to managed care enrollees. 1. For all beneficiaries newly enrolling in managed care plans in New York city on or after April first, two thousand twelve, and for all beneficiaries enrolled in managed care plans in New York city on or after April first, two thousand fourteen, and for all beneficiaries mandated to enroll in managed care plans, managed care plans shall only cover home care services if delivered under contract to providers that have been expressly approved by the department of health or its designee to provide home care services to managed care beneficiaries in the social services district where the beneficiary resides. This requirement shall apply to all beneficiaries whose managed care is financed, in whole or in part, by the medical assistance program of New York state.

2. Approval for eligibility to provide home care services to managed care beneficiaries shall take the form of a certified provider agreement

entered into between the provider of home care services and the department of health or its designee, specifying the terms of the provider's eligibility to provide home care services to managed care beneficiaries, its rights and obligations in relation to the managed care plan authorizing such services, and any contingencies necessary to ensure that the provider of home care services delivers satisfactory performance throughout the duration of the agreement. The department of health or its designee shall have responsibility for overseeing all approved agencies' compliance with the terms and conditions of their provider agreements on an ongoing basis.

3. No provider agreement shall be valid for periods greater than three years. No limit shall be placed on the number of times a provider may be reapproved for eligibility to serve managed care beneficiaries. The department of health or its designee shall reserve the right to revoke any approval to provide home care services to managed care beneficiaries at any time in instances where the approved agency has been in material non-compliance with the terms of the certified provider agreement.

4. No provider of home care services shall be approved for eligibility to serve managed care beneficiaries unless the provider of home care services meets at least one of the following minimum criteria:

(a) the provider, or an affiliate of the provider, has an established record of providing home care services to the medicaid personal care program and under contract with the human resources administration in New York city;

(b) the provider is affiliated with a long term home health care program or managed long term care plan; or

(c) the provider or its affiliate has an exceptional prior record of investing in the quality and sustainability of the long term care work-

force, including, but not limited to, the provision of training through a department of health approved training program and the provision of health and education benefits to employees.

5. Except for material instances of non-compliance with program requirements, all providers of home care services to the medicaid personal care program under contract with the human resources administration as of January first, two thousand eleven, shall be approved for eligibility to subcontract with managed care plans in New York city through March thirty-first, two thousand fifteen.

6. No provider shall be approved as eligible to provide home care services to managed care beneficiaries unless it compensates all its home care employees in compliance with the provisions of section thirty-six hundred fourteen-c of the public health law.

7. For the New York city social services district, no provider shall be approved unless the total dollar value of all employee compensation paid by the provider to its home care employees who were employees in the medicaid personal care program as of January first, two thousand eleven, inclusive of wages, benefits, payments in lieu of benefits, and paid time off, calculated on an average hourly basis, is no less than the most common prevailing level of total compensation paid to employees by agencies providing medicaid personal care program services under contract with the human resources administration as of January first, two thousand eleven, as determined by the human resources administration.

8. Providers of home care services to more than three hundred fifty managed long term care or long term home health care beneficiaries as of January first, two thousand eleven, must be afforded an opportunity to apply for approval to provide home care services to managed long term

care beneficiaries for periods beginning no later than April first, two thousand twelve, provided that all such applicants shall still be considered for approval in accordance with all otherwise applicable provisions of this section.

9. All approved providers, as well as all providers seeking approval to provide home care services to managed care beneficiaries shall furnish to the department of health or its designee, upon their request, all information necessary to implement any provision of this section.

10. For purposes of this section:

(a) home care services shall mean all services provided by home health aides, personal care aides, home attendants or other licensed or unlicensed personnel whose primary responsibilities include the provision of in home assistance with activities of daily living, instrumental activities of daily living, or health related tasks.

(b) providers of home care services shall mean licensed home care services agencies, consumer directed personal assistance programs or entities providing home care services to the Medicaid Personal Care Program under contract with the Human Resources Administration in New York city as of January first, two thousand eleven.

(c) The Medicaid Personal Care Program shall include all services provided under New York state's medical assistance program in New York city, including both the Home Attendant Program and the Consumer Directed Personal Assistance Program.

(d) "Managed care plan" means any managed care program or demonstration covering personal care or home health aide services, and which receives premiums funded, in whole or in part, by the New York state medical assistance program, including but not limited to all medicaid managed care, medicaid managed long term care, medicaid advantage, and

medicaid advantage plus plans, and all programs of all inclusive care for the elderly.

§ 34. The public health law is amended by adding a new section 2806-a to read as follows:

§ 2806-a. Temporary operator. 1. For the purposes of this section: (a) the term "established operator" shall mean the operator of a general hospital or a diagnostic and treatment center that has been established and issued an operating certificate as such pursuant to this article; and (b) the term "temporary operator" shall mean any person or entity that:

(i) agrees to operate the general hospital or a diagnostic and treatment center on a temporary basis in the best interests of the patients and the community served by the general hospital or by the diagnostic and treatment center; and

(ii) has demonstrated that he or she has the character, competence and financial ability to operate the general hospital or the diagnostic and treatment center in compliance with applicable standards.

2. (a) When a statement of deficiencies has been issued by the department and upon a determination by the commissioner that there exist significant management failures, including but not limited to administrative, operational or clinical deficiencies or financial instability, in a general hospital or in a diagnostic and treatment center that (i) seriously endanger the life, health or safety of patients or (ii) jeopardize existing or continued access to necessary services within the community, he or she shall appoint a temporary operator to assume sole control over and sole responsibility for the operations of that general hospital or diagnostic and treatment center. The appointment of a tempo-

rary operator shall be in addition to any other remedies provided by law.

(b) The established operator of a general hospital or a diagnostic and treatment center may at any time request the commissioner to appoint a temporary operator. Upon receiving such a request, the commissioner may, if he or she determines that such an action is necessary to restore or ensure the provision of quality care to the patients, enter into an agreement with the established operator for the appointment of a temporary operator to assume sole control over and sole responsibility for the operations of that general hospital or diagnostic and treatment center.

3. A temporary operator appointed pursuant to this section shall use his or her best efforts to correct or eliminate any deficiencies, management failures or financial instability in the general hospital or diagnostic and treatment center. Such correction or elimination of deficiencies, management failures or financial instability shall not include major alterations of the physical structure of the facility. During the term of his or her appointment, the temporary operator shall have the authority to direct the management of the general hospital or diagnostic and treatment center in all aspects of operation and shall be afforded full access to the accounts and records of the facility. The temporary operator shall, during this period, operate the general hospital or diagnostic and treatment center in such a manner as to ensure safety and the quality of health care for the patients. The temporary operator shall have the power to let contracts therefor or incur expenses on behalf of the general hospital or diagnostic and treatment center, provided that where individual items of repairs, improvements or supplies exceed ten thousand dollars, the temporary operator shall

obtain price quotations from at least three reputable sources. The temporary operator shall not be required to file any bond. No security interest in any real or personal property comprising the facility or contained within the facility, or in any fixture of the facility, shall be impaired or diminished in priority by the temporary operator. Neither the temporary operator nor the department shall engage in any activity that constitutes a confiscation of property without the payment of fair compensation.

4. The temporary operator shall be entitled to a reasonable fee, as determined by the commissioner, and necessary expenses incurred during his or her performance as temporary operator, to be paid from the revenue of the general hospital or diagnostic and treatment center. The temporary operator shall collect incoming payments from all sources and apply them first to the reasonable fee and to costs incurred in the performance of his or her functions as temporary operator. The temporary operator shall be liable only in his or her capacity as temporary operator for injury to person and property by reason of conditions of the general hospital or diagnostic and treatment center in a case where an established operator would have been liable; he or she shall not have any liability in his or her personal capacity, except for gross negligence and intentional acts.

5. The initial term of the appointment of the temporary operator shall not exceed one hundred twenty days. Additional appointments of up to ninety days may be made when the commissioner determines that additional terms are necessary to correct the deficiencies, management failures or financial instability that required the appointment of the temporary operator. 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 a report describing the actions taken during the appointment to address such deficiencies, management failures and/or financial instability. The report shall reflect best efforts to produce a full and complete accounting.

6. The commissioner shall, upon making a determination to appoint a temporary operator pursuant to paragraph (a) of subdivision two of this section, cause the established operator of the general hospital or diagnostic and treatment center to be notified of the determination by registered or certified mail addressed to the principal office of the established operator. Upon receipt of such notification at the principal office of the established operator and before the expiration of ten days thereafter, the established operator may request an administrative hearing on the determination to be held no later than sixty days from the date of the appointment of the temporary operator. Any such hearing shall be strictly limited to the issue of whether the determination of the commissioner is supported by substantial evidence.

7. No provision contained in this section shall be deemed to relieve the established operator or any other person of any civil or criminal liability incurred, or any duty imposed by law, by reason of acts or omissions of the established operator or any other person prior to the appointment of any temporary operator hereunder; nor shall anything contained in this section be construed to suspend during the term of the appointment of the temporary operator any obligation of the established operator or any other person for the payment of taxes or other operating and maintenance expenses of the facility nor of the established operator or any other person for the payment of mortgages or liens.

§ 35. The public health law is amended by adding a new article 29-AA to read as follows:

ARTICLE 29-AA

PATIENT CENTERED MEDICAL HOMES

Section 2959-a. Multipayor patient centered medical home program.

§ 2959-a. Multipayor patient centered medical home program. 1. Notwithstanding any inconsistent provision of law, the commissioner is authorized to establish a program whereby enhanced payments are made to clinicians and clinics statewide that are certified as medical homes for the purpose of improving health care outcomes and efficiency through patient care continuity and coordination of health services.

2. Medical homes certified pursuant to this section may provide services to: recipients eligible for medical assistance pursuant to title eleven of article five of the social services law ("Medicaid fee-for-service"); enrollees eligible for medical assistance pursuant to such title and enrolled in approved managed care organizations pursuant to section three hundred sixty-four-j of such title ("Medicaid managed care"); enrollees eligible for family health plus and enrolled in approved organizations pursuant to title eleven-D of article five of the social services law ("family health plus"); enrollees eligible for the child health insurance program and enrolled in approved organizations pursuant to title one-A of article twenty-five of this chapter ("child health plus program"); enrollees and subscribers of commercial managed care plans operating in accordance with the provisions of article forty-four of this chapter or by health maintenance organizations organized and operating in accordance with article forty-three of the insurance law; enrollees and subscribers of other commercial insurance products; and employees of employer-sponsored self-insured plans.

3. (a) In order to promote improved quality of, and access to, health care services and promote improved clinical outcomes, it is the policy

of the state to encourage cooperative, collaborative and integrative arrangements among payors of health care services and health care services providers who might otherwise be competitors, under the active supervision of the commissioner. It is the intent of the state to supplant competition with such arrangements only to the extent necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws to payors of health care services and health care services providers with respect to the planning, implementation and operation of the multipayor patient centered medical home program.

(b) The commissioner or his or her duly authorized representative may engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws, and may inspect or request additional documentation from payors of health care services and health care services providers to verify that medical homes certified pursuant to this section operate in accordance with its intent and purpose.

4. The commissioner is authorized to participate in, actively supervise, facilitate and approve multiple primary care medical home collaboratives around the state with health care services providers, which may include hospitals, diagnostic and treatment centers, and private practices, and payors of health care services, including employers, health plans and insurers, to establish: (a) the boundaries of each program and the providers eligible to participate; (b) practice standards for each medical home program consistent with existing standards developed by national accrediting and professional organizations, including but not limited to the joint principles of the American College of Physicians ("ACP"), the American Academy of Family Physicians ("AAFP"), the Ameri-

can Academy of Pediatrics ("AAP"), and the American Osteopathic Association ("AOA"), and standards developed by the National Committee for Quality Assurance ("NCQA"); (c) methodologies by which payors will provide enhanced rates of payment to certified medical homes; and (d) methodologies to pay additional amounts for medical homes that meet specific process or outcome standards established by each multipayor patient centered medical home collaborative.

5. The commissioner is authorized to establish an advisory group of state agencies and stakeholders, such as professional organizations and associations, to identify legal and/or administrative barriers to the sharing of care management and care coordination services among participating health care services providers and to make recommendations for statutory and/or regulatory changes to address such barriers.

6. Patient, payor and health care services provider participation in the multipayor patient centered medical home program shall be on a voluntary basis.

7. Clinics and clinicians participating under the Adirondack medical home multipayor demonstration program established pursuant to section twenty-nine hundred fifty-nine of this chapter, or the statewide patient centered medical home program established pursuant to section three hundred sixty-four-m of the social services law, are not eligible for enhanced payments pursuant to this section.

8. Subject to the availability of funding and federal financial participation, the commissioner is authorized:

(a) To pay enhanced rates of payment under Medicaid fee-for-service, Medicaid managed care, family health plus and child health plus to clinics and clinicians that are certified as patient centered medical homes under this title;

(b) To pay additional amounts for medical homes that meet specific process or outcome standards specified by the commissioner in consultation with each multipayor patient centered medical home collaborative; and

(c) To test new models of payment to high volume Medicaid primary care medical home practices that incorporate risk adjusted global payments combined with care management and pay for performance adjustments.

9. (a) The commissioner is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or entities chosen to assist in the implementation of the health home provisions of section three hundred sixty-five-l of the social services law. Responsibilities of the contractor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and preparation of reports.

(b) 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 paragraph (a) of this subdivision without a competitive bid or request for proposal process, provided, however, that:

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

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) 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

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

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

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

§ 36. Subparagraph (xi) of paragraph (b) of subdivision 35 of section 2807-c of the public health law, as added by section 2 of part C of chapter 58 of the laws of 2009, is amended and three new subparagraphs (xii), (xiii) and (xiv) are added to read as follows:

(xi) Rates for teaching general hospitals shall include reimbursement for direct and indirect graduate medical education as defined and calculated pursuant to such regulations. In addition, such regulations shall specify the reports and information required by the commissioner to assess the cost, quality and health system needs for medical education provided[.];

(xii) Such regulations may incorporate quality related measures pertaining to potentially preventable conditions and complications, including, but not limited to, diseases or complications of care acquired in the hospital and injuries sustained in the hospital;

(xiii) Such regulations may incorporate quality related measures pertaining to the inappropriate use of certain medical procedures,

including, but not limited to, cesarean deliveries, coronary artery bypass grafts and percutaneous coronary interventions;

(xiv) Such regulations may impose a fee on general hospital sufficient to cover the costs of auditing the institutional cost reports submitted by general hospitals.

§ 37. The social services law is amended by adding a new section 365-l to read as follows:

§ 365-l. Health homes. 1. Notwithstanding any law, rule or regulation to the contrary, the commissioner of health is authorized, in consultation with the commissioners of the office of mental health, office of alcoholism and substance abuse services, and office for people with developmental disabilities, to (a) establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to Medicaid enrollees with chronic conditions, (b) establish payment methodologies for health home services based on factors including but not limited to the complexity of the conditions providers will be managing, the anticipated amount of patient contact needed to manage such conditions, and the health care cost savings realized by provision of health home services, (c) establish the criteria under which a Medicaid enrollee will be designated as being an eligible individual with chronic conditions for purposes of this program, (d) assign any Medicaid enrollee designated as an eligible individual with chronic conditions to a provider of health home services.

2. In addition to payments made for health home services pursuant to subdivision one of this section, the commissioner is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner.

3. Until such time as the commissioner obtains necessary waivers of the federal social security act, Medicaid enrollees assigned to providers of health home services will be allowed to opt out of such services.

4. Payments authorized pursuant to this section will be made with state funds only, to the extent that such funds are appropriated therefore, until such time as federal financial participation in the costs of such services is available.

5. The commissioner is authorized to submit amendments to the state plan for medical assistance and/or submit one or more applications for waivers of the federal social security act, to obtain federal financial participation in the costs of health home services provided pursuant to this section, and as provided in subdivision three of this section.

6. Notwithstanding any limitations imposed by section three hundred sixty-four-l of this title on entities participating in demonstration projects established pursuant to such section, the commissioner is authorized to allow such entities which meet the requirements of this section to provide health home services.

7. Notwithstanding any law, rule, or regulation 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 jointly establish a single set of operating and reporting requirements and a single set of construction and survey requirements for entities that:

(a) can demonstrate experience in the delivery of health, and mental health and/or alcohol and substance abuse services and/or services to persons with developmental disabilities, and the capacity to offer integrated delivery of such services in each location approved by the commissioner; and

(b) meet the standards established pursuant to subdivision one of this section for providing and receiving payment for health home services; provided, however, that an entity meeting the standards established pursuant to subdivision one of this section shall not be required to be an integrated service provider pursuant to this subdivision.

In establishing a single set of operating and reporting requirements and a single set of construction and survey requirements for entities described in this subdivision, the commissioners of the department of health, the office of mental health, the office for people with develop-mental disabilities, and the office of alcoholism and substance abuse services are authorized to waive any regulatory requirements as are necessary to avoid duplication of requirements and to allow the inte-grated delivery of services in a rational and efficient manner.

8. (a) The commissioner of health is authorized to contract with one or more entities to assist the state in implementing the provisions of this section. Such entity or entities shall be the same entity or enti-ties chosen to assist in the implementation of the multipayor patient centered medical home program pursuant to section twenty-nine hundred fifty-nine-a of the public health law. Responsibilities of the contrac-tor shall include but not be limited to: developing recommendations with respect to program policy, reimbursement, system requirements, reporting requirements, evaluation protocols, and provider and patient enrollment; providing technical assistance to potential medical home and health home providers; data collection; data sharing; program evaluation, and prepa-ration of reports.

(b) 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 of health is authorized to enter into a contract or contracts under paragraph (a) of this subdivision without a competitive bid or request for proposal process, provided, however, that:

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

(1) A description of the proposed services to be provided pursuant to the contract or contracts;

(2) The criteria for selection of a contractor or contractors;

(3) 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

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

(ii) All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health; and

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

§ 38. Intentionally Omitted.

§ 39. Intentionally Omitted.

§ 40. Paragraph (u) of subdivision 2 of section 365-a of the social services law, as amended by section 42 of part B of chapter 58 of the laws of 2010, is amended to read as follows:

(u) screening, brief intervention, and referral to treatment [**in hospital outpatient and emergency departments and free-standing diagnostic and treatment centers**] of individuals at risk for substance abuse including referral to the appropriate level of intervention and treat-

ment in a community setting; provided, however, that the provisions of this paragraph relating to screening, brief intervention, and referral to treatment services shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in such costs.

§ 41. Paragraphs (d) and (e) of subdivision 1 and paragraphs (c) and (d) of subdivision 2 of section 4403-f of the public health law, paragraph (d) of subdivision 1 as amended by section 6 of part C of chapter 58 of the laws of 2007, paragraph (e) of subdivision 1 as amended by section 65-d of part A of chapter 57 of the laws of 2006, paragraph (c) of subdivision 2 as added by chapter 659 of the laws of 1997 and paragraph (d) of subdivision 2 as amended by section 9 of part C of chapter 58 of the laws of 2007, and paragraphs (d) and (e) of subdivision 1 as relettered by section 7 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

(d) [**"Approved managed long term care demonstration" means the sites approved by the commissioner to participate in the "Evaluated Medicaid Long Term Care Capitation Program".**

(e)] "Health and long term care services" means services including, but not limited to [**primary care, acute care,**] home and community-based and institution-based long term care and ancillary services (that shall include medical supplies and nutritional supplements) that are necessary to meet the needs of persons whom the plan is authorized to enroll. **The managed long term care plan may also cover primary care and acute care if so authorized.**

(c) [**a description that demonstrates the cost-effectiveness of the program as compared to the cost of services clients would otherwise have received;**

[**(d)**] adequate documentation of the appropriate licenses, certifications or approvals to provide care as planned, including contracts with such providers as may be necessary to provide the full complement of services required to be provided under this section.

§ 41-a. Subdivision 3 of section 4403-f of the public health law, as amended by chapter 627 of the laws of 2008, is amended to read as follows:

3. Certificate of authority; approval. The commissioner shall not approve an application for a certificate of authority unless the applicant demonstrates to the commissioner's satisfaction:

(a) [**the relative cost effectiveness to the medical assistance program when compared to other managed long term care plans proposing to serve, or serving, comparable populations;**

(b)] that it will have in place acceptable quality-assurance mechanisms, grievance procedures, mechanisms to protect the rights of enrollees and case management services to ensure continuity, quality, appropriateness and coordination of care;

[**(c)**] **(b)** that it will include an enrollment process which shall ensure that enrollment in the plan is informed [**and voluntary by enrollees or their representatives and a voluntary disenrollment process**]. The application shall [**include the specific grounds that would warrant involuntary disenrollment provided, however,**] **describe the disenrollment process, which shall provide that** an otherwise eligible enrollee shall not be involuntarily disenrolled on the basis of health status;

[**(d)**] **(c)** satisfactory evidence of the character and competence of the proposed operators and reasonable assurance that the applicant will provide high quality services to an enrolled population;

[**(e)**] **(d)** sufficient management systems capacity to meet the requirements of this section and the ability to efficiently process payment for covered services;

[**(f)**] **(e)** readiness and capability to [**achieve full capitation for services reimbursed pursuant to title XVIII of the federal social security act or, for an applicant designated as an eligible applicant prior to April first, two thousand seven pursuant to paragraph (d) of subdivision six of this section that has its principal place of business in Bronx county and is unable to achieve such full capitation, readiness and capability to achieve full capitation on a scheduled basis for**] **maximize reimbursement of and coordinate** services reimbursed pursuant to title XVIII of the federal social security act [**or capability and protocols for benefit coordination for services reimbursed pursuant to such title**] and all other applicable benefits, with such benefit coordination including, but not limited to, measures to support sound clinical decisions, reduce administrative complexity, coordinate access to services, maximize benefits available pursuant to such title and ensure that necessary care is provided;

[**(g)**] **(f)** readiness and capability to [**achieve full capitation for**] **arrange and manage covered services and coordinate other** services reimbursed pursuant to title XIX of the federal social security act;

[**(h)**] **(g)** willingness and capability of taking, or cooperating in, all steps necessary to secure and integrate any potential sources of funding for services provided by the managed long term care plan, including, but not limited to, funding available under titles XVI, XVIII, XIX and XX of the federal social security act, the federal older Americans act of nineteen hundred sixty-five, as amended, or any successor provisions subject to approval of the director of the state office for aging, and

through financing options such as those authorized pursuant to section three hundred sixty-seven-f of the social services law;

[**(i)**] **(h)** that the **contractual** arrangements for **providers of** health and long term care services **in the benefit package are sufficient to** ensure the availability and accessibility of such services to the proposed enrolled population **consistent with guidelines established by the commissioner; with respect to individuals in receipt of such services prior to enrollment, such guidelines shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care**; and

[**(j)**] **(i)** that the applicant is financially responsible and may be expected to meet its obligations to its enrolled members.

§ 41-b. Subdivisions 5, 6, 7 and 10 of section 4403-f of the public health law, subdivision 5 as amended by section 15 of part C of chapter 58 of the laws of 2007, subdivisions 6 and 7 as added by chapter 659 of the laws of 1997, paragraphs (a), (b) and (c) of subdivision 6 as amended by section 6 of part C of chapter 58 of the laws of 2010, paragraph (d) of subdivision 6 as amended by section 17 of part C of chapter 58 of the laws of 2007, paragraphs (c) and (d) of subdivision 7 as amended by section 18 of part C of chapter 58 of the laws of 2007, paragraphs (e) and (g) of subdivision 7 as relettered by section 20 of part C of chapter 58 of the laws of 2007, paragraph (h) of subdivision 7 as added by section 65-c of part A of chapter 57 of the laws of 2006, paragraph (i) as added by section 65-f of part A of chapter 57 of the laws of 2006, and such paragraphs (h) and (i) as relettered by section 20 of part C of chapter 58 of the laws of 2007, paragraph (f) of subdivision 7 as amended by section 7 of part C of chapter 58 of the laws of 2010, subparagraph (iii) of paragraph (h) of subdivision 7 as amended by

section 19 of part C of chapter 58 of the laws of 2007, subdivision 10 as amended by chapter 192 of the laws of 2006 and renumbered by section 22 of part C of chapter 58 of the laws of 2007, are amended to read as follows:

5. Applicability of other laws. A managed long term care plan [**or approved managed long term care demonstration**] shall be subject to the provisions of the insurance law and regulations applicable to health maintenance organizations, this article and regulations promulgated pursuant thereto. To the extent that the provisions of this section are inconsistent with the provisions of this chapter or the provisions of the insurance law, the provisions of this section shall prevail.

6. Approval authority. (a) An applicant shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that the applicant complies with the operating requirements for a managed long term care plan under this section. The commissioner shall issue no more than [**fifty**] **seventy-five** certificates of authority to managed long term care plans pursuant to this section. [**For purposes of issuance of no more than fifty certificates of authority, such certificates shall include those certificates issued pursuant to paragraphs (b) and (c) of this subdivision.**]

(b) An operating demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. [**Except as otherwise expressly provided in paragraphs (d) and (e) of subdivision seven of this section, nothing**] **Nothing** in this section shall be construed to affect the continued legal authority of an operating demonstration to operate its previously approved program.

[**(c) An approved managed long term care demonstration shall be issued a certificate of authority as a managed long term care plan upon a determination by the commissioner that such demonstration complies with the operating requirements for a managed long term care plan under this section. Notwithstanding any inconsistent provision of law to the contrary, all authority for the operation of approved managed long term care demonstrations which have not been issued a certificate of authority as a managed long term care plan, shall expire one year after the adoption of regulations implementing managed long term care plans.**

(d) The majority leader of the senate and the speaker of the assembly may each designate in writing up to fifteen eligible applicants to apply to be approved managed long term care demonstrations or plans. The commissioner may designate in writing up to eleven eligible applicants to apply to be approved managed long term care demonstrations or plans.]

7. Program oversight and administration. (a)(i) The commissioner shall promulgate regulations to implement this section and to ensure the quality, appropriateness and cost-effectiveness of the services provided by managed long term care plans. The commissioner may waive rules and regulations of the department, including but not limited to, those pertaining to duplicative requirements concerning record keeping, boards of directors, staffing and reporting, when such waiver will promote the efficient delivery of appropriate, quality, cost-effective services and when the health, safety and general welfare of enrollees will not be impaired as a result of such waiver. In order to achieve managed long term care plan system efficiencies and coordination and to promote the objectives of high quality, integrated and cost effective care, the commissioner may establish a single coordinated surveillance process, allow for a comprehensive quality improvement and review process to meet

component quality requirements, and require a uniform cost report. The commissioner shall require managed long term care plans to utilize quality improvement measures, based on health outcomes data, for internal quality assessment processes and may utilize such measures as part of the single coordinated surveillance process.

(ii) Notwithstanding any inconsistent provision of the social services law to the contrary, the commissioner shall, pursuant to regulation, determine whether and the extent to which the applicable provisions of the social services law or regulations relating to approvals and authorizations of, and utilization limitations on, health and long term care services reimbursed pursuant to title XIX of the federal social security act, including, but not limited to, fiscal assessment requirements, are inconsistent with the flexibility necessary for the efficient administration of managed long term care plans and such regulations shall provide that such provisions shall not be applicable to enrollees or managed long term care plans, provided that such determinations are consistent with applicable federal law and regulation.

(b) The commissioner shall, to the extent necessary, submit the appropriate waivers, including, but not limited to, those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act, or successor provisions, and any other waivers necessary to achieve the purposes of high quality, integrated, and cost effective care and integrated financial eligibility policies under the medical assistance program or pursuant to title XVIII of the federal social security act. **In addition, the commissioner is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections eleven hundred fifteen and nineteen hundred fifteen of the federal social security act or successor**

provisions, and any other waivers necessary to require medical assistance recipients who are twenty-one years of age or older and who require community-based long term care services, as specified by the commissioner, for more than one hundred and twenty days, to receive such services through an available plan certified pursuant to this section or other care coordination program specified by the commissioner. Copies of such original waiver applications shall be provided to the chairman of the senate finance committee and the chairman of the assembly ways and means committee simultaneously with their submission to the federal government. **The commissioner shall develop a workgroup to further evaluate and promote the transition of persons in receipt of home and community-based long term care services into managed long term care plans and other care coordination models.**

(c)(i) A managed long term care plan shall not use deceptive or coercive marketing methods to encourage participants to enroll. A managed long term care plan shall not distribute marketing materials to potential enrollees before such materials have been approved by the commissioner.

(ii) The commissioner shall ensure, through periodic reviews of managed long term care plans, that enrollment was [**a voluntary and**] **an** informed choice; such plan has only enrolled persons whom it is authorized to enroll, and plan services are promptly available to enrollees when appropriate. Such periodic reviews shall be made according to standards as determined by the commissioner in regulations.

(d) Notwithstanding any provision of law, rule or regulation to the contrary, the commissioner may issue a request for proposals to carry out reviews of enrollment and assessment activities in managed long term care plans and operating demonstrations with respect to enrollees eligi-

ble to receive services under title XIX of the federal social security act to determine if enrollment meets the requirements of subparagraph (ii) of paragraph (c) of this subdivision; and that assessments of such enrollees' health, functional and other status, for the purpose of adjusting premiums, were accurate. [**Evaluations shall address each bidder's ability to ensure that enrollments in such plans are promptly reviewed and that medical assistance required to be furnished pursuant to title eleven of article five of the social services law will be appropriately furnished to the recipients for whom the local commissioners are responsible pursuant to section three hundred sixty-five of such title and that plan implementation will be consistent with the proper and efficient administration of the medical assistance program and managed long term care plans.**]

(e) The commissioner may, in his or her discretion for the purpose of protection of enrollees, impose measures including, but not limited to, bans on further enrollments and requirements for use of enrollment brokers until any identified problems are resolved to the satisfaction of the commissioner.

(f) Continuation of a certificate of authority issued under this section shall be contingent upon satisfactory performance by the managed long term care plan in the delivery, continuity, accessibility, cost effectiveness and quality of the services to enrolled members; compliance with applicable provisions of this section and rules and regulations promulgated thereunder; the continuing fiscal solvency of the organization; and, federal financial participation in payments on behalf of enrollees who are eligible to receive services under title XIX of the federal social security act.

(g) [**The commissioner shall ensure that (i) a process exists for the resolution of disputes concerning the accuracy of assessments performed pursuant to paragraphs (d) and (e) of this subdivision; and (ii) the tasks described in paragraphs (d) and (e) of this subdivision are consistently administered.**

(h)] (i) Managed long term care plans and demonstrations may enroll eligible persons in the plan or demonstration upon the completion of a comprehensive assessment that shall include, but not be limited to, an evaluation of the medical, social and environmental needs of each prospective enrollee in such program. This assessment shall also serve as the basis for the development and provision of an appropriate plan of care for the [**prospective**] enrollee. **Upon approval of federal waivers pursuant to paragraph (b) of this subdivision which require medical assistance recipients who require community-based long term care services to enroll in a plan, and upon approval of the commissioner, a plan may enroll an applicant who is currently receiving home and community-based services and complete the comprehensive assessment within thirty days of enrollment provided that the plan continues to cover transitional care until such time as the assessment is completed.**

(ii) The assessment shall be completed by a representative of the managed long term care plan or demonstration, in consultation with the prospective enrollee's health care practitioner **as necessary**. The commissioner shall prescribe the forms on which the assessment shall be made.

(iii) The [**completed assessment and documentation of the**] enrollment **application** shall be submitted by the managed long term care plan or demonstration to the [**local department of social services, or to a contractor selected pursuant to paragraph (d) of this subdivision,**]

entity designated by the department prior to the commencement of services under the managed long term care plan or demonstration. For purposes of reimbursement of the managed long term care plan or demonstration, if the [**completed assessment and documentation are**] **enrollment application is** submitted on or before the twentieth day of the month, the enrollment shall commence on the first day of the month following the completion and submission and if the [**completed assessment and documentation are**] **enrollment application is** submitted after the twentieth day of the month, the enrollment shall commence on the first day of the second month following submission. Enrollments conducted by a plan or demonstration shall be subject to review and audit by the department [**and by the local social services district**] or a contractor selected pursuant to paragraph (d) of this subdivision.

(iv) Continued enrollment in a managed long term care plan or demonstration paid for by government funds shall be based upon a comprehensive assessment of the medical, social and environmental needs of the recipient of the services. Such assessment shall be performed at least [**annually**] **every six months** by the managed long term care plan serving the enrollee. The commissioner shall prescribe the forms on which the assessment will be made.

[**(i)**] **(h)** The commissioner shall, upon request by a managed long term care plan[**, approved managed long term care demonstration,**] or operating demonstration, and consistent with federal regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, share with such plan or demonstration the following data if it is available:

(i) information concerning utilization of services and providers by each of its enrollees prior to and during enrollment, including but not

limited to utilization of emergency department services, prescription drugs, and hospital and nursing facility admissions.

(ii) aggregate data concerning utilization and costs for enrollees and for comparable cohorts served through the Medicaid fee-for-service program.

10. [**The**] **Notwithstanding any inconsistent provision to the contrary, the enrollment and disenrollment process and** services provided or arranged by all operating demonstrations or any program that receives designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, **must meet all applicable federal requirements. Services** may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services.

§ 42. The social services law is amended by adding a new section 365-m to read as follows:

§ 365-m. Administration and management of behavioral health services. 1. The commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the commissioner of health and with the approval of the division of the

budget, shall have responsibility for jointly designating regional entities to provide administrative and management services for the purposes of prior approving and coordinating the provision of behavioral health services, and integrating such behavioral health services with other services available under this title, for recipients of medical assistance who are not enrolled in managed care, and for such approval, coordination, and integration of behavioral health services that are not provided through managed care programs under this title for individuals regardless of whether or not such individuals are enrolled in managed care programs. Such regional entities shall also be responsible for safeguarding against unnecessary utilization of such care and services and assuring that payments are consistent with the efficient and economical delivery of quality care.

2. In exercising this responsibility, the commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to contract, after consultation with the commissioner of health, with regional behavioral health organizations or other entities. Such contracts may include responsibility for receipt, review, and determination of prior authorization requests for behavioral health care and services, consistent with criteria established or approved by the commissioners of mental health and alcoholism and substance abuse services, and authorization of appropriate care and services based on documented patient medical need.

3. 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 to the contrary, the commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to

enter into a contract or contracts under subdivisions one and two of this section without a competitive bid or request for proposal process, provided, however, that:

(a) the office of mental health and the office of alcoholism and substance abuse services shall post on their websites, for a period of no less than thirty days:

(i) a description of the proposed services to be provided pursuant to the contractor 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 commissioners; and

(c) the commissioners of the office of mental health and the office of alcoholism and substance abuse services, in consultation with the commissioner of health, shall select such contractor or contractors that, in their discretion, have demonstrated the ability to effectively, efficiently, and economically integrate behavioral health and health services; have the requisite expertise and financial resources; have demonstrated that their directors, sponsors, members, managers, partners or operators have the requisite character, competence and standing in the community, and are best suited to serve the purposes of this section.

4. The commissioners of the office of mental health, the office of alcoholism and substance abuse services and the department of health, shall have the responsibility for jointly designating on a regional basis, after consultation with the city of New York's local social services district and local governmental unit, as such term is defined in the mental hygiene law, and after consultation of other affected counties, a limited number of specialized managed care plans, special need managed care plans, and/or integrated physical and behavioral health provider systems capable of managing the behavioral and physical health needs of medical assistance enrollees with significant behavioral health needs. Initial designations of such plans or provider systems should be made no later than April first, two thousand thirteen, provided, however, such designations shall be contingent upon a determination by such state commissioners that the entities to be designated have the capacity and financial ability to provide services in such plans or provider systems, and that the region has a sufficient population and service base to support such plans and systems. Once designated, the commissioner of health shall make arrangements to enroll such enrollees in such plans or integrated provider systems and to pay such plans or provider systems on a capitated or other basis to manage, coordinate, and pay for behavioral and physical health medical assistance services for such enrollees. Notwithstanding any inconsistent provision of section one hundred twelve and one hundred sixty-three of the state finance law, and section one hundred forty-two of the economic development law, or any other law to the contrary, the designations of such plans and provider systems, and any resulting contracts with such plans, providers or provider systems are authorized to be entered into by such state commissioners without a competitive bid or request for proposal

process. Oversight of such contracts with such plans, providers or provider systems shall be the joint responsibility of such state commissioners, and for contracts affecting the city of New York, also with the city's local social services district and local governmental unit, as such term is defined in the mental hygiene law.

§ 43. Paragraph (c) of subdivision 6 of section 367-a of the social services law, as amended by chapter 41 of the laws of 1992 and subparagraph (iii) as amended by section 47 of part C of chapter 58 of the laws of 2009, is amended to read as follows:

(c) (i) Co-payments charged pursuant to this subdivision for non-institutional services shall not exceed the following table, provided, however, that the department may establish standard co-payments for services based upon the average or typical payment for that service:

State's payment for the services	Maximum co-payment chargeable to recipient
$10 or less	$[**.50**] **.60**
$10.01 to $25	$[**1.00**] **1.15**
$25.01 to $50	$[**2.00**] **2.30**
$50.01 or more	$[**3.00**] **3.40**

(ii) co-payments charged pursuant to this subdivision for each discharge for inpatient care shall be [**twenty-five**] **thirty** dollars.

(iii) Notwithstanding any other provision of this paragraph, co-payments charged for each generic prescription drug dispensed shall be one dollar **and fifteen cents** and for each brand name prescription drug dispensed shall be three dollars **and forty cents**; provided, however, that the co-payments charged for each brand name prescription drug on

the preferred drug list established pursuant to section two hundred seventy-two of the public health law and the co-payments charged for each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision four of section three hundred sixty-five-a of this title shall be one dollar **and fifteen cents**.

(iv) The co-payment for emergency room services provided for non-urgent or non-emergency medical care shall be six dollars and forty cents; provided however that co-payments pursuant to this subparagraph shall not be required with respect to emergency services or family planning services and supplies.

§ 44. Paragraph (d) of subdivision 6 of section 367-a of the social services law is amended by adding six new subparagraphs (ix), (x), (xi), (xii), (xiii), and (xiv) to read as follows:

(ix) vision care;

(x) dental services;

(xi) audiology services;

(xii) physician services;

(xiii) nurse practitioner services;

(xiv) rehabilitation services including occupational therapy; physical therapy and speech therapy;

§ 45. Subparagraph (ii) of paragraph (f) of subdivision 6 of section 367-a of the social services law, as amended by section 42 of part C of chapter 58 of the laws of 2005, is amended and a new subparagraph (iii) is added to read as follows:

(ii) In the year commencing April first, two thousand five and for each year thereafter, **and ending in the year concluding on March thirty-first, two thousand eleven,** no recipient shall be required to pay more than a total of two hundred dollars in co-payments required by this

subdivision, nor shall reductions in payments as a result of such co-payments exceed two hundred dollars for any recipient.

(iii) In the year commencing April first, two thousand eleven and for each year thereafter, no recipient shall be required to pay more than a total of three hundred dollars in co-payments required by this subdivision, nor shall reductions in payments as a result of such co-payments exceed three hundred dollars for any recipient.

§ 46. Subdivision 2-a of section 369-ee of the social services law, as amended by section 26 of part E of chapter 63 of the laws of 2005, is amended to read as follows:

2-a. Co-payments. Subject to federal approval pursuant to subdivision six of this section, persons receiving family health plus coverage under this section shall be responsible to make co-payments in accordance with the terms of subdivision six of section three hundred sixty-seven-a of this article, including those individuals who are otherwise exempted under the provisions of subparagraph (iv) of paragraph (b) of subdivision six of section three hundred sixty-seven-a of this article, provided however, that notwithstanding the provisions of paragraphs (c) and (d) of such subdivision:

(i) co-payments charged for each generic prescription drug dispensed shall be three dollars and for each brand name prescription drug dispensed shall be six dollars;

(ii) the co-payment charged for each dental service visit shall be five dollars, provided that no enrollee shall be required to pay more than twenty-five dollars per year in co-payments for dental services; [**and**]

(iii) the co-payment for clinic services [**and**]**,** physician services**,** **and nurse practitioner services** shall be five dollars; **and**

(iv) the co-payment for emergency room services provided for non-urgent or non-emergency medical care shall be six dollars and forty cents; provided however that co-payments pursuant to this paragraph shall not be required with respect to emergency services or family planning services and supplies;

and provided further that the limitations in paragraph (f) of such subdivision shall not apply.

§ 47. Section 2510 of the public health law is amended by adding a new subdivision 13 to read as follows:

13. "Co-payment" means a payment made on behalf of an eligible child to a health care provider for a covered health care service provided to such child in an amount to be determined by the commissioner consistent with federal standards and specified in applicable contracts. Aggregate co-payment amounts collected by health care providers pursuant to this subdivision shall not exceed three hundred dollars per year per eligible child.

§ 47-a. Subdivision 8 of section 2511 of the public health law is amended by adding three new paragraphs (f), (g) and (h) to read as follows:

(f) The commissioner shall adjust subsidy payments made to approved organizations on and after April first, two thousand eleven through March thirty-first, two thousand twelve, so that the amount of each such payment is reduced by one and seven-tenths percent.

(g) Effective October first, two thousand eleven, the commissioner shall reduce subsidy payments made to approved organizations to reflect estimated collections of co-payment amounts imposed pursuant to subdivision thirteen of section twenty-five hundred ten of this title and as specified in applicable contracts based on the number of covered health

care service visits reported by an approved organization on the Medicaid Managed Care Operating Report submitted to the department for the calendar year ending December thirty-first, two thousand ten and adjusted annually on July first to reflect the visits reported for the preceding calendar year.

(h) The commissioner may increase subsidy payments made to approved organizations that voluntarily participate in the multi-payor patient centered medical home program to reflect additional costs associated with enhanced payments made to certified medical homes by approved organizations as required by article twenty-nine-AA of this chapter.

§ 48. The public health law is amended by adding a new section 2997-d to read as follows:

§ 2997-d. Hospital, nursing home, home care, special needs assisted living residences and enhanced assisted living residences palliative care support. 1. (a) "Palliative care" means health care treatment, including interdisciplinary end-of-life care, and consultation with patients and family members, to prevent or relieve pain and suffering and to enhance the patient's quality of life, including hospice care under article forty of this chapter.

(b) "Appropriate" has the same meaning as paragraph (a) of subdivision one of section twenty-nine hundred ninety-seven-c of this title.

2. General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article forty-six-B of this chapter shall establish policies and procedures to provide patients with advanced life limiting conditions and illnesses who might benefit from palliative care and pain management services with access to information

and counseling regarding palliative care and pain management options appropriate to the patient. Policies must include provision for patients who lack capacity to make medical decisions, so that access to such information and counseling shall be provided to the persons who are legally authorized to make medical decisions on behalf of such patients.

3. General hospitals, nursing homes, organizations licensed or certified pursuant to article thirty-six of this chapter, and organizations licensed as special needs assisted living residences or enhanced assisted living residences pursuant to article forty-six-B of this chapter shall facilitate access to appropriate palliative care and pain management consultations and services including but not limited to referrals consistent with patient needs and preferences.

§ 49. The commissioner of health shall establish a workgroup comprised of county officials, representatives of the nursing home industry, representatives of organized labor unions, representatives from the department of health and the division of budget, and any other interested individuals or representatives to develop a plan and the necessary legislation to establish a public benefit corporation for the purpose of operating and managing public nursing homes.

The workgroup shall prepare and submit a report and draft legislation to the governor and the legislature no later than November 1, 2011.

§ 50. Legislative findings. Legislative intent. The legislature finds that integration and coordination of health care services is essential to the improvement of health care quality, efficiency, access and outcomes. The federal Patient Protection and Affordable Care Act creates several health system demonstration and pilot programs, intended to promote and assess delivery system and payment reforms, that require integration of services, coordination among providers, or a combination

of the two. Expanding these programs to include non-governmental payers may strengthen their impact, but will require collaboration among competing payers. In addition, collaborative arrangements among, or consolidation of, providers may be necessary to preserve access to essential services in some communities, while improving the quality of the services they provide and the efficiency of their operations, as well as minimizing unnecessary increases in the cost of care.

Federal and state antitrust laws may prohibit or discourage such collaboration or consolidation beneficial to residents of New York state, given their potential for, or actual, reduction in competition. The legislature finds that such agreements should be permitted and encouraged. Under these circumstances, competition as currently mandated by federal and state antitrust laws should be supplanted by a regulatory program to permit and encourage cooperative, collaborative and integrative agreements between health care providers, payers, and others, that are beneficial to New York residents when the benefits of such agreements outweigh any disadvantages caused by their potential or actual adverse effects on competition. Regulatory oversight of such arrangements should be provided to ensure that the benefits of such agreements outweigh any disadvantages attributable to any reduction in competition that may result from the agreements. Accordingly, the legislature intends to authorize a regulatory program to permit and oversee integration, consolidation, collaboration, and coordination among and between providers and payers, where necessary to assure access to essential health care services, to improve health care quality and outcomes, to enhance efficiency, or to minimize the cost of health care.

§ 51. The public health law is amended by adding a new article 29-E to read as follows:

ARTICLE 29-E

IMPROVED INTEGRATION OF HEALTH CARE AND FINANCING

Section 2999-aa. Antitrust provisions, state oversight.

2999-bb. Department authority.

§ 2999-aa. Antitrust provisions, state oversight. 1. In order to promote improved quality and efficiency of, and access to, health care services and to promote improved clinical outcomes to the residents of New York, it shall be the policy of the state to encourage cooperative, collaborative and integrative arrangements between health care providers, payers and others who might otherwise be competitors, under the active supervision of the commissioner. To the extent such arrangements might be anti-competitive within the meaning and intent of the state and federal antitrust laws, the intent of the state is to supplant competition with such arrangements as necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws with respect to activities undertaken by health care providers and others pursuant to this article, where the benefits of such arrangements outweigh any disadvantages likely to result from a reduction of competition.

2. The commissioner or his or her duly authorized representative may also engage in appropriate state supervision necessary to promote state action immunity under the state and federal antitrust laws.

§ 2999-bb. Department authority. The department shall promulgate regulations to implement this article. The department shall further be authorized to impose fees as appropriate to facilitate the implementation of this article. This article is not intended to limit the authority of the attorney general of the state of New York.

§ 52. Article 29-D of the public health law is amended by adding a new title 4 to read as follows:

Title 4

New York State Medical Indemnity Fund

§ 2999-g. Purpose of this Article. Creation of the New York state medical indemnity fund. There is hereby created the New York state medical indemnity fund (the "fund"). The purpose of the fund is to provide a funding source for certain costs associated with birth related neurological injuries, in order to reduce premium costs for medical malpractice insurance coverage.

§ 2999-h. Definitions. As used in this title, unless the context or subject matter requires otherwise:

(a) "Birth related neurological injury" means an injury to the brain or spinal cord of a live infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation or by other medical services provided or not provided during delivery admission that rendered the infant with a permanent and substantial motor impairment or with a developmental disability as that term is defined by section 1.03 of the mental hygiene law. This definition shall apply to live births only.

(b) "Fund" means the New York state medical indemnity fund.

(c) "Medically necessary health care costs" means the future medical, dental, rehabilitation, custodial, durable medical equipment, home

modifications, assistive technology, vehicle modifications, prescription and non-prescription medications, and other health care costs actually incurred for services rendered to and supplies utilized by qualified plaintiffs, which are medically necessary as that term is defined by the commissioner in regulation.

(d) "Qualified plaintiffs" means those plaintiffs who (i) have been found by a jury or court to have sustained a birth-related neurological injury as the result of medical malpractice, or (ii) have sustained a birth-related neurological injury as the result of alleged medical malpractice, and have settled their lawsuits therefor.

§ 2999-i. Custody and administration of the fund. (a) The commissioner of taxation and finance shall be the custodian of the fund. All payments from the fund shall be made by the commissioner of taxation and finance upon certificates signed by the superintendent of financial regulation, or his or her designee, as hereinafter provided. The fund shall be separate and apart from any other fund and from all other State monies. No monies from the fund shall be transferred to any other fund, nor shall any such monies be applied to the making of any payment for any purpose other than the purpose set forth in this title.

(b) The fund shall be administered by the superintendent of financial regulation or his or her designee in accordance with the provisions of this article.

(c) The expense of administering the fund, including the expenses incurred by the department, shall be paid from the fund.

(d) Monies for the fund will be provided pursuant to this chapter.

(e) Beginning April first, two thousand twelve and annually thereafter, the superintendent of financial regulation shall cause to be deposited into the fund, subject to available appropriations, an amount equal

to the difference between the amount appropriated to the fund in the preceding year, as increased by the adjustment factor defined in subdivision (g) of this section, and the assets of the fund at the conclusion of that fiscal year.

(f) Following the deposit referenced in subdivision (e) of this section, the superintendent of financial regulation shall conduct an actuarial calculation of the estimated liabilities of the fund for the coming year resulting from the qualified plaintiffs enrolled in the fund. The administrator shall from time to time adjust such calculation. If the total of all current estimates of liabilities equals eighty percent of the fund's assets, then the fund shall not accept any new enrollments until a new deposit has been made pursuant to subdivision (e) of this section. When, as a result of such new deposit, the fund's liabilities no longer exceed the fund's assets, the fund administrator shall enroll new qualified plaintiffs in the order that an application for enrollment has been submitted in accordance with subdivision six of section twenty-nine hundred ninety-nine-j of this title.

(g) For purposes of this section, the adjustment factor referenced in this section shall be the ten year rolling average 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.

§ 2999-j. Payments from the fund. 1. The fund shall be used to pay the (i) medically necessary health care costs of qualified plaintiffs, (ii) existing Medicaid liens asserted against the proceeds of any recovery for the birth related neurological injuries sustained by such qualified plaintiffs, and (iii) the portion of the fees of the qualified plaintiffs' attorneys deemed to be attributable to such lien amount or amounts.

2. In determining the amount of medically necessary health care costs to be paid from the Fund, any such cost or expense that was or will, with reasonable certainty, be paid, replaced or indemnified from any collateral source as provided by subdivision (a) of section forty-five hundred forty-five of the civil practice law and rules shall not constitute a medically necessary health care cost and shall not be paid from the fund. For purposes of this title, "collateral source" shall not include medicare or Medicaid.

3. In determining the amount of medically necessary health care costs to be paid from the fund, there shall be proportionately deducted from each claim submitted to the fund the amounts necessary for payment of the set-offs, adjustments and deductions as set forth in subdivision (e) of section five thousand thirty-one of the civil practice law and rules.

4. The amount of medically necessary health care costs to be paid from the fund shall be calculated on the basis of Medicaid rates of reimbursement or, where no such rates are available, as defined by the commissioner in regulation. Any dispute as to whether any cost is medically necessary shall be determined by the commissioner.

5. On a form to be prescribed and furnished by the fund, the qualified plaintiff shall file with the fund claims for the payment from the fund of medically necessary health care costs, any existing Medicaid liens, and the portion of the fee of the qualified plaintiff's attorney deemed to be attributable to such lien amount or amounts.

6. A qualified plaintiff shall be enrolled when (a) such plaintiff, or any of the defendants in regard to the plaintiff's claim, makes an application for enrollment by providing the fund administrator with a certified copy of the judgment or of the court approved settlement agreement; and (b) the fund administrator determines upon the basis of

such judgment or settlement agreement and any additional information the fund administrator shall request that the plaintiff is a qualified plaintiff; provided that no enrollment shall occur when the fund is closed to enrollment pursuant to subdivision (f) of section twenty-nine hundred ninety-nine-i of this title.

6-a. As to all claims, the fund administrator shall:

(a) determine which of such costs are medically necessary health care costs to be paid from the fund; and

(b) thereupon certify to the commissioner of taxation and finance those costs that have been determined to be medically necessary health care costs to be paid from the fund.

7. The qualified plaintiff's claim for the payment of any existing Medicaid liens shall be accompanied by evidence of any such liens and, as to such claim, the fund administrator shall:

(a) confirm the existence and amount of such liens; and

(b) accept and process claims for payment of such liens; and

(c) thereupon certify to the commissioner of taxation and finance those liens that have been determined to be existing valid Medicaid liens to be paid from the fund.

With regard to the qualified plaintiff's claim for the payment of the portion of the fee of the qualified plaintiff's attorney deemed to be attributable to the existing Medicaid liens, the fund administrator shall accept and process claims for payment of such fee, assuming that the existing Medicaid lien is the last component of the judgment or settlement sum to be paid.

8. Any dispute concerning any determination by the fund administrator with regard to that portion of the attorney's fee shall be referred to the commissioner.

9. Payments from the fund shall be made by the commissioner of taxation and finance on the said certificate of the superintendent of financial regulation. No payment shall be made by the commissioner of taxation and finance in excess of the amount certified. Promptly upon receipt of the said certificate of the superintendent of financial regulation, the commissioner of taxation and finance shall pay (i) the qualified plaintiff's health care provider or reimburse the qualified plaintiff the amount so certified for payment, (ii) the lien amount or amounts so certified for payment, and (iii) the qualified plaintiff's attorney the portion of the fee so certified for payment.

10. Payment from the fund shall not give the fund any right of recovery against any qualified plaintiff or such qualified plaintiff's attorney except in the case of fraud or mistake.

11. All health care providers shall accept from qualified plaintiffs assignments of the right to receive payments from the fund for medically necessary health care costs.

12. Health insurers (other than medicare and Medicaid) shall be the primary payers of medically necessary health care costs of qualified plaintiffs. Such costs shall be paid from the fund only to the extent that health insurers or other collateral sources are not otherwise obligated to make payments therefor. Health insurers that make payments for medically necessary health care costs to or on behalf of qualified plaintiffs shall have no right of recovery against and shall have no lien upon the fund or any person or entity nor shall the fund constitute an additional payment source to offset the payments otherwise contractually required to be made by such health insurers.

13. Except as provided for by this title, no payment shall be required to be made by any defendant or such defendant's insurer for medically

necessary health care costs, or for the existing Medicaid lien amounts, or for the portion of the fee of the qualified plaintiff's attorney deemed to be attributable to such lien amounts, and no judgment shall be made or entered requiring that any such payment be made by any defendant or such defendant's insurer.

14. The determination of the qualified plaintiff's attorney's fee shall be based upon the entire sum awarded by the jury or the court or the full sum of the settlement, as the case may be. The portion of the qualified plaintiff's attorney's fee deemed to be attributable to the existing Medicaid lien shall be paid in accordance with subdivision seven of this section and shall not be paid out of the Medicaid lien amount. The portion of the qualified plaintiff's attorney's fee that is allocated to all other elements of damages shall be paid in a lump sum by the defendants and their insurers pursuant to section four hundred seventy-four-a of the judiciary law; provided however that the portion of the attorney fee that is allocated to the non-fund elements of damages shall be deducted from the non-fund portion of the award in a proportional manner.

15. The commissioner of health and the superintendent of financial regulation shall promulgate, amend and enforce all reasonable rules and regulations necessary for the proper administration of the fund in accordance with the provisions of this section, including, but not limited to, those concerning the payment of claims and concerning the actuarial calculations necessary to determine, annually, the total amount to be paid into the fund as provided herein, and as otherwise needed to implement this title.

§ 52-a. Article 29-D of the public health law is amended by adding a new title 5 to read as follows:

Title 5

New York State Hospital Quality Initiative

Section 2999-m. New York state hospital quality initiative.

§ 2999-m. New York state hospital quality initiative. The New York state hospital quality initiative, including the New York state obstetrical patient safety workgroup, will be created in the department of health to be comprised of medical, hospital and academic experts and other stakeholders chosen by the commissioner.

The New York state quality initiative will oversee the general dissemination of initiatives, guidance, and best practices to general hospitals. Activities will include but not be limited to: building cultures of patient safety and implementing evidence based care in target areas. The workgroup will undertake collaborative work to improve obstetrical care outcomes and quality of care, based on identifying and implementing evidence based practices, and clinical protocols that can be standardized and adopted by hospitals including but not limited to:

(a) Surveying, reviewing and analyzing current "best" practices employed in obstetrical cases, including exploring the use of "virtual grand rounds";

(b) Undertaking a review of "closed claims" in an effort to develop a set of "standard best practices" for deliveries in New York state;

(c) Formulating and recommending to the commissioner best practice standards and designing new programs for implementation and improved outcomes, including but not limited to, clinical bundles for high priority conditions, electronic fetal monitoring training and certification, and team training; and

(d) Engaging the existing regional perinatal center network in dialogues regarding the above topics and making recommendations to

improve and/or upgrade assistance and communication to smaller hospitals.

§ 52-b. Subdivision 1 of section 2807-v of the public health law is amended by adding a new paragraph (iii) to read as follows:

(iii) Funds shall be reserved and set aside and accumulated from year to year and shall be made available, including income from investment funds, for the purpose of supporting the New York state medical indemnity fund as authorized pursuant to title four of article twenty-nine-D of this chapter, for the following periods and in the following amounts, provided, however, that the commissioner is authorized to seek waiver authority from the federal centers for medicare and Medicaid for the purpose of securing Medicaid federal financial participation for such program, in which case the funding authorized pursuant to this paragraph shall be utilized as the non-federal share for such payments:

One hundred million dollars for the period April first, two thousand eleven through March thirty-first, two thousand twelve.

§ 52-c. The public health law is amended by adding a new section 2807-d-1 to read as follows:

§ 2807-d-1. Hospital quality contributions. 1. Notwithstanding any contrary provision of law and subject to the receipt of all necessary federal approvals or waivers, for periods on and after July first, two thousand eleven, a quality contribution shall be imposed on the inpatient revenue of each general hospital equal to three tenths of one percent of such revenue, as defined in accordance with paragraph (a) of subdivision three of section twenty-eight hundred seven-d of this article, and provided further, however, that on and after July first, two thousand eleven, an additional quality contribution equal to four percent of such inpatient revenue shall be imposed with regard to all

such inpatient revenue that is received for the provision of inpatient obstetrical patient care services, provided, however, that such additional quality contribution is subject to receipt of all necessary federal approvals or waivers, as determined as necessary by the commissioner, and provided further, however, that in the event the commissioner, in consultation with the director of the budget, determines that such quality contribution and such additional quality contribution shall raise less than or more than the total quality collection amount set forth in subdivision two of this section, then in that event the commissioner, in consultation with the director of the budget, may promulgate regulations, and may promulgate emergency regulations, increasing or decreasing such quality contributions by amounts sufficient to ensure the collection of such annual quality contribution amount and to ensure that fifty-five percent of such aggregate amount is raised by such quality contribution and forty-five percent is raised by such additional quality contribution.

2. The annual quality contribution amount referenced in subdivision one of this section shall be one hundred seventy million dollars for the state fiscal year beginning April first, two thousand eleven, and for each subsequent state fiscal year thereafter it shall be the amount of the preceding year as increased by the ten year rolling average of the medical component of the consumer price index as published by the United States department of labor, bureau of labor statistics, for the preceding ten years.

3. The quality contributions described in this section shall be administered in accordance with and subject to the provisions of subdivisions four, five, six, seven, eight and twelve of section twenty-eight hundred seven-d of this article, provided, however, that such quality contrib-

utions shall be deposited in the HCRA resources fund as established pursuant to section ninety-two-dd of the state finance law; and provided further, however, that such contributions shall not be an allowable cost in the determination of reimbursement rates of payment computed pursuant to this article.

4. The collection of the quality contributions described in this section shall be suspended and the amounts already paid for that fiscal year shall be refunded proportionately to each contributor if a two hundred fifty thousand dollar limitation for non-economic damages pursuant to article fifty-C of the civil practice law and rules is not in place.

§ 52-d. Section 3012-a of the civil practice law and rules, as amended by chapter 507 of the laws of 1987, is amended to read as follows:

§ 3012-a. Certificate of merit in medical, dental and podiatric malpractice actions. (a) In any action for medical, dental or podiatric malpractice, the complaint shall be accompanied by a certificate, executed by the attorney for the plaintiff, declaring that:

(1) the attorney has reviewed the facts of the case and has consulted as to each named defendant, with at least one physician in medical malpractice actions, at least one dentist in dental malpractice actions or at least one podiatrist in podiatric malpractice actions who is licensed to practice in this state or any other state, who is currently in active practice in the same specialty as the defendant, and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action, and that the attorney has concluded on the basis of such review and consultation that there is a reasonable basis for the commencement of such action against each defendant named in the complaint; or

(2) the attorney was unable to obtain the consultation required by paragraph one of this subdivision because a limitation of time, established by article two of this chapter, would bar the action and that the certificate required by paragraph one of this subdivision could not reasonably be obtained before such time expired. If a certificate is executed pursuant to this subdivision, the certificate required by this section shall be filed within ninety days after service of the complaint[; **or**

(3) the attorney was unable to obtain the consultation required by paragraph one of this subdivision because the attorney had made three separate good faith attempts with three separate physicians, dentists or podiatrists, in accordance with the provisions of paragraph one of this subdivision to obtain such consultation and none of those contacted would agree to such a consultation].

(b) Where a certificate is required pursuant to this section, a single certificate shall be filed for each **defendant named in the** action[, **even if more than one defendant has been named in the complaint or is**] **and for each defendant who is** subsequently named.

(c) Where the attorney intends to rely solely on the doctrine of "res ipsa loquitur", this section shall be inapplicable. In such cases, the complaint shall be accompanied by a certificate, executed by the attorney, declaring that the attorney is solely relying on such doctrine and, for that reason, is not filing a certificate required by this section.

(d) If a request by the plaintiff for the records of the plaintiff's medical or dental treatment by the defendants has been made and such records have not been produced, the plaintiff shall not be required to serve the certificate required by this section until ninety days after such records have been produced.

(e) For purposes of this section, and subject to the provisions of section thirty-one hundred one of this chapter, an attorney who submits a certificate as required by paragraph one or two of subdivision (a) of this section and the physician, dentist or podiatrist with whom the attorney consulted shall not be required to disclose the identity of the physician, dentist or podiatrist consulted and the contents of such consultation; provided, however, that when the attorney makes a claim under paragraph three of subdivision (a) of this section that he was unable to obtain the required consultation with the physician, dentist or podiatrist, the court may, upon the request of a defendant made prior to compliance by the plaintiff with the provisions of section thirty-one hundred of this chapter, require the attorney to divulge to the court the names of physicians, dentists or podiatrists refusing such consultation.

(f) The provisions of this section shall not be applicable to a plaintiff who is not represented by an attorney.

(g) The plaintiff may, in lieu of serving the certificate required by this section, provide the defendant or defendants with the information required by paragraph one of subdivision (d) of section thirty-one hundred one of this chapter within the period of time prescribed by this section.

§ 52-e. Subparagraphs (i) and (ii) of paragraph 1 of subdivision (d) of section 3101 of the civil practice law and rules, subparagraph (i) as amended by chapter 184 of the laws of 1988, and subparagraph (ii) as amended by chapter 165 of the laws of 1991, are amended to read as follows:

(i) Upon request, each party shall identify each person whom the party expects to call as an expert witness at trial and shall disclose in

reasonable detail the subject matter on which each expert is expected to testify, the substance of the facts and opinions on which each expert is expected to testify, the qualifications of each expert witness and a summary of the grounds for each expert's opinion. However, where a party for good cause shown retains an expert an insufficient period of time before the commencement of trial to give appropriate notice thereof, the party shall not thereupon be precluded from introducing the expert's testimony at the trial solely on grounds of noncompliance with this paragraph. In that instance, upon motion of any party, made before or at trial, or on its own initiative, the court may make whatever order may be just. [**In an action for medical, dental or podiatric malpractice, a party, in responding to a request, may omit the names of medical, dental or podiatric experts but shall be required to disclose all other information concerning such experts otherwise required by this paragraph.**]

(ii) In an action for medical, dental or podiatric malpractice, [**any party may, by written offer made to and served upon all other parties and filed with the court, offer to disclose the name of, and to make available for examination upon oral deposition, any person the party making the offer expects to call as an expert witness at trial. Within twenty days of service of the offer, a party shall accept or reject the offer by serving a written reply upon all parties and filing a copy thereof with the court. Failure to serve a reply within twenty days of service of the offer shall be deemed a rejection of the offer. If all parties accept the offer, each party shall be required to produce his or her expert witness for examination upon oral deposition upon receipt of a notice to take oral deposition in accordance with rule thirty-one hundred seven of this chapter. If any party, having made or accepted the offer, fails to make that party's expert available for oral deposition,**

that party shall be precluded from offering expert testimony at the trial of the action] a party shall be required to produce each person so identified by such party as an expert witness for examination upon oral deposition upon receipt of a notice to take oral deposition after such time as the producing party complies with subparagraph (i) of this paragraph.

§ 52-f. The civil practice law and rules is amended by adding a new rule 3409 to read as follows:

Rule 3409. Settlement conference in dental, podiatric and medical malpractice actions. In every dental, podiatric or medical malpractice action, the court shall hold a mandatory settlement conference within forty-five days after the filing of the note of issue and certificate of readiness or, if a party moves to vacate the note of issue and certificate of readiness, within forty-five days after the denial of such motion. Where parties are represented by counsel, only attorneys fully familiar with the action and authorized to dispose of the case, or accompanied by a person empowered to act on behalf of the party represented, will be permitted to appear at the conference. Where appropriate, the court may order parties, representatives of parties, representatives of insurance carriers or persons having an interest in any settlement to also attend in person or telephonically at the settlement conference. The chief administrative judge shall by rule adopt procedures to implement such settlement conference.

§ 52-g. Intentionally omitted.

§ 52-h. Subdivision 2 of section 2805-m of the public health law, as amended by chapter 808 of the laws of 1987, is amended to read as follows:

2. Notwithstanding any other provisions of law, none of the records, documentation or committee actions or records required pursuant to sections twenty-eight hundred five-j and twenty-eight hundred five-k of this article, the reports required pursuant to section twenty-eight hundred five-l of this article nor any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except [**as hereinafter provided or**] as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. [**The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.**]

§ 52-i. The civil practice law and rules is amended by adding a new article 50-C to read as follows:

ARTICLE 50-C

DAMAGE AWARDS

Section 5051. Definition.

5052. Damage awards.

§ 5051. Definition. As used in this article, "noneconomic damages" means nonpecuniary damages arising from pain and suffering, loss of services, loss of consortium, or other nonpecuniary damages.

§ 5052. Damage awards. In any medical, dental, or podiatric malpractice action, the prevailing plaintiff may be awarded:

(a) economic and pecuniary damages; and

(b) noneconomic damages suffered by the injured plaintiff, not to exceed two hundred fifty thousand dollars, provided, however, that such limitation shall be adjusted in accordance with the Consumer Price Index for all Urban Consumers (CPI-U), as published annually by the United States Department of Labor, Bureau of Labor Statistics.

§ 52-j. Subdivision (c) of section 5031 of the civil practice law and rules is REPEALED and subdivisions (d), (e), (f), (g) and (h) are relettered subdivisions (c), (d), (e), (f) and (g).

§ 52-k. Subdivisions (c), (d), (e) and (f) of section 5031 of the civil practice law and rules, as added by chapter 86 of the laws of 2003 and as relettered by section fifty-two-j of this act, are amended to read as follows:

(c) The findings of future economic and pecuniary damages except in wrongful death actions **and in actions subject to title 4 of article 29-D of the public health law**, shall be used to determine a stream of payments for each such item of damages by applying (i) the growth rate, to the (ii) annual amount in current dollars, for the (iii) period of years, all of such items as determined by the finder of fact for each such item of damages. The court shall determine the present value of the stream of payments for each such item of damages by applying a discount rate to the stream of payments. After determining the present value of the stream of payments for future economic and pecuniary damages, thirty-five percent of that present value shall be paid in a lump sum, and the stream of payments for future economic and pecuniary damages shall be adjusted accordingly by proportionately reducing each item of the remaining stream of payments for future economic and pecuniary damages and paying those amounts over time in the form of an annuity in accordance with the provisions set forth in subdivision [**(g)**] **(f)** of this

section, subject to the adjustments and deductions specified in subdivision [**(f)**]**(e)** of this section.

(d) The discount rate to be used in determining the present value of all streams of payments for periods of up to twenty years shall be the rate in effect for the ten-year United States Treasury Bond on the date of the verdict. As to any streams of payments for which the period of years exceeds twenty years, the discount rate to be used in determining the present value shall be calculated by averaging, on an annual basis, the rate in effect for the ten-year United States Treasury Bond on the date of the verdict for the first twenty years and two percentage points above the rate in effect for the ten-year United States Treasury Bond on the date of the verdict for the years after twenty years.

(e) After making the applicable calculations set forth above:

(1) The court shall apply any set-offs for comparative negligence and settlements by deducting them proportionately from each item of the damages awards, including the lump sum payments specified in subdivisions (b)[**, (c),**] and [**(d)**] **(c)** of this section, and the present value of the streams of payments specified in [**such subdivisions**] **subdivision** (c) [**and (d)**]. After such deductions, the streams of payments specified in [**such subdivisions**] **subdivision** (c) [**and (d)**] and their present value shall be adjusted accordingly.

(2) The court shall then deduct the litigation expenses of the plaintiff's attorney proportionately from each remaining item of the damages awards, including the remaining lump sum payments specified in such subdivisions (b)[**, (c),**] and [**(d)**] **(c)**, and the present value of the remaining streams of payments specified in [**such subdivisions**] **subdivision** (c) [**and (d)**], and such expenses shall be paid in a lump sum. After said deductions, the streams of payments specified in [**such**

subdivisions] subdivision (c) [**and (d)**] and their present value shall be adjusted accordingly.

(3) The court shall then determine the attorney's fees based upon the remaining damages awards, including the remaining lump sum payments specified in such subdivisions (b)[**, (c),**] and [**(d)**] (c), and the present value of the remaining streams of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**]. The attorney's fees shall be deducted proportionately from each item of the remaining damages awards, including the remaining lump sum payments specified in such subdivisions (b) and (c)[**, and (d),**] and the present value of the remaining streams of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**], and such fees shall be paid in a lump sum. After said deductions, the stream of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**] and their present value shall be adjusted accordingly.

(4) Any liens which are not the subject of a separate award by the finder of fact shall then be deducted proportionately from each item of the remaining damages awards, including the remaining lump sum payments specified in such subdivisions (b)[**, (c),**] and [**(d)**] (c), and the present value of the remaining streams of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**], and such liens shall be paid in a lump sum. After said deductions, the stream of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**] and their present value shall be adjusted accordingly.

(f) The defendants and their insurance carriers shall be required to offer and to guarantee the purchase and payment of an annuity contract to make annual payments in equal monthly installments of the remaining streams of payments specified in [**such subdivisions**] subdivision (c) [**and (d)**], after making the deductions and adjustments prescribed in

subdivision [**(f)**] **(e)** of this section. The annuity contract shall provide that the payments shall run from the date of the verdict (unless some other date is specified in the verdict) for the period of years determined by the finder of fact (except the stream of payments for future pain and suffering, which shall not exceed eight years) or the life of the plaintiff, whichever is shorter, except that:

(1) awards for lost earnings shall be paid for the full term of the award determined by the finder of fact; and

(2) awards for any item of economic or pecuniary damages as to which the finder of fact found that the loss or item of damage is permanent, the payments for that item shall continue to run for the entire life of the plaintiff, increasing each year beyond the period of years determined by the finder of fact at the same growth rate as determined by the finder of fact.

§ 52-l. Section 5034 of the civil practice law and rules, as amended by chapter 446 of the laws of 1999, is amended to read as follows:

§ 5034. Failure to make payment. If at any time following entry of judgment, a judgment debtor fails for any reason to make a payment in a timely fashion according to the terms of this article, the judgment creditor may petition the court which rendered the original judgment for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum. In calculating the amount of the lump sum judgment, the court shall total the remaining periodic payments due and owing to the judgment creditor, as calculated pursuant to subdivision [**(e)**] **(d)** of section five thousand thirty-one of this article, and shall not convert these amounts to their present value. The court may also require the payment of interest on the outstanding judgment.

§ 52-m. The creation and continuation of the New York State Medical Indemnity Fund established pursuant to title 4 of article 29-D of the public health law, as added by section fifty-two of this act, is contingent upon the application of a two hundred fifty thousand dollar limitation for non-economic damages, defined in article 50-C of the civil practice law and rules, as added by section fifty-two of this act; provided, however, that payments pursuant to section 2999-j of the public health law, as added by section fifty-two of this act shall continue to be made as set forth in such section with respect to any qualified plaintiff enrolled in such fund prior to any suspension of such limitation for non-economic damages.

§ 53. Subdivision 6 of section 369 of the social services law, as added by chapter 170 of the laws of 1994, is amended to read as follows:

6. For purposes of this section, [**the term**] **an individual's** "estate" [**means**] **includes** all **of the individual's** real and personal property and other assets [**included within the individual's estate and**] passing under the terms of a valid will or by intestacy. **An individual's estate also includes any other property in which the individual has any legal title or interest at the time of death, including jointly held property, retained life estates, and interests in trusts, to the extent of such interests; provided, however, that a claim against a recipient of such property by distribution or survival shall be limited to the value of the property received or the amount of medical assistance benefits otherwise recoverable pursuant to this section, whichever is less.**

§ 54. Subparagraph 12 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 42-a of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(12) is a disabled person at least sixteen years of age, but under the age of sixty-five, who: would be eligible for benefits under the supplemental security income program but for earnings in excess of the allowable limit; has net available income that does not exceed two 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, for a one-person or two-person household, as defined by the commissioner in regulation; has household resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, **other than retirement accounts,** that do not exceed [**the amount described in subparagraph four of paragraph (a) of subdivision two of this section**] **twenty thousand dollars** for a one-person **household** or **thirty thousand dollars for a** two-person household, as defined by the commissioner in regulation; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, disabled means having a medically determinable impairment of sufficient severity and duration to qualify for benefits under section 1902(a)(10)(A)(ii)(xv) of the social security act; or

§ 55. The mental hygiene law is amended by adding a new section 31.08 to read as follows:

§ 31.08 Compliance with operational standards by hospitals.

(a) Notwithstanding the provisions of section 31.07 of this article, a hospital as defined in section 1.03 of this chapter, which is a ward, wing, unit, or other part of a hospital, as defined in article twenty-eight of the public health law, which provides services for persons with mental illness pursuant to an operating certificate issued by the

commissioner of mental health, may be deemed to be in compliance with applicable provisions of this chapter and other applicable laws, rules and regulations, provided that such hospital has been accredited by The Joint Commission, or any other hospital accrediting organization to which the Centers for Medicare and Medicaid Services has granted deeming status, and which the commissioner of mental health shall have determined has accrediting standards sufficient to assure the commissioner that hospitals so accredited are in compliance with such provisions of law, rules and regulations. The commissioner may exempt any such hospital from the annual inspection and visitation requirements established in section 31.07 of this article, provided that:

1. such hospital has a history of compliance with such provisions of law, rules and regulations and a record of providing good quality care, as determined by the commissioner;

2. a copy of the survey report and the certificate of accreditation of The Joint Commission or other approved accrediting organization is submitted by the accrediting body or the hospital to the commissioner, within seven days of issuance to the hospital;

3. The Joint Commission or other accrediting organization has agreed to and does evaluate, as part of its accreditation survey, any minimal operational standards established by the commissioner which are in addition to the minimal operational standards of accreditation of The Joint Commission or other accrediting organization; and

4. there are no constraints placed upon access by the commissioner to The Joint Commission or other approved accrediting organization survey reports, plans of correction, interim self-evaluation reports, notices of noncompliance, progress reports on correction of areas of noncompli-

ance, or any other related reports, information, communications or materials regarding such hospital.

(b) Any hospital governed by the provisions of subdivision (a) of this section shall at all times be subject to inspection or visitation by the commissioner to determine compliance with applicable law, regulations, standards or conditions as deemed necessary by the commissioner. Any such hospital shall be subject to the full range of licensing enforcement authority of the commissioner.

(c) Any hospital governed by the provisions of subdivision (a) of this section shall notify the commissioner immediately upon receipt of notice by The Joint Commission or other approved accrediting organization, or any communication the hospital may receive that such organization will be recommending that such hospital not be accredited, not have its accreditation renewed, or have its accreditation terminated, or upon receipt of notice or other communication from the Centers for Medicare and Medicaid Services regarding a determination that the hospital will be terminated from participation in the Medicare program because it is not in compliance with one or more conditions of participation in such program, or has deficiencies that either individually or in combination jeopardize the health and safety of patients or are of such character as to seriously limit the provider's capacity to render adequate care.

§ 56. The mental hygiene law is amended by adding a new section 32.14 to read as follows:

§ 32.14 Compliance with operational standards by providers of services in hospitals.

(a) Notwithstanding the provisions of section 32.13 of this article, a provider of services as defined in section 1.03 of this chapter that occupies a ward, wing, unit, or other part of a hospital, as defined in

article twenty-eight of the public health law, which provides services for persons with mental disabilities pursuant to an operating certificate issued by the commissioner, may be deemed to be in compliance with applicable provisions of this chapter and other applicable laws, rules and regulations in regard to services provided at such ward, wing, unit or other part of a hospital, provided that such hospital has been accredited by The Joint Commission, or any other accrediting organization to which the Centers for Medicare and Medicaid Services has granted deeming status, and which the commissioner shall have determined has accrediting standards sufficient to assure the commissioner that providers of services occupying a ward, wing, unit or other part of such hospital so accredited are in compliance with such provisions of law, rules and regulations in regard to services provided at such ward, wing, unit or other part of a hospital. The commissioner may exempt any such provider of services, in regard to services provided at such ward, wing, unit or other part of a hospital, from the annual inspection and visitation requirements established in section 32.13 of this article, provided that:

1. such provider of services has a history of compliance with such provisions of law, rules and regulations and a record of providing good quality care, as determined by the commissioner;

2. a copy of the survey report and the certificate of accreditation of The Joint Commission or other approved accrediting organization is submitted by the accrediting body or the provider of services to the commissioner, within seven days of issuance to such provider of services;

3. The Joint Commission or other approved accrediting organization has agreed to and does evaluate, as part of its accreditation survey, any

minimal operational standards established by the commissioner which are in addition to the minimal operational standards of accreditation of The Joint Commission or other accrediting organization; and

4. there are no constraints placed upon access by the commissioner to The Joint Commission or other approved accrediting organization survey reports, plans of correction, interim self-evaluation reports, notices of noncompliance, progress reports on correction of areas of noncompliance, or any other related reports, information, communications or materials regarding such provider of services.

(b) Any provider of services governed by the provisions of subdivision (a) of this section shall at all times be subject to inspection or visitation by the commissioner to determine compliance with applicable law, regulations, standards or conditions as deemed necessary by the commissioner. Any such provider of services shall be subject to the full range of certification enforcement authority of the commissioner.

(c) Any provider of services governed by the provisions of subdivision (a) of this section shall notify the commissioner immediately upon receipt of notice by The Joint Commission or other approved accrediting organization, or any communication the provider of services may receive that such organization will be recommending that such provider of services not be accredited, not have its accreditation renewed, or have its accreditation terminated, or upon receipt of notice or other communication from the Centers for Medicare and Medicaid Services regarding a determination that the provider of services will be terminated from participation in the Medicare or Medicaid program because it is not in compliance with one or more conditions of participation in such program, or has deficiencies that either individually or in combination jeopard-

ize the health and safety of patients or are of such character as to seriously limit the provider's capacity to render adequate care.

§ 57. Notwithstanding any other provision of law to the contrary, the requirements set forth in section 2805-t of the public health law are hereby suspended until October 1, 2012.

§ 58. Section 2805-l of the public health law, as added by chapter 266 of the laws of 1986, subdivision 3 as amended by chapter 542 of the laws of 2000, subdivision 4 as added and subdivision 5 as renumbered by chapter 632 of the laws of 2006, is amended to read as follows:

§ 2805-l. [**Incident**] **Serious event** reporting. 1. **(a)** All hospitals[, **as defined in subdivision ten of section twenty-eight hundred one of this article,**] shall be required to report [**incidents**] **events** described by subdivision two of this section to the department in a manner and within time periods as may be specified by regulation of the department.

(b) For purposes of this section, "hospital" means any general hospital or diagnostic and treatment center.

2. The following [**incidents**] **events** shall be reported to the department:

(a) patients' deaths or impairments of bodily functions in circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards;

(b) fires in the hospital which disrupt the provision of patient care services or cause harm to patients or staff;

(c) equipment malfunction during treatment or diagnosis of a patient which did or could have adversely affected a patient or hospital personnel;

(d) poisoning occurring within the hospital;

(e) strikes by hospital staff;

(f) disasters or other emergency situations external to the hospital environment which affect hospital operations; and

(g) termination of any services vital to the continued safe operation of the hospital or to the health and safety of its patients and personnel, including but not limited to the anticipated or actual termination of telephone, electric, gas, fuel, water, heat, air conditioning, rodent or pest control, laundry services, food or contract services.

3. **Notwithstanding any provision of this section to the contrary, the commissioner is authorized to modify, by regulation, the reportable events required by this section, consistent with national consensus standards.**

4. The hospital shall conduct an investigation of [**incidents**] **events** described in paragraphs (a) through (d) of subdivision two of this section within thirty days of obtaining knowledge of any information which reasonably appears to show that such an [**incident**] **event** has occurred, provided that, if the hospital reasonably expects such investigation to extend beyond such thirty day period, the hospital shall notify the department of such expectation and the reason therefor, and shall inform the department of the expected completion date of the investigation. The hospital shall provide to the department a copy of the investigation report within twenty-four hours of completion. Nothing herein shall limit the authority of the department to conduct an investigation of [**incidents**] **events** occurring in [**general**] hospitals.

5. The department shall:

(a) analyze event reports, findings of the investigations, their root cause analyses, and corrective action plans to determine patterns of

systemic failure in the health care system and identify successful methods to correct these failures; and

(b) communicate to facilities the department's conclusions, if any, regarding event reports, patterns of systemic failure, and recommendations for corrective action resulting from the analysis of submissions from facilities.

[**4**] **6**. The commissioner shall establish protocols for hospital personnel where a patient under the age of eighteen years dies during transportation to the hospital or while at the hospital, under circumstances other than those related to the natural course of illness, disease or proper treatment in accordance with generally accepted medical standards. Such protocols shall address matters including, but not limited to, the following:

(a) medical and social history, and examination of the patient;

(b) preservation of evidence and chain of custody;

(c) questioning of the patient's family, guardian or person in parental authority;

(d) circumstances surrounding the injury resulting in death;

(e) determination of the cause of death;

(f) notification of law enforcement personnel; and

(g) reporting requirements under title six of article six of the social services law.

In developing such protocols, the commissioner shall consult with the office of children and family services, local departments of social services, coordinators of child fatality review teams established pursuant to section four hundred twenty-two-b of the social services law, law enforcement agencies, pediatricians preferably with expertise in the

area of child abuse and maltreatment or forensic pediatrics, and such other persons as the commissioner deems necessary.

[**5**] **7**. The commissioner shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate to effectuate the purposes of this section.

§ 59. Subdivision 4 of section 854 of the general municipal law, as amended by chapter 541 of the laws of 1982, is amended to read as follows:

(4) "Project" - shall mean any land, any building or other improvement, and all real and personal properties located within the state of New York and within or outside or partially within and partially outside the municipality for whose benefit the agency was created, including, but not limited to, machinery, equipment and other facilities deemed necessary or desirable in connection therewith, or incidental thereto, whether or not now in existence or under construction, which shall be suitable for manufacturing, warehousing, research, commercial or industrial purposes or other economically sound purposes identified and called for to implement a state designated urban cultural park management plan as provided in title G of the parks, recreation and historic preservation law and which may include or mean an industrial pollution control facility, a recreation facility, educational or cultural facility, **a hospital, a continuing care retirement community,** a horse racing facility or a railroad facility, provided, however, no agency shall use its funds in respect of any project wholly or partially outside the municipality for whose benefit the agency was created without the prior consent thereto by the governing body or bodies of all the other municipalities in which a part or parts of the project is, or is to be, located.

§ 60. Section 854 of the general municipal law is amended by adding a new subdivision 13 to read as follows:

(13) "Hospital" - shall mean a facility authorized to conduct activities in this state, pursuant to article twenty-eight of the public health law. Nothing in this article shall be deemed to waive any applicable requirement for an operating facility certificate, consent or any other approval as provided by law.

§ 61. Section 15 of chapter 66 of the laws of 1994 amending the public health law, the general municipal law and the insurance law relating to the financing of life care communities, as amended by chapter 381 of the laws of 2007, is amended to read as follows:

§ 15. This act shall take effect immediately, provided, however that the amendment made to subdivision 4 of section 854 of the general municipal law by section eight of this act shall not affect the reversion of such subdivision as provided by section 5 of chapter 905 of the laws of 1986, as amended and that where the continuing care retirement community council is authorized to promulgate regulations by this act, it is hereby authorized to implement the provisions of this act in advance of such regulations[; **and provided further that sections one, three, seven, eight, nine, ten, eleven, twelve and thirteen of this act, and paragraph m of subdivision 2 of section 4602 of the public health law, as added by section two of this act, shall apply only to applicants for a certificate of authority pursuant to article 46 of the public health law that have been approved to receive and have received such certificate of authority on or before January 31, 2008**].

§ 62. Section 461-m of the social services law, as amended by chapter 462 of the laws of 1996, is amended to read as follows:

§ 461-m. Death and felony crime reporting. The operator of an adult home or residence for adults shall have an affirmative duty to report any death **involving circumstances other than those related to the natural course of illness or disease**, or attempted suicide of a resident**,** to the department within twenty-four hours of [**its**] occurrence, and shall also have an affirmative duty to report to an appropriate law enforcement authority if it is believed that a felony crime may have been committed against a resident of such facility as soon as possible, or in any event within forty-eight hours. In addition, the operator shall send any reports involving a resident who had at any time received services from a mental hygiene service provider to the state commission on quality of care [**for the mentally disabled**] **and advocacy for persons with disabilities**.

§ 63. Subdivision 38 of section 2 of the social services law is amended by adding four new paragraphs (f), (g), (h) and (i) to read as follows:

(f) "Verification organization" means an entity which uses electronic means including but not limited to contemporaneous telephone verification or contemporaneous verified electronic data to verify whether a service or item was provided to an eligible medicaid recipient. For each service or item the verification organization shall capture:

(i) the identity of the individual providing services or items to the medicaid recipient;

(ii) the identity of the Medicaid recipient; and

(iii) the date, time, duration, location and type of service or item.

A list of verification organizations shall be jointly developed by the department of health and the office of the medicaid inspector general.

(g) "Exception report" means an electronic report containing all the data fields in paragraph (f) of this subdivision for conflicts between services or items on the basis of the identity of the person providing the service or item to the medicaid recipient, the identity of the medicaid recipient, and/or time, date, duration or location of service;

(h) "Conflict report" means an electronic report containing all of the data fields in paragraph (f) of this subdivision detailing incongruities in services or items between scheduling and/or location of service when compared to a duty roster.

(i) "Participating provider" means a certified home health agency, long term home health agency or personal care provider with total medicaid reimbursements exceeding fifteen million dollars per calendar year.

§ 64. The social services law is amended by adding a new section 363-e to read as follows:

§ 363-e. Preclaim review for participating providers of medical assistance program services and items. Every service or item within a claim submitted by a participating provider shall be reviewed and verified by a verification organization prior to submission of a claim to the department of health. The verification organization shall declare each service or item to be verified or unverified. Each participating provider shall receive and maintain reports from the verification organization which shall contain data on:

1. verified services or items, including whether a service appeared on a conflict or exception report before verification and how that conflict or exception was resolved; and

2. services or items that were not verified, including conflict and exception report data for these services.

§ 65. Subparagraph (iii) of paragraph (d) of subdivision 1 of section 367-a of the social services law, as amended by section 53 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

(iii) When payment under part B of title XVIII of the federal social security act for items and services provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act and for items and services provided to qualified medicare beneficiaries under part B of title XVIII of the federal social security act would exceed the amount that otherwise would be made under this title if provided to an eligible person other than a person who is also a beneficiary under part B or is a qualified medicare beneficiary, the amount payable **for services covered** under this title shall be twenty percent of the amount of any co-insurance liability of such eligible persons pursuant to federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under such part B; provided, however, amounts payable under this title for items and services provided to eligible persons who are also beneficiaries under part B or to qualified medicare beneficiaries by an ambulance service under the authority of an operating certificate issued pursuant to article thirty of the public health law, a psychologist licensed under article one hundred fifty-three of the education law, or a facility under the authority of an operating certificate issued pursuant to article sixteen, thirty-one or thirty-two of the mental hygiene law [**and with respect to outpatient hospital and clinic items and services provided by a facility under the authority of an operating certificate issued pursuant to article twenty-eight of the public health law**], shall not be less than the amount of any co-insurance liability of such eligible persons or such qualified medicare

beneficiaries, or for which such eligible persons or such qualified medicare beneficiaries would be liable under federal law were they not eligible for medical assistance or were they not qualified medicare beneficiaries with respect to such benefits under part B.

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

(g) Notwithstanding any provision of this section to the contrary, amounts payable under this title for medical assistance in the form of hospital outpatient services or diagnostic and treatment center services pursuant to article twenty-eight of the public health law provided to eligible persons who are also beneficiaries under part B of title XVIII of the federal social security act shall not exceed the approved medical assistance payment level less the amount payable under part B.

§ 66. Section 2807 of the public health law is amended by adding a new subdivision 20 to read as follows:

20. For periods on or after October first, two thousand eleven, the commissioner is authorized to seek all necessary federal approvals to establish payment methodologies with "accountable care organizations" ("ACO") as described in section eighteen hundred ninety-nine of the federal social security act for the purpose of improving the quality, coordination and accountability of services provided to Medicaid fee-for-service patients in New York. The commissioner may promulgate regulations, including emergency regulations, pertaining to ACOs. Such regulations shall include, but not be limited to, establishing quality standards for ACOs and establishing mechanisms for relating reimbursement to the achieving of such quality standards.

§ 67. Section 18 of part B of chapter 58 of the laws of 2010, amending chapter 474 of the laws of 1996, amending the education law and other

laws relating to rates for residential healthcare facilities and other laws relating to Medicaid payments, is amended to read as follows:

§ 18. Notwithstanding any contrary provision of law, surcharges and assessments due and owing pursuant to sections 2807-j, 2807-s and 2807-t of the public health law for any period prior to January 1, [**2010**] **2011**, which are paid and accompanied by all required reports and which are received on or before December 31, [**2010**] **2011** shall not be subject to interest or penalties as otherwise provided in such sections, provided, however, that such reports may be based on estimates by payors and designated providers of services of the amounts owed, subject to subsequent audit by the commissioner of health or the commissioner's designee, and provided further, however, with regard to all principal, interest and penalty amounts collected by the commissioner of health prior to the effective date of this act, the penalty provisions of sections 2807-j, 2807-s and 2807-t of the public health law shall remain in full force and effect and such amounts collected shall not be subject to further adjustment pursuant to this section, and provided further, however, that payments of principal amounts of surcharges and assessments which were paid late and received prior to the effective date of this provision, and in regard to which interest and penalty amounts have not been collected, shall not be subject to such interest and penalties, and provided, further, however, that the provisions of this section shall not apply to delinquent amounts which have been referred by the commissioner of health for recoupment or collection proceeding. Furthermore, the provisions of this section shall not apply to any surcharge or assessment payments made in response to a final audit finding issued by the commissioner of health or the commissioner's designee.

§ 68. Section 2807-j of the public health law is amended by adding a new subdivision 13 to read as follows:

13. (a) Notwithstanding any inconsistent provisions of this section or any other contrary provision of law, for periods on or after July first, two thousand eleven, each third party payor which has entered into an election agreement with the commissioner pursuant to subdivision five of this section may, as a condition of such election, be required by the commissioner to pay to the commissioner or the commissioner's designee, a percentage surcharge equal to the surcharge percent set forth in paragraph (c) of subdivision two of this section for the same period and applied to all payments made by such third party payors for patient care services provided within the state of New York by physicians in physician offices or in urgent care facilities that are not otherwise licensed pursuant to this article and which are billed as surgery or radiology services in accordance with the Current Procedure Terminology, fourth edition, as published by the American Medical Association.

(b) Such payments shall be made and reported at the same time and in the same manner as the payments and reports which are otherwise submitted by each third party payor to the commissioner or the commissioner's designee in accordance with this section. Such payments shall be subject to audit by the commissioner in the same manner as the other payments otherwise submitted and reported pursuant to this section. The commissioner may take all measures to collect delinquent payments due pursuant to this subdivision as are otherwise permitted with regard to delinquent payments due pursuant to other subdivisions of this section.

(c) Surcharges pursuant to this subdivision shall not apply to payments made by third party payors for services provided to patients insured by Medicaid or by the child health plus program or to any

patient in a category that is exempt from surcharge obligations assessed pursuant to subdivisions one through twelve of this section.

§ 69. Subparagraph (iii) of paragraph (b) of subdivision 25 of section 2808 of the public health law, as added by section 31 of part B of chapter 109 of the laws of 2010, is amended and a new subparagraph (iv) is added to read as follows:

(iii) payment to a facility for reserved bed days provided on behalf of such person for non-hospitalization leaves of absence may not exceed ten days in any twelve month period[.]**; and**

(iv) payments for reserved bed days for temporary hospitalizations shall only be made to a residential health care facility if at least fifty percent of the facility's residents eligible to participate in a Medicare managed care plan are enrolled in such a plan.

§ 70. Subdivision 1 of section 2801 of the public health law, as separately amended by chapters 297 and 416 of the laws of 1983, is amended to read as follows:

1. "Hospital" means a facility or institution engaged principally in providing services by or under the supervision of a physician or, in the case of a dental clinic or dental dispensary, of a dentist, for the prevention, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, public health center, diagnostic center, treatment center, dental clinic, dental dispensary, rehabilitation center other than a facility used solely for vocational rehabilitation, nursing home, tuberculosis hospital, chronic disease hospital, maternity hospital, lying-in-asylum, out-patient department, out-patient lodge, dispensary and a laboratory or central service facility serving one or more such institutions, but the term hospital shall not include an institution, sani-

tarium or other facility engaged principally in providing services for the prevention, diagnosis or treatment of mental disability and which is subject to [**the powers of visitation, examination, inspection and investigation of the department of mental hygiene except for those distinct parts of**] **licensure under the mental hygiene law, although** such a facility which [**provide**] **also provides** hospital service **shall be subject to the powers of visitation, examination, inspection and investigation of the department**. The provisions of this article shall not apply to a facility or institution engaged principally in providing services by or under the supervision of the bona fide members and adherents of a recognized religious organization whose teachings include reliance on spiritual means through prayer alone for healing in the practice of the religion of such organization and where services are provided in accordance with those teachings.

§ 71. Subdivision (a) of section 16.03 of the mental hygiene law, as added by chapter 786 of the laws of 1983, paragraph 3 as amended by chapter 555 of the laws of 1993, is amended to read as follows:

(a) No provider of services shall engage in any of the following activities without an operating certificate issued by the commissioner pursuant to this article:

(1) Operation of a residential facility for the care and treatment of the mentally retarded or developmentally disabled including a family care home.

(2) [**Operation of any distinct part of a general hospital or other facility possessing an operating certificate, pursuant to article twenty-eight of the public health law, operated for the primary purpose of providing residential or non-residential services for the mentally retarded or developmentally disabled.**

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

§ 72. Subdivision (a) of section 31.02 of the mental hygiene law, as amended by chapter 804 of the laws of 1975 and such section as renumbered by chapter 978 of the laws of 1977, paragraph 3 as amended by chapter 555 of the laws of 1993, paragraph 4 as added by chapter 947 of the laws of 1981, paragraph 5 as added by chapter 351 of the laws of 1985, and paragraph 6 as added by chapter 723 of the laws of 1989, is amended to read as follows:

(a) Except as provided in subdivision (b) of this section no provider of services shall engage in any of the following activities without an

operating certificate issued by the commissioner pursuant to this article:

1. operation of a residential facility or institution, including a community residence, for the care, custody, or treatment of the mentally disabled; provided, however, that giving domestic care and comfort to a person in the home shall not constitute such an operation.

2. [**operation of any part of a general hospital for the purpose of providing residential or non-residential services for the mentally disabled.**

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

[**4.**] **3.** operation of a residential treatment facility for children and youth.

[**5.**] **4.** operation of a residential care center for adults.

[**6.**] **5.** operation of a comprehensive psychiatric emergency program.

§ 73. Subdivision (a) of section 32.05 of the mental hygiene law, as added by chapter 558 of the laws of 1999, is amended to read as follows:

(a) Except as provided in subdivision (b) of this section no provider of services shall engage in any of the following activities without an operating certificate issued by the commissioner pursuant to this article:

1. operation of a residential program, including a community residence for the care, custody, or treatment of persons suffering from chemical abuse or dependence; provided, however, that giving domestic care and comfort to a person in the home shall not constitute such an operation; **or**

2. [**operation of a discrete unit of a hospital or other facility possessing an operating certificate pursuant to article twenty-eight of the public health law for the purpose of providing residential or non-residential chemical dependence services; or**

3.] operation of a program established or maintained by a provider of services for the rendition of out-patient or non-residential chemical dependence services; provided, however, that such operation shall not be deemed to include (i) professional practice, within the scope of a professional license or certificate issued by an agency of the state, by an appropriately licensed individual or by a partnership of such individuals, or by a professional service corporation duly incorporated pursuant to the business corporation law wherein all professionals bear the same professional license, or a university faculty practice corpo-

ration duly incorporated pursuant to the not-for-profit corporation law, unless more than fifty percent of such practice by either such corporation consists of the rendering of chemical dependence services; or (ii) non-residential services which are chartered or issued a certificate of incorporation pursuant to the education law; or (iii) pastoral counseling by a clergyman or minister, including those defined as clergyman or minister by section two of the religious corporations law; or (iv) services which are exclusively prevention strategies and approaches as defined in section 1.03 of this chapter.

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

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services under this title who are: (i) discharged from the nursing facility to the community; (ii) enrolled in a plan certified pursuant to section forty-four hundred three-f of the public health law; and (iii) while so enrolled, not considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

§ 75. Intentionally Omitted.

§ 76. Subdivision 6 of section 364-i of the social services law is amended by adding a new paragraph (a-2) to read as follows:

(a-2) At the time of application for presumptive eligibility pursuant to this subdivision, a pregnant woman who resides in a social services

district that has implemented the state's managed care program pursuant to section three hundred sixty-four-j of this title must choose a managed care provider. If a managed care provider is not chosen at the time of application, the pregnant woman will be assigned to a managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of paragraph (f) of subdivision four of section three hundred sixty-four-j of this title.

§ 77. Paragraphs (b), (c), (d) and (f) of subdivision 3 of section 364-j of the social services law are REPEALED, paragraph (e) is relettered paragraph (d), and two new paragraphs (b) and (c) are added to read as follows:

(b) The following medical assistance recipients shall not be required to participate in a managed care program established pursuant to this section:

(i) individuals with a chronic medical condition who are being treated by a specialist physician that is not associated with a managed care provider in the individual's social services district may defer participation in the managed care program for six months or until the course of treatment is complete, whichever occurs first; and

(ii) Native Americans.

(c) The following medical assistance recipients shall not be eligible to participate in a managed care program established pursuant to this section:

(i) a person eligible for Medicare participating in a capitated demonstration program for long term care;

(ii) an infant living with an incarcerated mother in a state or local correctional facility as defined in section two of the correction law;

(iii) a person who is expected to be eligible for medical assistance for less than six months;

(iv) a person who is eligible for medical assistance benefits only with respect to tuberculosis-related services;

(v) individuals receiving hospice services at time of enrollment;

(vi) a person who has primary medical or health care coverage available from or under a third-party payor which may be maintained by payment, or part payment, of the premium or cost sharing amounts, when payment of such premium or cost sharing amounts would be cost-effective, as determined by the local social services district;

(vii) a person receiving family planning services pursuant to subparagraph eleven of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

(viii) a person who is eligible for medical assistance pursuant to paragraph (v) of subdivision four of section three hundred sixty-six of this title; and

(ix) a person who is Medicare/Medicaid dually eligible and who is not enrolled in a Medicare managed care plan.

§ 77-a. Paragraph (g) of subdivision 3 of section 364-j of the social services law, as amended by chapter 649 of the laws of 1996, and subparagraph (i) as amended by section 30 of part C of chapter 58 of the laws of 2008, is amended to read as follows:

[**(g)**] (e) The following categories of individuals [**will not**] may be required to enroll with a managed care program [**until**] when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the [**commissioner**] commissioners of the department of mental health, the office for persons with developmental disabilities, and the office of alcohol and substance abuse services:

(i) an individual dually eligible for medical assistance and benefits under the federal Medicare program and enrolled in a Medicare managed care plan offered by an entity that is also a managed care provider; provided that (notwithstanding paragraph (g) of subdivision four of this section):

(a) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and enrolls in another Medicare managed care plan that is also a managed care provider, the individual shall be (if required by the commissioner under this paragraph) enrolled in that managed care provider;

(b) if the individual changes his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, but enrolls in another Medicare managed care plan that is not also a managed care provider, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(c) if the individual disenrolls from his or her Medicare managed care plan as authorized by title XVIII of the federal social security act, and does not enroll in another Medicare managed care plan, the individual shall be disenrolled from the managed care provider in which he or she was enrolled and withdraw from the managed care program;

(d) nothing herein shall require an individual enrolled in a managed long term care plan, pursuant to section forty-four hundred three-f of the public health law, to disenroll from such program.

(ii) an individual eligible for supplemental security income;

(iii) HIV positive individuals; [**and**]

(iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section forty-four hundred one of the public health law[.];

(v) a person receiving services provided by a residential alcohol or substance abuse program or facility for the mentally retarded;

(vi) a person receiving services provided by an intermediate care facility for the mentally retarded or who has characteristics and needs similar to such persons;

(vii) a person with a developmental or physical disability who receives home and community-based services or care-at-home services through existing waivers under section nineteen hundred fifteen (c) of the federal social security act or who has characteristics and needs similar to such persons;

(viii) a person who is eligible for medical assistance pursuant to subparagraph twelve or subparagraph thirteen of paragraph (a) of subdivision one of section three hundred sixty-six of this title;

(ix) a person receiving services provided by a long term home health care program, or a person receiving inpatient services in a state-operated psychiatric facility or a residential treatment facility for children and youth;

(x) certified blind or disabled children living or expected to be living separate and apart from the parent for thirty days or more;

(xi) residents of nursing facilities;

(xii) a foster child in the placement of a voluntary agency or in the direct care of the local social services district;

(xiii) a person or family that is homeless; and

(xiv) individuals for whom a managed care provider is not geographically accessible so as to reasonably provide services to the person. A

managed care provider is not geographically accessible if the person cannot access the provider's services in a timely fashion due to distance or travel time.

§ 78. Subparagraph (v) of paragraph (e) of subdivision 4 of section 364-j of the social services law, as amended by section 14 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(v) Upon delivery of the pre-enrollment information, the local district or the enrollment organization shall certify the participant's receipt of such information. Upon verification that the participant has received the pre-enrollment education information, a managed care provider, a local district or the enrollment organization may enroll a participant into a managed care provider. Managed care providers must submit enrollment forms to the local department of social services. Upon enrollment, participants will sign an attestation that they have been informed that: participants have a choice of managed care providers; participants have a choice of primary care practitioners; and, except as otherwise provided in this section, including but not limited to the exceptions listed in subparagraph (iii) of paragraph (a) of this subdivision, participants must exclusively use their primary care practitioners and plan providers. The commissioner of health [**or with respect to a managed care plan serving participants in a city with a population of over two million, the local department of social services in such city,**] may suspend or curtail enrollment or impose sanctions for failure to appropriately notify clients as required in this subparagraph.

§ 79. Subparagraph (i) of paragraph (f) of subdivision 4 of section 364-j of the social services law, as amended by section 14 of part C of chapter 58 of the laws of 2004, is amended to read as follows:

(i) Participants **shall choose a managed care provider at the time of application for medical assistance; if the participant does not choose such a provider the commissioner shall assign such participant to a managed care provider in accordance with subparagraphs (ii), (iii), (iv) and (v) of this paragraph. Participants already in receipt of medical assistance** shall have no less than [**sixty**] **thirty** days from the date selected by the district to enroll in the managed care program to select a managed care provider, and as appropriate, a mental health special needs plan, and shall be provided with information to make an informed choice. Where a participant has not selected such a provider or mental health special needs plan, the commissioner of health shall assign such participant to a managed care provider, and as appropriate, to a mental health special needs plan, taking into account capacity and geographic accessibility. The commissioner may after the period of time established in subparagraph (ii) of this paragraph assign participants to a managed care provider taking into account quality performance criteria and cost. Provided however, cost criteria shall not be of greater value than quality criteria in assigning participants.

§ 80. Paragraphs (d), (e), and (f) of subdivision 5 of section 364-j of the social services law, as added by section 15 of part C of chapter 58 of the laws of 2004, are amended to read as follows:

(d) Notwithstanding any inconsistent provision of this title and section one hundred sixty-three of the state finance law, the commissioner of health [**or the local department of social services in a city with a population of over two million**] may contract with managed care providers approved under paragraph (b) of this subdivision, without a competitive bid or request for proposal process, to provide coverage for participants pursuant to this title.

(e) Notwithstanding any inconsistent provision of this title and section one hundred forty-three of the economic development law, no notice in the procurement opportunities newsletter shall be required for contracts awarded by the commissioner of health [**or the local department of social services in a city with a population of over two million**], to qualified managed care providers pursuant to this section.

(f) The care and services described in subdivision four of this section will be furnished by a managed care provider pursuant to the provisions of this section when such services are furnished in accordance with an agreement with the department of health [**or the local department of social services in a city with a population of over two million**], and meet applicable federal law and regulations.

§ 81. Paragraph (k) of subdivision 2 of section 365-a of the social services law, as amended by chapter 659 of the laws of 1997, is amended to read as follows:

(k) care and services furnished by an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections forty-four hundred three, forty-four hundred three-a or forty-four hundred eight-a of the public health law (as added by chapter six hundred thirty-nine of the laws of nineteen hundred ninety-six) or a health maintenance organization authorized under article forty-three of the insurance law, to eligible individuals residing in the geographic area served by such entity, when such services are furnished in accordance with an agreement approved by the department which meets the requirements of federal law and regulations [**provided, that no such agreement shall allow for medical assistance payments on a capitated basis for nursing facility, home care or other long term care services of a duration and scope defined in**

regulations of the department of health promulgated pursuant to section forty-four hundred three-f of the public health law, unless such entity has received a certificate of authority as a managed long term care plan or is an operating demonstration or is an approved managed long term care demonstration, pursuant to such section].

§ 82. Paragraph (a) of subdivision 1 of section 367-f of the social services law, as amended by section 37 of part D of chapter 58 of the laws of 2009, is amended to read as follows:

(a) "Medicaid extended coverage" shall mean eligibility for medical assistance (i) without regard to the resource requirements of section three hundred sixty-six of this title, or in the case of an individual covered under an insurance policy or certificate described in subdivision two of this section that provided a residential health care facility benefit less than [**three**] **two** years in duration, without consideration of an amount of resources equivalent to the value of benefits received by the individual under such policy or certificate, as determined under the rules of the partnership for long-term care program; (ii) without regard to the recovery of medical assistance from the estates of individuals and the imposition of liens on the homes of persons pursuant to section three hundred sixty-nine of this title, with respect to resources exempt from consideration pursuant to subparagraph (i) of this paragraph; provided, however, that nothing in this section shall prevent the imposition of a lien or recovery against property of an individual on account of medical assistance incorrectly paid; and (iii) based on an income eligibility standard for married couples equal to the amount of the minimum monthly maintenance needs allowance defined in paragraph (h) of subdivision two of section three hundred sixty-six-c of this title, and for single individuals equal to one-half of such

amount; provided, however, that the commissioner of health shall not be required to implement the provisions of this subparagraph if the use of such income eligibility standards will result in a loss of federal financial participation in the costs of Medicaid extended coverage furnished in accordance with subparagraphs (i) and (ii) of this paragraph.

§ 83. Subdivision 1 of section 190 of the tax law, as amended by section 17 of part B of chapter 58 of the laws of 2004, is amended to read as follows:

1. General. A taxpayer shall be allowed a credit against the tax imposed by this article, other than the taxes and fees imposed by sections one hundred eighty and one hundred eighty-one of this article, equal to [**twenty**] **forty** percent of the premium paid during the taxable year for long-term care insurance. In order to qualify for such credit, the taxpayer's premium payment must be for the purchase of or for continuing coverage under a long-term care insurance policy that qualifies for such credit pursuant to section one thousand one hundred seventeen of the insurance law.

§ 84. Paragraph (a) of subdivision 25-a of section 210 of the tax law, as amended by section 18 of part B of chapter 58 of the laws of 2004, is amended to read as follows:

(a) A taxpayer shall be allowed a credit against the tax imposed by this article equal to [**twenty**] **forty** percent of the premium paid during the taxable year for long-term care insurance. In order to qualify for such credit, the taxpayer's premium payment must be for the purchase of or for continuing coverage under a long-term care insurance policy that qualifies for such credit pursuant to section one thousand one hundred seventeen of the insurance law.

§ 85. Paragraph 1 of subsection (aa) of section 606 of the tax law, as amended by section 1 of part P of chapter 61 of the laws of 2005, is amended to read as follows:

(1) Residents. A taxpayer shall be allowed a credit against the tax imposed by this article equal to [**twenty**] **forty** percent of the premium paid during the taxable year for long-term care insurance. In order to qualify for such credit, the taxpayer's premium payment must be for the purchase of or for continuing coverage under a long-term care insurance policy that qualifies for such credit pursuant to section one thousand one hundred seventeen of the insurance law. If the amount of the credit allowable under this subsection for any taxable year shall exceed the taxpayer's tax for such year, the excess may be carried over to the following year or years and may be deducted from the taxpayer's tax for such year or years.

§ 86. Paragraph 1 of subsection (k) of section 1456 of the tax law, as amended by section 20 of part B of chapter 58 of the laws of 2004, is amended to read as follows:

(1) A taxpayer shall be allowed a credit against the tax imposed by this article equal to [**twenty**] **forty** percent of the premium paid during the taxable year for long-term care insurance. In order to qualify for such credit, the taxpayer's premium payment must be for the purchase of or for continuing coverage under a long-term care insurance policy that qualifies for such credit pursuant to section one thousand one hundred seventeen of the insurance law.

§ 87. Paragraph 1 of subdivision (m) of section 1511 of the tax law, as amended by section 21 of part B of chapter 58 of the laws of 2004, is amended to read as follows:

(1) A taxpayer shall be allowed a credit against the tax imposed by this article equal to [**twenty**] **forty** percent of the premium paid during the taxable year for long-term care insurance. In order to qualify for such credit, the taxpayer's premium payment must be for the purchase of or for continuing coverage under a long-term care insurance policy that qualifies for such credit pursuant to section one thousand one hundred seventeen of the insurance law.

§ 88. Subparagraph 11 of paragraph (a) of subdivision 1 of section 366 of the social services law, as amended by section 1-h of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(11) for purposes of receiving family planning services eligible for reimbursement by the federal government at a rate of ninety percent, is not otherwise eligible for medical assistance and whose income is two hundred percent or less of the comparable federal income official poverty line (as defined and annually revised by the United States department of health and human services); provided, however, that such ninety percent limitation shall not apply to those services identified by the commissioner of health as services, including treatment for sexually transmitted diseases, generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement**; 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**. The commissioner of health shall submit whatever waiver applications as may be necessary to receive federal financial participation for services provided under this subparagraph and the provisions of this subparagraph

shall be effective if and so long as such federal financial participation shall be available; or

§ 89. Paragraph (e) of subdivision 2 of section 365-a of the social services law, as amended by chapter 170 of the laws of 1994, is amended to read as follows:

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

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

(iii) the commissioner is authorized to provide assistance to persons receiving services under this paragraph who are transitioning to receiving care from a managed long term care plan certified pursuant to section forty-four hundred three-f of the public health law;

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

§ 90. (a) Notwithstanding any other provision of law to the contrary, for the state fiscal year period beginning April 1, 2011 and each state fiscal year thereafter, all Medicaid payments made for services provided on and after April 1, 2011, shall, except as hereinafter provided, be subject to a uniform two percent reduction and such reduction shall be applied, to the extent practicable, in equal amounts during the fiscal year, provided, however, that an alternative method may be considered at the discretion of the commissioner of health and the director of the budget based upon consultation with the health care industry including but not limited to, a uniform reduction in Medicaid rates of payments or other reductions provided that any method selected achieves no less than $345,000,000 in Medicaid state share savings annually, except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, 2012 and each state fiscal year thereafter.

(b) The following types of appropriations shall be exempt from reductions pursuant to this section:

(i) any reductions that would violate federal law including, but not limited to, payments required pursuant to the federal Medicare program;

(ii) any reductions related to payments pursuant to article 32, article 31 and article 16 of the mental hygiene law;

(iii) payments the state is obligated to make pursuant to court orders or judgments;

(iv) payments for which the non-federal share does not reflect any state funding; and

(v) at the discretion of the commissioner of health and the director of the budget, payments with regard to which it is determined by the commissioner of health and the director of the budget that application of reductions pursuant to this section would result, by operation of federal law, in a lower federal medical assistance percentage applicable to such payments.

(c) Reductions to Medicaid payments or Medicaid rates of payments made pursuant to this section shall be subject to the receipt of all necessary federal approvals.

§ 91. Notwithstanding any inconsistent provision of state law, rule or regulation to the contrary, subject to federal approval, the year to year rate of growth of department of health state funds 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.

§ 92. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected department of health state funds medicaid expenditures, and if the director of the budget determines that such expenditures are expected to cause medicaid disbursements for such period to exceed the projected department of health medicaid state funds disbursements in the enacted budget financial plan pursuant to subdivision 3 of section 23 of the state finance law, the commissioner of health, in consultation with the director of the budget, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit level specified in the enacted budget financial plan, provided, however, such projections may be adjusted by the director of the budget to account for any changes in the New York state federal medical assistance percentage amount established

pursuant to the federal social security act, changes in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund.

1. Such medicaid savings allocation plan shall be designed, to reduce the disbursements authorized by the appropriations herein in compliance with the following guidelines: (1) reductions shall be made in compliance with applicable federal law, including the provisions of the Patient Protection and Affordable Care Act, Public Law No. 111-148, and the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (collectively "Affordable Care Act") and any subsequent amendments thereto or regulations promulgated thereunder; (2) reductions shall be made in a manner that complies with the state Medicaid plan approved by the federal centers for medicare and medicaid services, provided, however, that the commissioner of health is authorized to submit any state plan amendment or seek other federal approval, including waiver authority, to implement the provisions of the medicaid savings allocation plan that meets the other criteria set forth herein; (3) 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 of health, under the Affordable Care Act; (4) reductions shall be made uniformly among categories of services, to the extent practicable, and shall be made uniformly within a category of service, to the extent practicable, except where the commissioner of health determines that there are sufficient grounds for non-uniformity, including but not limited to: the extent to which specific categories of services contributed to department of health medicaid state funds spending in excess of the limits

specified herein; the need to maintain safety net services in underserved communities; the need to encourage or discourage certain activities by providers of particular health care services in order to improve quality of and access to care; or 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 medicaid savings allocation plan; and (5) reductions shall be made in a manner that does not unnecessarily create administrative burdens to Medicaid applicants and recipients or providers.

2. In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid 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 or discontinuing Medicaid 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 2807 and 3614 of the public health law, section 18 of chapter 2 of the laws of 1988, and 18 NYCRR 505.14(h).

§ 93. 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.

§ 94. 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.

§ 95. 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.

§ 96. This act shall take effect immediately and shall be deemed to have been in full force and effect on and after April 1, 2011; provided however, that:

(a) the amendment to subparagraph 1 of paragraph (c) of subdivision 10 of section 2807-c of the public health law made by section one of this act shall not affect the expiration of such subparagraph and shall expire and be deemed repealed therewith;

(b) the amendments to section 272 of the public health law, made by sections nine, sixteen and seventeen of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith;

(b-1) the amendments to subdivision 9 of section 367-a of the social services law made by section ten of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(c) the amendments to subdivision 22 of section 6802 of the education law, made by section twelve of this act shall not affect the repeal of such subdivision and shall expire and be deemed repealed therewith;

(d) the amendments to section 271 of the public health law, made by sections thirteen, fourteen and fifteen of this act shall not affect the repeal of such section and shall expire and be deemed repealed therewith;

(e) the amendments to subparagraph (i) of paragraph (b-1) of subdivision 1 of section 2807-c of the public health law made by section thirty-two of this act shall not affect the expiration of such paragraph and shall be deemed to expire therewith;

(f) the amendments to section 4403-f of the public health law made by sections forty-one, forty-one-a and forty-one-b of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(g) the amendments to subdivision 6 of section 367-a of the social services law, made by sections forty-three, forty-four and forty-five of this act shall not affect the repeal of such subdivision and shall expire and be deemed repealed therewith;

(h) sections thirty-six, fifty, fifty-one and sixty-eight of this act shall take effect on the ninetieth day after it shall have become a law;

(i) the amendments to section 2807-j of the public health law made by section sixty-eight of this act shall not affect the expiration of such section and shall be deemed to expire therewith;

(j) sections five, twenty, twenty-one, twenty-four, twenty-seven, forty-one, forty-one-a, forty-one-b, forty-three, forty-four, forty-five, forty-six, forty-eight, fifty-four, fifty-eight, seventy, seventy-one, seventy-two and seventy-three of this act shall take effect on the one hundred eightieth day after it shall have become a law;

(k) section forty-seven of this act shall take effect on October 1, 2011;

(l) the amendments to paragraph 6 of subdivision (a) of section 31.02 of the mental hygiene law made by section seventy-two of this act shall not affect the repeal of such paragraph and shall be deemed to be repealed therewith;

(m) the amendments to section 364-j of the social services law made by sections seventy-seven, seventy-seven-a, seventy-eight, seventy-nine and eighty of this act shall not affect the repeal of such section and shall be deemed repealed therewith;

(n) the amendments to paragraph (k) of subdivision 2 of section 365-a of the social services law made by section eighty-one of this act shall not affect the expiration of such subdivision and shall be deemed to expire therewith;

(o) section twelve of this act shall take effect August 1, 2011;

(p) sections thirteen, fourteen, fifteen, sixteen, seventeen and eighteen shall take effect May 1, 2011;

(q) section twenty-three of this act shall take effect December 1, 2011;

(r) section forty of this act shall take effect September 1, 2011;

(s) sections sixty-nine, eighty-two, eighty-three, eighty-four, eighty-five, eighty-six, and eighty-seven of this act shall take effect on

January 1, 2012 and shall apply to taxable years beginning on or after January 1, 2012;

(t) section thirty-five of this act shall expire and be deemed repealed April 1, 2015;

(u) section ninety-one of this act shall take effect April 1, 2012;

(v) 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, provided that the department of health may promulgate regulations including on an emergency basis, necessary to implement this act, prior to its effective date;

(w) 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;

(x) the commissioner of health and the superintendent of insurance and any appropriate council may take any steps necessary to implement this act prior to its effective date;

(y) 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 insurance 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;

(z) sections fifty-two through fifty-two-m of this act shall take effect on the ninetieth day after it shall have become law, provided that it shall apply to birth-related neurological injury lawsuits in existence as of the date of enactment and to all birth-related neurological injury lawsuits commenced subsequently to the date of enactment,

and provided further that the commissioner of health and the superintendent of financial regulations shall be authorized to promulgate any regulations as necessary to implement such sections prior to such effective date, including on an emergency basis; and

(aa) the provisions of this act shall become effective notwithstanding the failure of the commissioner of health or the superintendent of insurance or any council to adopt or amend or promulgate regulations implementing this act.