

**Amendments to the
STATE OPERATIONS BUDGET BILL
(Senate 2800-A and Assembly 4000-A)**

DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

- Page 70, Line 22, After "system" and before ";", insert
 "and shall report such information to a task force established by executive order; and provided further, the commissioner shall close facilities as recommended by such task force so long as such recommendations are in accord with the terms of the executive order"
- Page 70, Line 22-26, Strike out
 "that any such facilities shall be closed after the commissioner considers the recommendations of a task force established by executive order, but"
- Page 70, Line 27-28, Strike out
 "within the time period as prescribed by"
 and insert
 "in accord with the terms of"
- Page 70, Line 32, Strike out and insert ", "
 ". Any such closures may be undertaken"
- Page 70, Line 40, After "the", insert "task force or the"
- Page 72, Line 33, After "system" and before ";", insert
 "and shall report such information to a task force established by executive order; and provided further, the commissioner shall close facilities as recommended by such task force so long as such recommendations are in accord with the terms of the executive order"
- Page 72, Line 33-37, Strike out
 "that any such facilities shall be closed after the commissioner considers the recommendations of a task force established by executive order, but"

- Page 72, Line 38-39, Strike out
 "within the time period as prescribed by"
 and insert
 "in accord with the terms of"
- Page 72, Line 43, Strike out and insert ", "
 ". Any such closures
 may be undertaken"
- Page 73, Line 7, After "the", insert "task force or the"
- Page 74, Line 28, After "system" and
 before ";", insert
 "and shall report such information to a task
 force established by executive order; and
 provided further, the commissioner shall
 close facilities as recommended by such task
 force so long as such recommendations are in
 accord with the terms of the executive
 order"
- Page 74, Line 28-32, Strike out
 "that any such facilities shall be closed
 after the commissioner considers the
 recommendations of a task force established
 by executive order, but"
- Page 74, Line 33-34, Strike out
 "within the time period as prescribed by"
 and insert
 "in accord with the terms of"
- Page 74, Line 38, Strike out and insert ", "
 ". Any such closures
 may be undertaken"
- Page 74, Line 46, After "the", insert "task force or the"
- Page 75, Line 40, After "system" and
 before ";", insert
 "and shall report such information to a task
 force established by executive order; and
 provided further, the commissioner shall
 close facilities as recommended by such task
 force so long as such recommendations are in
 accord with the terms of the executive
 order"

- Page 75, Line 40-44, Strike out
 "that any such facilities shall be closed after the commissioner considers the recommendations of a task force established by executive order, but"
- Pages 75-76, Line 45-1, Strike out
 "within the time period as prescribed by"
 and insert
 "in accord with the terms of"
- Page 76, Line 5, Strike out and insert ", "
 ". Any such closures may be undertaken"
- Page 76, Line 13, After "the", insert "task force or the"
- Page 77, Line 36, After "system" and before ";", insert
 "and shall report such information to a task force established by executive order; and provided further, the commissioner shall close facilities as recommended by such task force so long as such recommendations are in accord with the terms of the executive order"
- Page 77, Line 36-40, Strike out
 "that any such facilities shall be closed after the commissioner considers the recommendations of a task force established by executive order, but"
- Page 77, Line 41-42, Strike out
 "within the time period as prescribed by"
 and insert
 "in accord with the terms of"
- Page 78, Line 2, Strike out and insert ", "
 ". Any such closures may be undertaken"
- Page 78, Line 10, After "the", insert "task force or the"
- Page 79, Line 18, After "system" and before ";", insert
 "and shall report such information to a task force established by executive order; and provided further, the commissioner shall

close facilities as recommended by such task force so long as such recommendations are in accord with the terms of the executive order"

Page 79, Line 18-22, Strike out

"that any such facilities shall be closed after the commissioner considers the recommendations of a task force established by executive order, but"

Page 79, Line 23-24, Strike out

"within the time period as prescribed by"

and insert

"in accord with the terms of"

Page 79, Line 28, Strike out and insert ", " ". Any such closures may be undertaken"

Page 79, Line 36, After "the", insert "task force or the"

DEPARTMENT OF HEALTH

Page 320, Line 49, After "Grant", insert

"-- Notwithstanding sections 112 and 163 of the state finance law, or any other inconsistent provision of law, the commissioner of health is authorized to enter into a contract without a request for proposal process or any other competitive process to the Computer Services Corporation, for the purposes set forth in the early innovator federal grant awarded to the department of health by the federal centers for medicare and medicaid services pursuant to the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), to the entity or entities specified in such grant, up to the amount needed for implementation of such grant"

**Amendments to the
AID TO LOCALITIES BUDGET BILL
(Senate 2803-A and Assembly 4003-A)**

PREAMBLE

Page 1, Line 9, After "2011" and
before ".", insert
"except as otherwise noted"

Page 2, Line 16, After "2011" and
before ".", insert
"except as otherwise noted"

STATE EDUCATION DEPARTMENT

Page 60, Line 4, Strike out "18,727,587,000"
and insert "35,618,422,000"

Page 60, Line 6, Strike out "6,240,479,000"
and insert "9,335,479,000"

Page 60, Line 8, Strike out "29,052,154,000"
and insert "49,037,989,000"

Page 60, Line 28, Strike out "25,344,236,000"
and insert "45,330,071,000"

Page 62, Line 15, Strike out "For"
and insert
"Notwithstanding any inconsistent provision of law, for"

Page 62, Line 16, Before "provided", insert
"for the 2011-12 and 2012-13 state fiscal years"

Page 62, Line 16, After "that" insert

"not more than 40.01 percent of this appropriation shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, nor more than 18.42 percent of this appropriation shall be available for remaining payments for the 2011-12 school year payable in the 2012-13 state fiscal year and provided further that notwithstanding any inconsistent provision of law, the remaining amounts available for the 2012-13 school year shall be apportioned to school districts pursuant to the education law and subject to the limitations of this appropriation including the gap elimination adjustment as provided for herein unless, however: 1) a chapter of the laws of 2011 or 2012 enacted hereafter establishes formulae for the apportionment of general support for public schools for the 2012-13 school year; and, 2) such formulae shall ensure that such amounts calculated pursuant to such formulae shall not exceed the product of the personal income growth index multiplied by the statewide total of such apportionments, including the gap elimination adjustment, due and owing during the base

school year to school districts and boards of cooperative educational services from the general support for public schools as computed based on an electronic data file used to produce the school aid computer listing produced by the commissioner in support of the enacted budget for the base year, and the personal income growth index shall be the average of the quotients for each year in the period commencing with the 2005-06 state fiscal year and finishing with the 2009-10 state fiscal year of the total personal income of the state for each such year divided by the total personal income of the state for the immediately preceding state fiscal year, but not less than one, and the total personal income of the state shall be the total personal income of the state of New York as published by the United States department of commerce based on the data available most proximate and prior to February 1, 2011; and, 3) provided further that, such chapter shall be enacted into law prior to April 1, 2012.

Provided that, notwithstanding any inconsistent provision of law,"

Page 62,	Line 18,	Strike out	
			"for the 2011-12 state fiscal year"
		and insert	
			"for the 2011-12 school year"
Page 62,	Line 22,	After "district," insert	
			"and shall also reduce payments due to each district for the 2012-13 school year within the 2012-13 state fiscal year pursuant to section 3609-a of the education law by an amount based on the gap elimination adjustment for the 2012-13 school year computed for such district,"
Page 62,	Line 25,	Strike out	"adjustment"
		and insert	"adjustments"
Page 62,	Line 26,	After "2011", insert	"or 2012"
Page 62,	Line 28,	After "2011-12", insert	"and 2012-13"
Page 62,	Line 28,	Strike out	"year"
		and insert	"years"
Page 62,	Line 32,	Strike out	"adjustment"
		and insert	"adjustments"
Page 62,	Line 45,	After "ment", insert	
			"for the 2011-12 school year"
Page 63,	Line 35,	After "adjustment" insert	
			"for the 2011-12 school year"

Page 67, Between lines
11 and 12, Insert

"Provided further that, the gap elimination adjustment for a district for the 2012-13 school year shall equal the product of the gap elimination adjustment percentage for such district and the excess growth amount, where the gap elimination adjustment percentage shall be the quotient of the gap elimination adjustment amount set forth for each school district as "GAP ELIMINATION ADJUSTMENT" under the heading "2011-12 ESTIMATED AIDS" in the school aid computer listing produced by the commissioner in support of the executive budget proposal for the 2011-12 school year and entitled "BT111-2", divided by the statewide total of all such gap elimination adjustment amounts set forth for all districts in such school aid computer listing, and the excess growth amount shall be the positive difference, if any, of (1) the statewide total, excluding the gap elimination adjustment for the 2012-13 school year, of the apportionments due and owing during the current school year to school districts and boards of cooperative educational services from the general support for public schools less (2) the product of the personal income growth index multiplied by the statewide total of such apportionments, including the gap elimination adjustment for the 2011-12 school year, due and owing during the base school year to school districts and boards of cooperative educational services from the general support for public schools as computed based on an electronic data file used to produce the school aid computer listing produced by the commissioner in support of the enacted budget for the base year, and the personal income growth index shall be the average of the quotients for each year in the period commencing with the 2005-06 state fiscal year and finishing with the 2009-10 state fiscal year of the total personal income of the state for each such year divided by the total personal income of the state for the immediately preceding state fiscal year, but not less than one, and the total personal income of the state shall be the total personal income of the state of New York as published by the United States department of commerce based on the data available most proximate and prior to February 1, 2011."

Page 67, Line 14, After "2011-12", insert "and 2012-13"

Page 67, Line 14, Strike out "year"
and insert "years"

Page 67, Line 22, After "2011-12", insert "and 2012-13"

Page 67, Line 22, Strike out "year"
and insert "years"

Page 67, Between lines
32 and 33, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools

appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

- Page 67, Line 38, After "law" and before ",", insert
"for the 2011-12 and 2012-13 school years"
- Page 67, Line 44, Strike out "and entitled "BT111-2"" and insert
"submitted in the immediately preceding school year"
- Page 68, Line 16, After "Notwithstanding", insert
"section 40 of the state finance law or"
- Page 68, Lines 17-18, Strike out
"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
and insert
"this appropriation shall lapse on March 31, 2013"
- Page 68, Line 19, Strike out "10,588,590,000" and insert "26,462,319,000"
- Page 69, Line 41, After "12" insert "and 2012-13"
- Page 69, Line 41, Strike out "year" and insert "years"
- Page 69, Line 51, After "budget" and before ",", insert
"provided that no more than \$12,058,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"
- Page 69, Line 51, After "that", insert
"in each state fiscal year"
- Page 70, Between lines 14 and 15, Insert
"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the

2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 70, Line 24, After "Notwithstanding", insert
"section 40 of the state finance law or"

Page 70, Lines 25-27, Strike out
"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"

And insert

"this appropriation shall lapse on March 31, 2013"

Page 70, Line 27, Strike out "12,058,000"
and insert "29,283,000"

Page 70, Line 29, After "2011-12", insert "and 2012-13"

Page 70, Line 29, Strike out "year"
and insert "years"

Page 70, Line 42, After "for", insert "each"

Page 70, Line 43, After "year" and
before ",", insert

"and provided further that no more than \$8,750,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"

Page 71, Before line 1, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 71, Line 10, After "Notwithstanding", insert
"section 40 of the state finance law or"

Page 71, Lines 11-13, Strike out
"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"

and insert

"this appropriation shall lapse on March 31, 2013"

Page 71,	Line 13,	Strike out and insert	"8,750,000" "21,250,000"
Page 71,	Line 15,	After "2011-12", insert	"and 2012-13"
Page 71,	Line 15,	Strike out and insert	"year" "years"
Page 71,	Line 25,	After "\$3,285,000", insert	
		"for each such school year, and provided further that no more than \$2,300,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, and"	
Page 71,	Line 26,	After "provided", insert	"further"
Page 71,	Between lines 35 and 36,	Insert	
		"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."	
Page 71,	Line 45,	After "Notwithstanding", insert	
		"section 40 of the state finance law or"	
Page 71,	Lines 46-48,	Strike out	
		"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"	
		and insert	
		"this appropriation shall lapse on March 31, 2013"	
Page 71,	Line 48,	Strike out and insert	"2,300,000" "5,585,000"
Page 72,	Line 1,	After "2011-12", insert	"and 2012-13"
Page 72,	Line 1,	Strike out and insert	"year," "years, provided that no more than \$1,911,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, and"

- Page 72, Between lines
11 and 12, Insert
- "Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."
- Page 72, Line 21, After "Notwithstanding", insert
"section 40 of the state finance law or"
- Page 72, Lines 22-24, Strike out
- "funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
- and insert
- "this appropriation shall lapse on March 31, 2013"
- Page 72, Line 24, Strike out "1,911,000"
and insert "4,641,000"
- Page 72, Line 30, After "2011-12", insert "and 2012-13"
- Page 72, Line 31, Strike out "year"
and insert "years"
- Page 72, Line 40, After "program" and
before ".", insert
- ", provided that no more than \$3,500,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"
- Page 72, Between lines
40 and 41, Insert
- "Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."
- Page 72, Line 50, After "Notwithstanding", insert
"section 40 of the state finance law or"

Page 72-73, Lines 51-2, Strike out
 "funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
 and insert
 "this appropriation shall lapse on March 31, 2013"

Page 73, Line 2, Strike out "3,500,000"
 and insert "8,500,000"

Page 73, Line 4, After "2011-12", insert "and 2012-13"

Page 73, Line 4, Strike out "year"
 and insert "years"

Page 73, Line 8, After "law", insert
 ", provided that no more than \$13,650,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, and"

Page 73, Between lines 17 and 18, Insert
 "Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 73, Line 27, After "Notwithstanding", insert
 "section 40 of the state finance law or"

Page 73, Lines 28-30, Strike out
 "funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
 and insert
 "this appropriation shall lapse on March 31, 2013"

Page 73, Line 30, Strike out "13,650,000"
 and insert "33,150,000"

Page 73, Line 32, After "2011-12", insert "and 2012-13"

Page 73, Line 32, Strike out "year"
 and insert "years"

- Page 73, Line 37, After "law" and before ".", insert
 ", provided that no more than \$53,200,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"
- Page 74, Before lines 1, Insert
 "Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."
- Page 74, Line 10, After "Notwithstanding", insert
 "section 40 of the state finance law or"
- Page 74, Lines 11-13, Strike out
 "funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
 and insert
 "this appropriation shall lapse on March 31, 2013"
- Page 74, Line 13, Strike out "53,200,000"
 and insert "129,200,000"
- Page 74, Line 15, After "2011-12", insert "and 2012-13"
- Page 74, Line 16, Strike out "year"
 and insert "years"
- Page 74, Line 17, After "districts", insert
 ", provided that no more than \$1,890,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, and"
- Page 74, Between lines 31 and 32, Insert
 "Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 74, Line 41, After "Notwithstanding", insert
 "section 40 of the state finance law or"

Page 74, Lines 42-44, Strike out
 "funds appropriated herein shall be available for payment
 of liabilities hereafter to accrue"
 and insert
 "this appropriation shall lapse on March 31, 2013"

Page 74, Line 44, Strike out "1,890,000"
 and insert "4,590,000"

Page 74, Line 48, After "2011-12", insert "and 2012-13"

Page 74, Line 48, Strike out "year"
 and insert "years"

Page 74, Line 50, After "\$400,000", insert
 "in each such year"

Page 75, Line 5, After "ation", insert
 ", provided that no more than \$280,000 shall be available
 for 2011-12 state fiscal year payments for general support
 for public schools for the 2011-12 school year, and"

Page 75, Between lines
 14 and 15, Insert
 "Provided further that notwithstanding any provision of law
 to the contrary, in determining the final payment for the
 state fiscal year pursuant to section 3609-a of the
 education law, the general support for public schools
 appropriations for the state fiscal year ending March 31,
 2012 shall be deemed to include the portion of this
 appropriation made available for 2011-12 state fiscal year
 payments for general support for public schools for the
 2011-12 school year as provided for herein added to the
 sum of other such designated appropriated amounts."

Page 75, Line 24, After "Notwithstanding", insert
 "section 40 of the state finance law or"

Page 75, Lines 25-27, Strike out
 "funds appropriated herein shall be available for payment
 of liabilities hereafter to accrue"
 and insert
 "this appropriation shall lapse on March 31, 2013"

Page 75, Line 27, Strike out "280,000"
 and insert "680,000"

Page 75, Line 30, After "for", insert "each of"
 Page 75, Line 31, After "2011-12", insert "and 2012-13"
 Page 75, Line 31, Strike out "year,"
 and insert

"years, provided that no more than \$1,400,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, and"

Page 75, Between lines
 40 and 41, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 75, Line 50, After "Notwithstanding", insert

"section 40 of the state finance law or"

Page 75-76, Lines 51-2, Strike out

"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"

and insert

"this appropriation shall lapse on March 31, 2013"

Page 76, Line 2, Strike out "1,400,000"
 and insert "3,400,000"

Page 76, Line 6, After "year", insert

"and for services and expenses of a \$12,000,000 special academic improvement grants program for the 2012-13 school year"

Page 76, Line 8, After "law" and
 before ",", insert

", provided that no more than \$4,200,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"

Page 76, Between lines
 23 and 24, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the

education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

- Page 76, Line 33, After "Notwithstanding", insert
"section 40 of the state finance law or"
- Page 76, Lines 34-36, Strike out
"funds appropriated herein shall be available for payment of liabilities hereafter to accrue"
and insert
"this appropriation shall lapse on March 31, 2013"
- Page 76, Line 36, Strike out "4,200,000"
and insert "14,400,000"
- Page 76, Line 38, Strike out "2011-12"
and insert "2012-13"
- Page 76, Line 38, After "years" and
before ".", insert
", provided that no more than \$22,400,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 or prior school years"
- Page 77, Between lines
2 and 3, Insert
"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."
- Page 77, Line 15, Strike out
"or hereafter to accrue"
and insert
". Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"

Page 77, Line 15, Strike out "22,400,000"
and insert "54,400,000"

Page 77, Line 17, After "\$13,840,000", insert
"in each school year"

Page 77, Line 18, After "2011-12", insert "and 2012-13"

Page 77, Line 18, Strike out "year"
and insert "years"

Page 77, Line 27, After "year" and
before ".", insert

", provided that no more than \$9,688,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"

Page 77, Between lines
33 and 34, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 77, Lines 47-49, Strike out

", and funds appropriated herein shall be available for payment of aid hereafter to accrue"

and insert

". Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"

Page 77, Line 49, Strike out "9,688,000"
and insert "23,528,000"

Page 78, Line 2, After "2011-12", insert "and 2012-13"

Page 78, Line 2, Strike out "year"
and insert "years"

Page 78, Line 4, After "services,", insert

"provided that no more than \$518,409,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2010-11 and prior school years and no more than \$180,194,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year, provided that, notwithstanding any inconsistent provision of law in no

event shall such amounts paid in the 2011-12 state fiscal year exceed 50.00 percent of the amount appropriated herein and"

Page 78, Line 12, Strike out "and entitled "BT111-2""
and insert

"submitted in the immediately preceding school year"

Page 78, Between lines
31 and 32, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 and prior school years as provided for herein added to the sum of other such designated appropriated amounts."

Page 78, Lines 40-41, Strike out "or hereafter to accrue,"

Page 78, Line 47, After "program", insert

". Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"

Page 78, Line 47, Strike out "698,603,000"
and insert "1,397,329,000"

Page 78, Line 49, After "2011-12", insert "and 2012-13"

Page 78, Line 50, Strike out "year"
and insert "years"

Page 78, Line 50, After "\$25,000,000" and
before ",", insert

"for each such school year"

Page 78, Line 52, After "amount", insert

"in each such school year"

Page 79, Line 8, After "\$500,000", insert

"in each such school year"

Page 79, Line 14, After "icate" and
before ".", insert

", and provided that no more than \$17,500,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year"

Page 79, Between lines
24 and 25, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year as provided for herein added to the sum of other such designated appropriated amounts."

Page 79, Line 37, Strike out "or hereafter to accrue"
and insert

". Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"

Page 79, Line 37, Strike out "17,500,000"
and insert "42,500,000"

Page 79, Line 39, After "2010-11", insert "and 2011-12"

Page 79, Line 39, Strike out "year"
and insert "years"

Page 79, Line 41, After "law" and
before ".", insert

", provided that no more than \$96,000,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2010-11 and prior school years"

Page 80, Between lines
2 and 3, Insert

"Provided further that notwithstanding any provision of law to the contrary, in determining the final payment for the state fiscal year pursuant to section 3609-a of the education law, the general support for public schools appropriations for the state fiscal year ending March 31, 2012 shall be deemed to include the portion of this appropriation made available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 and prior school years as provided for herein added to the sum of other such designated appropriated amounts."

Page 80, Line 12, After "program", insert

". Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"

Page 80, Line 12, Strike out "96,000,000"
and insert "192,000,000"

Page 88,	Line 17,	Strike out and insert	"18,472,324,000" "35,363,159,000"
Page 93,	Line 13,	After "schools", insert	
		<p>"for the 2011-12 and 2012-13 school years, provided that, notwithstanding any other provision of law to the contrary, in computing the additional lottery grant pursuant to subparagraph (4) of paragraph (b) of subdivision 4 of section 92-c of the state finance law for the 2011-12 school year, the base grant shall not exceed \$1,970,000,000.</p> <p>Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"</p>	
Page 93,	Line 13,	Strike out and insert	"1,970,000,000" "3,991,000,000"
Page 93,	Line 15,	After "2010-11", insert	
		<p>"and June 2011-12"</p>	
Page 93,	Line 15,	After "payment", insert	
		<p>"s, provided that no more than \$240,000,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2010-11 school year.</p> <p>Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"</p>	
Page 93,	Line 15,	Strike out and insert	"240,000,000" "480,000,000"
Page 93,	Line 17,	After "2011-12", insert	"and 2012-13"
Page 93,	Line 17,	Strike out and insert	"year" "years"
Page 93,	Line 20,	After "law", insert	
		<p>", provided that no more than \$682,000,000 shall be available for 2011-12 state fiscal year payments for general support for public schools for the 2011-12 school year.</p> <p>Notwithstanding section 40 of the state finance law or any provision of law to the contrary, this appropriation shall lapse on March 31, 2013"</p>	
Page 93,	Line 20,	Strike out And insert	"682,000,000" "1,516,000,000"
Page 93,	Line 22,	Strike out And insert	"2,892,000,000" "5,987,000,000"

DEPARTMENT OF HEALTH

Page 349,	Line 3,	Strike out and insert	"15,159,857,290" "29,713,714,290"
Page 349,	Line 4,	Strike out and insert	"32,185,270,000" "61,105,414,000"
Page 349,	Line 5,	Strike out and insert	"6,539,181,300" "12,677,165,300"
Page 349,	Line 7,	Strike out and insert	"53,884,308,590" "103,496,293,590"
Page 365,	Line 10,	Strike out and insert	"988,154,000" "981,954,000"
Page 365,	Line 21,	After "act.", insert	

"Notwithstanding any inconsistent provision of law, rule or regulation:

1. Effective October 1, 2011, co-payments shall be made to health care providers on behalf of an eligible child enrolled in the child health insurance plan pursuant to title 1-A of article 25 of the public health law for covered health care services provided to such child in amounts to be determined by the commissioner of health consistent with federal standards and specified in applicable contracts. Aggregate co-payment amounts collected by health care providers pursuant to this paragraph shall not exceed \$300 per year per eligible child. The commissioner of health shall reduce subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law to reflect estimated collections of co-payment amounts imposed pursuant to this paragraph 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 of health for the calendar year ending December 31, 2010 and adjusted annually on July 1 to reflect the visits reported for the preceding calendar year; provided however, if this chapter appropriates sufficient additional funds to support subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law without imposing co-payments pursuant to this paragraph, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

2. The commissioner of health shall adjust subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law on and after April 1, 2011 through March 31, 2012, so that the amount of each such payment is reduced by one and seven tenths percent; provided however, if this chapter appropriates sufficient additional funds to support subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law without this reduction, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011."

Page 365,	Line 21,	Strike out and insert	"514,600,000" "511,100,000"
Page 365,	Line 23,	Strike out and insert	"514,600,000" "511,100,000"
Page 365,	Line 34,	After "law", insert	

"Notwithstanding any inconsistent provision of law, rule or regulation:

1. Effective October 1, 2011, co-payments shall be made to health care providers on behalf of an eligible child enrolled in the child health insurance plan pursuant to title 1-A of article 25 of the public health law for covered health care services provided to such child in amounts to be determined by the commissioner of health consistent with federal standards and specified in applicable contracts. Aggregate co-payment amounts collected by health care providers pursuant to this paragraph shall not exceed \$300 per year per eligible child. The commissioner of health shall reduce subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law to reflect estimated collections of co-payment amounts imposed pursuant to this paragraph 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 of health for the calendar year ending December 31, 2010 and adjusted annually on July 1 to reflect the visits reported for the preceding calendar year; provided however, if this chapter appropriates sufficient additional funds to support subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the

public health law without imposing co-payments pursuant to this paragraph, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

2. The commissioner of health shall adjust subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law on and after April 1, 2011 through March 31, 2012, so that the amount of each such payment is reduced by one and seven tenths percent; provided however, if this chapter appropriates sufficient additional funds to support subsidy payments made to approved organizations pursuant to subdivision 8 of section 2511 of the public health law without this reduction, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011."

Page 365,	Line 34,	Strike out and insert	"473,554,000" "470,854,000"
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Page 365,	Line 36,	Strike out and insert	"473,554,000" "470,854,000"
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Page 371,	Line 30,	Strike out and insert	"466,776,000" "510,776,000"
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Page 373,	Line 8,	After "program", insert	
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". Provided, however, up to \$57,000,000 may be utilized for the purpose of supporting the New York State medical indemnity fund established pursuant to a chapter of the laws of 2011"

Page 374,	Between lines 43 and 44,	Insert	
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"For services and expenses related to the Public Health Services Corps	1,000,000
For suballocation to the department of financial regulation for the purpose of supporting the New York state medical indemnity fund	43,000,000"

Page 374,	Line 45,	Strike out and insert	"466,776,000" "510,776,000"
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Strike Out

"MEDICAL ASSISTANCE ADMINISTRATION PROGRAM 1,347,500,000

General Fund
Local Assistance Account

For state reimbursement of local administrative expenses for medical assistance programs notwithstanding section 153 of the social services law.

The money hereby appropriated is available for payment of aid heretofore accrued or hereafter to accrue to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, and shall be available to the department net of disallowances, refunds, reimbursements, and credits.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, the office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an esti-

mate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law 545,050,000

For contractual services related to medical necessity and quality of care reviews related to medicaid patients. Subject to the approval of the director of the budget, all or part of this appropriation may be transferred to the health care standards and surveillance program, general fund - local assistance account 3,700,000

The amount appropriated herein, together with any federal matching funds obtained, may be available to the department, subject to the approval of the director of the budget, for contractual services related to a third party entity responsible for education of persons eligible for medical assistance regarding their options for enrollment in managed care plans. Subject to the approval of the director of the budget, all or a part of this appropriation may be transferred to the office of managed care, general fund - state purposes account. Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts 25,000,000

For state reimbursement of administrative expenses for the medical assistance program provided by the office of mental health, office for people with developmental disabilities and office of alcoholism and substance abuse services.

The money hereby appropriated is available for payment of aid heretofore accrued and hereafter to accrue. Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange with any other appropriation of the department of health with the approval of the director of the budget 100,000,000

Program account subtotal 673,750,000

Special Revenue Funds - Federal
Federal Health and Human Services Fund
Medicaid Administration Transfer Account

For reimbursement of local administrative expenses of medical assistance programs provided pursuant to title XIX of the federal social security act or its successor program.

The moneys hereby appropriated are to be available for payment of aid heretofore accrued or hereafter to accrue to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, shall be available to the department net of disallowances, refunds, reimbursements, and credits. The amounts appropriated herein may be available for costs associated with a common benefit identification card, and subject to the approval of the director of the budget, these funds may be transferred to the credit of the state operations account medicaid management information systems program.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, the office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law 573,750,000

For reimbursement of administrative expenses of the medical assistance program provided by the office of mental health, office for people with developmental disabilities, and office of alcoholism and substance abuse services provided pursuant to title XIX of the federal social security act. The money hereby appropriated is available for payment of aid heretofore accrued and hereafter to accrue. Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange with any other appropriation of the department of health with the approval of the director of budget 100,000,000

Program account subtotal 673,750,000

MEDICAL ASSISTANCE PROGRAM 48,751,877,000

General Fund
Local Assistance Account

For the medical assistance program, including administrative expenses, for local social services districts, and for medical care rates for authorized child care agencies.

The money hereby appropriated is to be available for payment of aid heretofore accrued or hereafter to accrue to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and to providers of family care where payment systems through the fiscal intermediaries are not operational, and shall be available to the department net of disallowances, refunds, reimbursements, and credits.

Notwithstanding any inconsistent provision of law to the contrary, funds may be used by the department for outside legal assistance on issues involving the federal government, the conduct of preadmission screening and annual resident reviews required by the state's medicaid program, computer matching with insurance carriers to insure that medicaid is the payer of last resort and activities related to the management of the pharmacy benefit available under the medicaid program.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds

herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health and the office of medicaid inspector general and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services, the office of Medicaid Inspector General, and state office for the aging with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law to the contrary, the moneys hereby appropriated may be used for payments to the centers for medicaid and medicare services for obligations incurred related to the pharmaceutical costs of dually eligible medicare/medicaid beneficiaries participating in the medicare drug benefit authorized by P.L. 108-173.

Notwithstanding any inconsistent provision of law, the moneys hereby appropriated shall not be used for any existing rates, fees, fee schedule, or procedures which may affect the cost of care and services provided by personal care providers, case managers, health maintenance organizations, out of state medical facilities which provide care and services to residents of the state, providers of transportation services, that are altered, amended, adjusted or otherwise changed by

a local social services district unless previously approved by the department of health and the director of the budget.

For services and expenses of the medical assistance program including hospital inpatient services 1,231,436,000

For services and expenses of the medical assistance program including hospital outpatient and emergency room services 422,696,000

For services and expenses of the medical assistance program including clinic services 378,652,000

For services and expenses of the medical assistance program including nursing home services 2,206,838,000

For services and expenses of the medical assistance program including other long term care services 2,611,714,000

For services and expenses of the medical assistance program including managed care services 4,093,988,000

For services and expenses of the medical assistance program including pharmacy services 310,421,000

For services and expenses of the medical assistance program including transportation services 111,102,000

For services and expenses of the medical assistance program including dental services 85,045,000

For services and expenses of the medical assistance program including non-institutional and other spending 1,061,470,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to pharmacy best practices initiatives including prior authorizations and prior approvals 6,800,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to utilization review activities including but not limited to utilization management for radiology and transportation management services 10,500,000

Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses

related to education of medicaid eligibles and recipients regarding the medicare part D program and recipient and provider notification and other program information as determined necessary by the commissioner of health. Subject to the approval of the director of the budget, a portion of this appropriation may be suballocated to other state agencies 2,500,000

Notwithstanding any inconsistent provision of law, subject to the approval of a plan by the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to making improvements in the long-term care system including long-term care restructuring, the nursing home transition and diversion waiver, and point-of-entry initiatives for the purpose of expanding and promoting a more coordinated level of care for the delivery of quality services in the community 1,750,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to required criminal background checks for non-licensed long-term care employees including employees of nursing homes, certified home health agencies, long term home health care providers, AIDS home care providers, and licensed home care service agencies 11,705,000

Notwithstanding any inconsistent provision of section 112 or 163 of the state finance law or any other contrary provision of the state finance law or any other contrary provision of law, the commissioner of health may, without a competitive bid or request for proposal process, enter into contracts with one or more certified public accounting firms for the purpose of conducting audits of disproportionate share hospital payments made by the state of New York to general hospitals and for the purpose of conducting audits of hospital cost reports as submitted to the state of New York in accordance with article 28 of the public health law. Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account 900,000

Notwithstanding any inconsistent provision of law, subject to a plan developed by the commissioner of health and approved by the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, will be available for demonstrations that develop and evaluate interventions targeted at medicaid beneficiaries who are otherwise exempt or excluded from mandatory Medicaid managed care and who have multiple comorbidities.

Notwithstanding section 112 and section 163 of the state finance law, for chronic illness demonstration projects authorized by section 364-1 of the social services law, the commissioner of health may allocate up to \$2,500,000 of the amount appropriated for contracts without a request for proposal process or any other competitive process 6,000,000

Notwithstanding any other provision of law, the money herein appropriated, together with any available federal matching funds, is available for transfer or suballocation to the state university of New York and its subsidiaries, or to contract without competition for services with the state university of New York research foundation, to provide support for the administration of the medical assistance program including activities such as dental prior approval, retrospective and prospective drug utilization review, development of evidence based utilization thresholds, data analysis, clinical consultation and peer review, clinical support for the pharmacy and therapeutic committee, and other activities related to utilization management and for health information technology support for the medicaid program 6,000,000

For grants to the civil service employees association, Local 1000, AFSCME, AFL-CIO to contribute to the union's cost of purchasing health insurance coverage under the family health plus (FHPlus) buy-in for child care providers represented by the union who do not otherwise qualify for coverage under FHPlus 6,800,000

For grants to the United Federation of Teachers, Local 2, AFT, AFL-CIO to contribute to the union's cost of purchasing health insurance coverage under the family health plus (FHPlus) buy-in for child care providers represented by the union who do not otherwise qualify for coverage under FHPlus 9,000,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, moneys appropri-

ated herein may be transferred to the general fund, state purposes account for services and expenses related to the independent audit of the internal controls of the school and preschool supportive health services programs as required by the New York state school supportive health services program compliance agreement with the centers for medicare and medicaid services.

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, the amount appropriated herein may be increased or decreased by interchange with any appropriation of the department of health 400,000

For services and expenses of the medical assistance program including medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services 4,000,000,000

Less an amount that may be allocated consistent, to the extent practicable, with the findings and recommendations contained in a report submitted by the medicaid redesign team pursuant to executive order number five. Provided, however, that if additional savings are necessary to meet the reduction in the level of medical assistance program state operating funds spending assumed herein, the commissioner of health and the New York state medicaid director, in consultation with the director of the budget, the commissioner of the office for people with developmental disabilities, the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, shall develop a plan to achieve such savings copies of which shall be provided to the department of audit and control, the chairperson of the senate finance committee and the chairperson of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2012, the commissioner of health may implement, to the extent practicable, the findings and recommendations submitted by the Medicaid redesign team or such plan as may otherwise be developed hereunder by, among other actions: 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; modify-
 ing or discontinuing Medicaid program
 benefits; seeking all necessary Federal
 approvals, including, but not limited to
 waivers and waiver amendments; and
 suspending time frames for notice,
 approval or certification of rate require-
 ments, 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) (2,850,000,000)

Program account subtotal 13,725,717,000

Special Revenue Funds - Federal
 Federal Health and Human Services Fund
 Medicaid Direct Account

For services and expenses for the medical
 assistance program, including administra-
 tive expenses for local social services
 districts, pursuant to title XIX of the
 federal social security act or its succes-
 sor program.

The moneys hereby appropriated are to be
 available for payment of aid heretofore
 accrued or hereafter to accrue to munici-
 palities, and to providers of medical
 services pursuant to section 367-b of the
 social services law, and for payment of
 state aid to municipalities and to provid-
 ers of family care where payment systems
 through the fiscal intermediaries are not
 operational, shall be available to the
 department net of disallowances, refunds,
 reimbursements, and credits.

Notwithstanding any other provision of law,
 the money hereby appropriated may be
 increased or decreased by interchange,
 with any appropriation of the department
 of health and the office of medicaid
 inspector general and may be increased or
 decreased by transfer or suballocation
 between these appropriated amounts and
 appropriations of the office of mental
 health, office for people with develop-
 mental disabilities, the office of alco-
 holism and substance abuse services, the
 department of family assistance office of
 temporary and disability assistance,
 office of children and family services,
 and state office for the aging with the
 approval of the director of the budget,
 who shall file such approval with the
 department of audit and control and copies
 thereof with the chairman of the senate
 finance committee and the chairman of the
 assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law.

For services and expenses of the medical assistance program including hospital inpatient services	4,876,642,000
For services and expenses of the medical assistance program including hospital outpatient and emergency room services ...	1,162,281,000
For services and expenses of the medical assistance program including clinic services	895,129,000
For services and expenses of the medical assistance program including nursing home services	4,036,725,000
For services and expenses of the medical assistance program including other long term care services	3,303,731,000
For services and expenses of the medical assistance program including managed care services	5,584,020,000
For services and expenses of the medical assistance program including pharmacy services	2,376,534,000
For services and expenses of the medical assistance program including transportation services	221,149,000
For services and expenses of the medical assistance program including dental services	176,107,000
For services and expenses of the medical assistance program including noninstitutional and other spending	4,828,516,000
For services and expenses of the medical assistance program including a series of targeted chronic illness demonstration projects.	

Notwithstanding section 112 and section 163 of the state finance law, for chronic illness demonstration projects authorized

by section 364-1 of the social services law, the commissioner of health may allocate up to \$2,500,000 of the amount appropriated for contracts without a request for proposal process or any other competitive process 6,000,000

Notwithstanding any other provision of law, the money herein appropriated, is available for transfer or suballocation to the state university of New York and its subsidiaries, or to contract without competition for services with the state university of New York research foundation, to provide support for the administration of the medical assistance program including activities such as dental prior approval, retrospective and prospective drug utilization review, development of evidence based utilization thresholds, data analysis, clinical consultation and peer review, clinical support for the pharmacy and therapeutic committee, and other activities related to utilization management and for health information technology support for the medicaid program 6,000,000

Notwithstanding any inconsistent provision of section 112 or 163 of the state finance law or any other contrary provision of the state finance law or any other contrary provision of law, the commissioner of health may, without a competitive bid or request for proposal process, enter into contracts with one or more certified public accounting firms for the purpose of conducting audits of disproportionate share hospital payments made by the state of New York to general hospitals and for the purpose of conducting audits of hospital cost reports as submitted to the state of New York in accordance with article 28 of the public health law. Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein 900,000

For services and expenses of the medical assistance program including medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services 4,000,000,000

For services and expenses of the medical assistance program including hospital inpatient, hospital outpatient and emergency room, clinic, nursing home, other long term care, managed care, pharmacy, transportation, dental, non-institutional and other spending, medical services provided at state facilities operated by

the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and for any other medical assistance services resulting from an increase in the federal medical assistance percentage pursuant to the American Recovery and Reinvestment Act. Funds appropriated herein shall be subject to all applicable reporting and accountability requirements contained in such act 1,204,000,000

Less an amount that may be allocated consistent, to the extent practicable, with the findings and recommendations contained in a report submitted by the medicaid redesign team pursuant to executive order number five. Provided, however, that if additional savings are necessary to meet the reduction in the level of medical assistance program special revenue funds - federal spending assumed herein, the commissioner of health and the New York state medicaid director, in consultation with the director of the budget, the commissioner of the office for people with developmental disabilities, the commissioner of the office of mental health and the commissioner of the office of alcoholism and substance abuse services, shall develop a plan to achieve such savings copies of which shall be provided to the department of audit and control, the chairperson of the senate finance committee and the chairperson of the assembly ways and means committee. Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2012, the commissioner of health may implement, to the extent practicable, the findings and recommendations submitted by the Medicaid redesign team or such plan as may otherwise be developed hereunder by, among other actions: 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 and 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) (2,582,000,000)

 Program account subtotal 30,095,734,000

Special Revenue Funds - Other
 HCRA Resources Fund
 Indigent Care Account

For the purpose of making payments to providers of medical care pursuant to section 367-b of the social services law, and for payment of state aid to municipalities where payment systems through fiscal intermediaries are not operational, to reimburse such providers for costs attributable to the provision of care to patients eligible for medical assistance. Payments from this appropriation to general hospitals related to indigent care pursuant to article 28 of the public health law respectively, when combined with federal funds for services and expenses for the medical assistance program pursuant to title XIX of the federal social security act or its successor program, shall equal the amount of the funds received related to health care reform act allowances and surcharges pursuant to article 28 of the public health law and deposited to this account less any such amounts withheld pursuant to subdivision 21 of section 2807-c of the public health law. Notwithstanding any inconsistent provision of law, the moneys hereby appropriated may be increased or decreased by interchange or transfer with any appropriation of the department of health with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee 791,500,000

 Program account subtotal 791,500,000

Special Revenue Funds - Other
 HCRA Resources Fund
 Medical Assistance Account

For the purpose of making payments, the money hereby appropriated is available for payment of aid heretofore accrued or hereafter accrued, to providers of medical care pursuant to section 367-b of the social services law, and for payment of

state aid to municipalities and the federal government where payment systems through fiscal intermediaries are not operational, to reimburse such providers for costs attributable to the provision of care to patients eligible for medical assistance. Notwithstanding any inconsistent provision of law, the moneys hereby appropriated may be increased or decreased by interchange or transfer with any appropriation of the department of health with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

For services and expenses related to the medical assistance program	146,400,000
For services and expenses of the medical assistance program related to the treatment of breast and cervical cancer	2,100,000
For services and expenses of the medical assistance program related to primary care case management. All or a portion of this appropriation may be transferred to state operations appropriations	2,000,000
For services and expenses of the medical assistance program related to disabled persons	23,500,000
For services and expenses of the medical assistance program related to physician services	85,200,000
For services and expenses of the medical assistance program related, but not limited to, pharmacy, inpatient, and nursing home services	1,786,626,000
For services and expenses of the medical assistance program related to the city of New York	124,700,000
For services and expenses of the medical assistance program related to providing distributions for supplemental medical insurance for medicare part B premiums, physician services, outpatient services, medical equipment, supplies and other health services	68,000,000
For services and expenses of the medical assistance program related to the family health plus program	628,400,000
For services and expenses of the medical assistance program related to providing financial assistance to residential health care facilities	15,000,000
For services and expenses of the medical assistance program related to supporting workforce recruitment and retention of personal care services or any worker with direct patient care responsibility for	

local social service districts which include a city with a population of over one million persons 136,000,000

For services and expenses of the medical assistance program related to supporting workforce recruitment and retention of personal care services for local social service districts that do not include a city with a population of over one million persons 11,200,000

For services and expenses of the medical assistance program related to supporting rate increases for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs, managed long term care plans and approved managed long term care operating demonstrations for recruitment and retention of health care workers 50,000,000

Program account subtotal 3,079,126,000

Special Revenue Funds - Other
 Miscellaneous Special Revenue Fund
 Medical Assistance Account

For the purpose of making payments to providers of medical care pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and the federal government where payment systems through fiscal intermediaries are not operational, to reimburse such providers for costs attributable to the provision of care to patients eligible for medical assistance.

For services and expenses of the medical assistance program including nursing home, personal care, certified home health agency, long term home health care program and hospital services 1,059,800,000

Program account subtotal 1,059,800,000

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Page 393, Between lines
 10 and 11, Insert

"MEDICAL ASSISTANCE ADMINISTRATION PROGRAM 2,741,000,000

General Fund
 Local Assistance Account

For state reimbursement of local administrative expenses for medical assistance programs notwithstanding section 153 of the social services law.

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made

from this account shall remain in full force and effect in accordance with the following schedule: 49 percent for the period April 1, 2011 to March 31, 2012; 51 percent for the period April 1, 2012 to March 31, 2013.

Notwithstanding section 40 of the state finance law or any provision of law to the contrary, subject to federal approval, department of health state funds medicaid spending, excluding payments for medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and further excluding any payments which are not appropriated within the department of health, in the aggregate, for the period April 1, 2011 through March 31, 2012, shall not exceed \$15,109,236,000 except as provided below and state share medicaid spending, in the aggregate, for the period April 1, 2012 through March 31, 2013, shall not exceed \$15,710,743,000, but in no event shall department of health state funds medicaid spending for the period April 1, 2011 through March 31, 2013 exceed \$30,819,979,000 provided, however, such aggregate limits 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, increases in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund, pursuant to a chapter establishing such fund. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected medicaid expenditures incurred both prior to and subsequent to such assessment for each such period, and if the director of the budget determines that such expenditures are expected to cause medicaid spending for such period to exceed the aggregate limit specified herein for such period, the state medicaid director, in consultation with the director of the budget and the commissioner of health, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit specified herein for such period.

Such medicaid savings allocation plan shall be designed, to reduce the expenditures 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, 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 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.

In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid spending 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).

The money hereby appropriated is available for payment of aid heretofore accrued to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, and shall be available to the department net of disallowances, refunds, reimbursements, and credits.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, the office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law

1,113,100,000

For contractual services related to medical necessity and quality of care reviews related to medicaid patients. Subject to the approval of the director of the budget, all or part of this appropriation may

be transferred to the health care standards and surveillance program, general fund - local assistance account 7,400,000

The amount appropriated herein, together with any federal matching funds obtained, may be available to the department, subject to the approval of the director of the budget, for contractual services related to a third party entity responsible for education of persons eligible for medical assistance regarding their options for enrollment in managed care plans. Subject to the approval of the director of the budget, all or a part of this appropriation may be transferred to the office of managed care, general fund - state purposes account. Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts 50,000,000

For state reimbursement of administrative expenses for the medical assistance program provided by the office of mental health, office for people with developmental disabilities and office of alcoholism and substance abuse services. The money hereby appropriated is available for payment of aid heretofore accrued . Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange with any other appropriation of the department of health with the approval of the director of the budget 200,000,000

 Program account subtotal 1,370,500,000

Special Revenue Funds - Federal
 Federal Health and Human Services Fund
 Medicaid Administration Transfer Account

For reimbursement of local administrative expenses of medical assistance programs provided pursuant to title XIX of the federal social security act or its successor program.

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the following schedule: 49 percent for the period April 1, 2011 to March 31, 2012; 51 percent for the period April 1, 2012 to March 31, 2013

The moneys hereby appropriated are to be available for payment of aid heretofore accrued to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, shall be available to the department net

of disallowances, refunds, reimbursements, and credits. The amounts appropriated herein may be available for costs associated with a common benefit identification card, and subject to the approval of the director of the budget, these funds may be transferred to the credit of the state operations account medicaid management information systems program.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health, and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, the office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law 1,170,500,000

For reimbursement of administrative expenses of the medical assistance program provided by the office of mental health, office for people with developmental disabilities, and office of alcoholism and substance abuse services provided pursuant to title XIX of the federal social security act. The money hereby appropriated is available for payment of aid heretofore accrued . Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange with

any other appropriation of the department
of health with the approval of the
director of budget 200,000,000

Program account subtotal 1,370,500,000

MEDICAL ASSISTANCE PROGRAM 96,932,562,000

General Fund
Local Assistance Account

For the medical assistance program, including administrative expenses, for local social services districts, and for medical care rates for authorized child care agencies.

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the following schedule: 49.50 percent for the period April 1, 2011 to March 31, 2012; 50.50 percent for the period April 1, 2012 to March 31, 2013.

Notwithstanding section 40 of the state finance law or any provision of law to the contrary, subject to federal approval, department of health state funds medicaid spending, excluding payments for medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and further excluding any payments which are not appropriated within the department of health, in the aggregate, for the period April 1, 2011 through March 31, 2012, shall not exceed \$15,109,236,000 except as provided below and state share medicaid spending, in the aggregate, for the period April 1, 2012 through March 31, 2013, shall not exceed \$15,710,743,000, but in no event shall department of health state funds medicaid spending for the period April 1, 2011 through March 31, 2013 exceed \$30,819,979,000 provided, however, such aggregate limits 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, increases in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund, pursuant to a chapter establishing such fund. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected medicaid expenditures incurred both prior to and subsequent to such assessment for each such period, and if the director of

the budget determines that such expenditures are expected to cause medicaid spending for such period to exceed the aggregate limit specified herein for such period, the state medicaid director, in consultation with the director of the budget and the commissioner of health, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit specified herein for such period.

Such medicaid savings allocation plan shall be designed, to reduce the expenditures 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, 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 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.

In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid spending 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).

Provided, notwithstanding any other law or rule to the contrary, that in order to make expenditures from these appropriations and achieve savings necessary to meet the department of health state funds medicaid expenditure cap as referenced above, a court shall issue an order in every medical, dental or podiatric malpractice action commenced during state fiscal year 2011-12 and state fiscal year 2012-13 pending before it, on its own motion or on the motion of any defendant in such action liable for damages arising from pain and suffering, loss of services, loss of consortium, or other nonpecuniary damages suffered by an injured plaintiff, limiting the recovery of such damages from every defendant liable for malpractice in such action, to no more than \$250,000, provided that such sum may be adjusted in accordance with Consumer Price Index for all Consumers, as published annually by the United States Department of Labor, Bureau of Labor Statistics, and further provided there shall be established the New York State Medical Indemnity Fund, to provide a funding source for certain costs associated with birth related neurological injuries pursuant to a chapter of the laws of 2011 enacted as legislation submitted by the governor, which fund shall be contingent upon the enactment of a \$250,000 cap on non economic damages pursuant to this appropriation or pursuant to such chapter.

The money hereby appropriated is to be available for payment of aid heretofore accrued to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and to providers of family care where payment systems through the fiscal intermediaries are not operational, and shall be available to the department net of disallowances, refunds, reimbursements, and credits.

Notwithstanding any inconsistent provision of law to the contrary, funds may be used by the department for outside legal assistance on issues involving the federal government, the conduct of preadmission screening and annual resident reviews required by the state's medicaid program, computer matching with insurance carriers to insure that medicaid is the payer of last resort and activities related to the management of the pharmacy benefit available under the medicaid program.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health and the office of medicaid inspector general and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance and office of children and family services, the office of Medicaid Inspector General, and state office for the aging with the approval of the director of the budget,

who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law to the contrary, the moneys hereby appropriated may be used for payments to the centers for medicaid and medicare services for obligations incurred related to the pharmaceutical costs of dually eligible medicare/medicaid beneficiaries participating in the medicare drug benefit authorized by P.L. 108-173.

Notwithstanding any inconsistent provision of law, the moneys hereby appropriated shall not be used for any existing rates, fees, fee schedule, or procedures which may affect the cost of care and services provided by personal care providers, case managers, health maintenance organizations, out of state medical facilities which provide care and services to residents of the state, providers of transportation services, that are altered, amended, adjusted or otherwise changed by a local social services district unless previously approved by the department of health and the director of the budget.

Notwithstanding any other provision of law, rule or regulation, to the contrary, for the period April 1, 2011 through March 31, 2013, 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 payment or other reductions provided that any method selected achieves no less than \$702,000,000 in medicaid state share savings, except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, 2013.

The following 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.

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.

Provided, however, if this chapter appropriates sufficient additional funds to support medicaid payments or medicaid rates of payments, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided for the period April 1, 2011 through March 31, 2013, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, for personal care services provided pursuant to section 365-a of the social services law, hospice services provided pursuant to article 40 of the public health law, foster care services provided pursuant to article 6 of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to calendar years on and after 2011 in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors for such calendar years shall also be applied to rates of payment for personal care services for such period provided in those local social service districts, including New York city, whose rates of payment for such services are established by such local social service districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social service

districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided for the period April 1, 2011 through March 31, 2013, trend factors attributable to such calendar years shall be established at no greater than zero percent, provided, however, that if this chapter provides sufficient additional funding to cover the cost of trend factor adjustments to the rates enumerated in this section, then provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for the period April 1, 2011 through March 31, 2013, 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. Provided however if this chapter provides sufficient additional funding to cover the cost of targeted medicaid reimbursement rate

reductions enumerated in this section, then the provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, 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: establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to enrollees with chronic conditions in the program of medical assistance for needy persons; 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; establish the criteria under which such an enrollee will be designated as being eligible to receive health home services; and assign any enrollee designated as an eligible individual to a provider of health home services. Until such time as the commissioner of health obtains necessary waivers of the federal social security act, enrollees assigned to providers of health home services will be allowed to opt out of such services. In addition to such payments made for health home services, the commissioner of health is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner. Payment for such health home services and such additional payments 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. The commissioner of health 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. Notwithstanding any limitations imposed by section 364 - 1 of the social services law, the commissioner is authorized to allow entities participating in demonstration projects established pursuant to such section to provide health home services. Notwithstanding any law, rule, or regulation to the contrary, the commissioners of the department of health,

the office of mental health, 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 can demonstrate experience in the delivery of health, and mental health and/or alcohol and substance abuse services and the capacity to offer integrated delivery in each location approved by the commissioner, and meet the standards for providing and receiving payment for health home services. 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, 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 integrated delivery of services in a rational and efficient manner. Provided, however, if this chapter appropriates sufficient additional funds to provide coverage for persons with chronic conditions under the program of medical assistance for needy persons without the savings to be achieved through the provision of health home services, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013: coverage under the medicaid program for enteral formula therapy is limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding or for treatment of an inborn error of metabolism, and no other nutritional or dietary supplements are covered; coverage under the medicaid program for prescription footwear and inserts is 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; coverage under the medicaid program for compression and support stockings is limited to coverage only for pregnancy or treatment of venous stasis ulcers; and the commissioner of health is authorized to require prior authorization for prescriptions of opioid analgesics in excess of four prescriptions in a 30-day period. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid coverage of such services without imposing such limitations, then the provisions of this

paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, when medicaid eligible persons are also beneficiaries under part B of title XVIII of the federal social security act and payment under part B would exceed the amount that would be paid by medicaid if the person were not eligible under part B or a qualified medicare beneficiary, the amount payable for services covered under the medicaid program for hospital outpatient services or diagnostic and treatment center services pursuant to article 28 of the public health law shall be 20 percent of the amount of any coinsurance liability of such eligible person pursuant to federal law if they were not eligible for medicaid or were not a qualified medicare beneficiary; provided however that in no event shall the amount payable for services covered under the medicaid program for such eligible person exceed the approved medical assistance payment level less the amount payable under part B. Provided, however, if this chapter appropriates sufficient additional funds to provide medical assistance payments under paragraph (d) of subdivision 1 of section 367-a of the social services law for hospital outpatient services or diagnostic and treatment center services in situations where payment under part B of title XVIII of the federal social security act would exceed the amount that otherwise would be paid by medicaid if the person were not eligible under part B or a qualified medicare beneficiary, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the maximum co-payment chargeable to a recipient of medicaid for non-institutional services shall be as follows: where the state's payment for the service is \$10 or less, the maximum co-payment shall be \$.60; where the state's payment for the service is from \$10.01 to \$25, the maximum co-payment shall be \$1.15; where the state's payment for the service is from \$25.01 to \$50, the maximum co-payment shall be \$2.30; where the state's payment for the service is \$50.01 or more, the maximum co-payment shall be \$3.40. The co-payment chargeable to a medicaid recipient for each discharge for inpatient care shall be \$30. The co-payment charged for each generic prescription drug dispensed shall

be \$1.15 and for each brand name prescription drug dispensed shall be \$3.40; provided, however, that the co-payment charged for each brand name prescription drug on the preferred drug list established pursuant to section 272 of the public health law and the co-payment charged for each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision 4 of section 365-a of the social services law shall be \$1.15. Co-payments shall apply to the following services in addition to those listed in paragraph (d) of subdivision 6 of section 367-a of the social services law: vision care; dental services; audiology services; physician services; nurse practitioner services; and rehabilitation services including occupational therapy, physical therapy and speech therapy. In the year commencing April 1, 2011 and for each year thereafter, no recipient shall be required to pay more than a total of \$300.00 in co-payments nor shall reductions in medicaid payments as a result of such co-payments exceed \$300.00 for any recipient. In both the medicaid and family health plus programs, the co-payment for emergency room services provided for non-urgent or non-emergency medical care shall be \$6.40; provided however that co-payments shall not be required with respect to emergency services or family planning services and supplies. The co-payment for nurse practitioner services in the family health plus program shall be \$5.00. Provided, however, if this chapter appropriates sufficient additional funds to allow the medicaid and family health plus programs to pay for services without the savings to be achieved by increasing the amount or scope of required co-payments, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, 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 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 behavioral health services with other services available under the medical assistance program, for recipients of medical assistance who are not enrolled in managed care, and for approval,

coordination, and integration of behavioral health services that are not provided through managed care programs under the medical assistance program 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. 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.

Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, or section 142 of the economic development law, or any other law, commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to enter into such contract or contracts without a competitive bid or request for proposal process; provided, however, that 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: a description of the proposed services to be provided pursuant to the contractor contracts; the criteria for selection of a contractor or contractors; 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 the manner by which a prospective contractor may seek such selection, which may include submission by electronic means. All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioners of the office of mental health and the office of alcoholism and substance abuse services. 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, are best suited to provide the required services.

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 governmental unit, as such term is defined in the mental hygiene law, and its local social services district, and with the prior 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 1, 2013, 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 112 and 163 of the state finance law, and section 142 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 governmental unit, as such term is defined in the mental hygiene law, and its local social services district.

Provided, however, if this chapter appropriates sufficient additional funds to provide coverage for behavioral health care and services under the program of medical assistance for needy persons without the savings to be achieved by contracting for the prior authorization of

such services, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

For services and expenses of the medical assistance program including hospital inpatient services.

Notwithstanding any contrary provision of law, in determining rates of payments for general hospital inpatient services by state governmental agencies effective for services provided for the period April 1, 2011 through March 31, 2013, the commissioner of health shall make such adjustments to such rates as are necessary and not inconsistent with otherwise directly applicable regulations, to reduce reimbursement with regard to services provided to hospital inpatients as a result, as determined by the commissioner of health, of potentially preventable conditions, hospital acquired conditions, injuries sustained while a hospital inpatient and the inappropriate use of certain medical procedures, including cesarean deliveries, coronary artery grafts and percutaneous coronary interventions 1,608,837,000

For services and expenses of the medical assistance program including hospital outpatient and emergency room services 773,050,000

For services and expenses of the medical assistance program including clinic services 684,627,000

For services and expenses of the medical assistance program including nursing home services.

Notwithstanding any contrary provision of law, for the period April 1, 2011 through March 31, 2013, with regard to adjustments to inpatient rates of payment made pursuant to section 2808 of the public health law for inpatient services provided by residential health care facilities for the period April 1, 2010 through March 31, 2012 and the period April 1, 2012 through March 31, 2013, the commissioner of health and the director of the budget shall, upon a determination by such commissioner and such director that such rate adjustments shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in total medicaid rates of payment for such services for either such state fiscal year, including payments made pursuant to subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, make such proportional adjustments to such rates as are necessary to reduce such total aggregate rate adjustments within each such year such that the aggregate total for each such year reflects no such increase or decrease, and provided further, however, that adjustments made pursuant to this

paragraph shall not be subject to subsequent correction or reconciliation, and provided further, however, that if this chapter provides sufficient additional funding to cover the cost of such rate adjustments to the rates enumerated in this paragraph, then provisions of this paragraph shall be deemed null and void as of March 31, 2011.

Notwithstanding any contrary provision of law, rule or regulation, for the period April 1, 2011 through March 31, 2013, 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, and provided further, however, that for that period no adjustment to rates of payment shall be made pursuant to paragraph (d) of subdivision 20 of section 2808 of the public health law as in effect on March 31, 2011, provided, however, that if this chapter provides sufficient additional funding to cover the cost of the adjustments to the rates enumerated in this section, then provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health shall not be required to revise certified rates of payment established pursuant to the public health law prior to April 1, 2013, based on consideration of rate appeals filed by residential health care facilities pursuant to section 2808 of the public health law or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of health of an application for construction under section 2802 of the public health law, in excess of aggregate amount of \$80,000,000 per state fiscal year, provided, however, that in revising such rates within such fiscal limits the commissioner of health may prioritize rate appeals for facilities which the commissioner of health determines are facing significant financial hardship and, further, the commissioner of health is authorized to enter into agreements with such facilities 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 of health, including, but not limited to, amounts owed pursuant to section 2807-d of the public health law, provided further, however, that such rate adjustment made pursuant to this section

remain fully subject to approval by the director of the budget in accordance with the provisions of subdivision 2 of section 2807 of the public health law.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, payments under the medicaid program to reserve a bed in a residential health care facility while a medicaid recipient is temporarily hospitalized or on leave of absence from the facility shall be made as follows: payments for reserved bed days shall be made at 95 percent of the medicaid rate otherwise payable to the facility for services provided on behalf of such recipient; payment for reserved bed days during temporary hospitalizations may not exceed fourteen days in any twelve month period; payment for reserved bed days for non-hospitalization leaves of absence may not exceed ten days in any twelve month period; and payments for reserved bed days for temporary hospitalizations shall only be made to a residential health care facility if at least 50 percent of the facility's residents eligible to participate in a medicare managed care plan are enrolled in such a plan. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payments for reserved bed days without regard to the percentage of a residential health care facility's residents that are enrolled in a medicare managed care plan, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

2,393,048,000

For services and expenses of the medical assistance program including other long term care services.

Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, for participating providers, meaning certified home health agencies, long term home health agencies and personal care providers with total medicaid reimbursements exceeding \$15,000,000 per calendar year, 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 provided that the verification organization shall declare each service or item to be verified or unverified and provided that each participating provider shall receive and maintain reports for the verification organization which shall contain data on verified items or services including whether a service appeared on a conflict or exception report before verification

and how that conflict or exception was resolved and items or services that were not verified, including conflict and exception report data for these services and provided that 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 provided that the verification organization shall declare each service or item to be verified or unverified. Provided, however, if this chapter appropriates sufficient additional funds to support participating providers of medical assistance program items subject to preclaim review otherwise provided for in the public health law, than the provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The amount of personal care services covered by the medicaid program shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.
2. The commissioner of health is authorized to adopt standards for the provision and management of personal care services covered by the medicaid program for individuals whose need for such services exceeds a specified level to be determined by the commissioner of health.
3. The commissioner of health is authorized to provide assistance to persons receiving personal care services covered by the medicaid program who are transitioning to receiving care from a managed long term care plan certified pursuant to section 4403-f of the public health law.
4. Provided, however, if this chapter appropriates sufficient additional funds to allow for the payment of personal care services at the level provided for in paragraph (e) of subdivision 2 of section 365-a of the social services law, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation,

- (a) for the period April 1, 2011 through March 31, 2013, 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, shall reflect ceiling

limitations determined in accordance with this section, provided, however, that at the discretion of the commissioner such ceilings may, as an alternative, be applied to payments for services provided for the period April 1, 2011 through March 31, 2012, except for such services provided to children and other discrete groups as may be determined by the commissioner. 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 2009 average per patient medicaid claims, weighted at a percentage as determined by the commissioner; and (ii) the 2009 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 1, 2011 through March 31, 2012. An interim payment or rate of payment adjustment effective April 1, 2011, 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 subdivision (a) of this section 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 2009 average per patient medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the commissioner; and (ii) the 2009 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 1, 2011 through March 31, 2012, 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 1, 2011 through March 31, 2012. 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), 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 section shall be based on medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year 2009. 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 2009 and medicaid paid claims, as determined by the commissioner, for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012. 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 section.
- (e) Payments or rate of payment adjustments determined pursuant to this section shall, for the period April 1, 2011 through March 31, 2012, be retroactively reconciled utilizing the methodology in paragraph (b) of this section and utilizing actual paid claims from such period.
- (f) Notwithstanding any inconsistent provision of this section, payments or rate of payment adjustments made pursuant to this section shall not result in an aggregate annual decrease in medicaid payments to providers subject to this section that is in excess of \$200,000,000, 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.

Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, for the period April 1, 2012 through March 31, 2013, 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, 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. 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 2009. The commissioner may require agencies to collect and submit any data required to implement this subdivision.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, benefits under the medical assistance program shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative 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 6 of article 3 of the social services law and other applicable provisions of law. Provided, however, if this chapter appropriates sufficient additional funds to allow medical assistance to be furnished in situations in which a responsible relative who is not absent from the household fails or refuses to provide necessary care and assistance, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any contrary law, rule or regulation, for the period April 1, 2011 through March 31, 2013 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, to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall reflect no separate payment for home care nursing services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The commissioner of health is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections 1115 and 1915 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 120 days, to receive such services through a managed long term care plan certified pursuant to section 4403-f of the public health law or other care coordination program specified by the commissioner.
2. With respect to persons in receipt of long term care services prior to enrollment, the commissioner of health shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care.

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 in to managed long term care plans and other care coordination models.

3. An entity shall not need a designation by the majority leader of the senate, the speaker of the assembly, or the commissioner of health in order to apply for a certificate of authority as a managed long term care plan.
4. Managed long term care plans may be authorized by the department of health to cover primary care and acute care.
5. Managed long term care enrollment applications will be processed by the department of health or its designee, and not by local departments of social services.
6. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payment for services on a fee-for-service basis without the savings to be achieved by requiring enrollment of medicaid recipients in managed long term care plans or other care coordination models, and by streamlining the process for enrolling participants in managed long term care plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

4,388,550,000

For services and expenses of the medical assistance program including managed care services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The following medicaid recipients shall not be required to participate in a managed care program established pursuant to section 364-j of the social services law: (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 Native Americans.
2. The following medicaid recipients shall not be eligible to participate in a managed care program established pursuant to section 364-j of the social services law: (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 2 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 costs 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 11 of paragraph (a) of subdivision 1 of section 366 of the social services law; (viii) a person who is eligible for medical assistance pursuant to paragraph (v) of subdivision 4 of section 366 of the social services law; and (ix) a person who is medicare/medicaid dually eligible and who is not enrolled in a medicare managed care plan.
3. The following categories of medicaid recipients may be required to enroll with a managed care program when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioner of mental health: (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 4 of this section): (ii) an individual eligible for supplemental security income; (iii) HIV positive individuals; (iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section 4401 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 1915 (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 12 or subparagraph 13 of paragraph (a) of subdivision 1 of section 366 of the social services; (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.

4. Applicants for medicaid and pregnant women applying for presumptive eligibility under the medicaid program shall be required to choose a managed care provider at the time of application; if the participant does not choose such a provider, the commissioner of health shall assign the applicant to a managed care provider in accordance with subparagraphs (ii) through (v) of paragraph (f) of subdivision 4 of section 364-j of the social services law. Individuals already in receipt of medicaid shall have no less than thirty days from the date selected by

their social services district to enroll in the managed care program to select a managed care provider, and as appropriate, a mental health special needs plan.

5. The department of health is authorized to contract with an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections 4403, 4403-a or 4408-a of the public health law (as added by chapter 639 of the laws of 1996) or a health maintenance organization authorized under article 43 of the insurance law, to eligible individuals residing in the geographic area served by such entity. Cities with a population of over 2,000,000 shall not be authorized to enter into medicaid managed care contracts with comprehensive health services plans. Such contracts may provide for medicaid payments on a capitated basis for nursing facility, home care or other long term care services of a duration and scope determined by the commissioner of health.

6. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payment for services on a fee-for-service basis without the savings to be achieved by expanding the populations allowed or required to participate in medicaid managed care, or by streamlining the process for enrolling participants in medicaid managed care plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

7,126,729,000

For services and expenses of the medical assistance program including pharmacy services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, payments for drugs which may not be dispensed without a prescription as required by section 6810 of the education law and for which payment is authorized under the medical assistance program pursuant to subdivision 2 of section 365-a of the social services law or under the family health plus program pursuant to subparagraph (v) of paragraph (e) of subdivision 1 of section 369-ee of the social services law may be included in the capitation payment for services or supplies provided to medical assistance or family health plus recipients by managed care organizations or other entities which are certified under article 44 of the public health law or licensed pursuant to article 43 of the insurance law or otherwise authorized by law to offer comprehensive health services plans to medical assistance or family health plus recipients. Provided, however, if this

chapter appropriates sufficient additional funds to allow such drugs to continue to be excluded as a benefit available to medical assistance and family health plus recipients through such comprehensive health services plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health is authorized to designate some or all of the drugs manufactured or marketed by a pharmaceutical manufacturer as non-preferred drugs under the preferred drug program established pursuant to section 272 of the public health law if: the commissioner of health has previously designated such pharmaceutical manufacturer as one with whom the commissioner is negotiating a manufacturer agreement, and included the drugs it manufactures or markets on the preferred drug list; and the commissioner has not reached a manufacturer agreement with such manufacturer. Provided, however, if this chapter appropriates sufficient additional funds to require the commissioner of health to designate as non-preferred all of the drugs manufactured or marketed by a manufacturer with whom the commissioner has been unable to reach a manufacturer agreement, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, for those drugs which may not be dispensed without a prescription as required by section 6810 of the education law and for which payment is authorized under the medical assistance program pursuant to subdivision 2 of section 365-a of the social services law, payments for such drugs and dispensing fees shall be limited to amounts established by the commissioner of health. Provided, however, if this chapter appropriates sufficient additional funds to allow the medical assistance program to continue to pay for drugs and dispensing fees in the amounts described in subdivision 9 of section 367-a of the social services law, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health may designate therapeutic

classes of drugs or individual drugs as preferred drugs in the medicaid preferred drug program established pursuant to section 272 of the public health law prior to any review that may be conducted by the pharmacy and therapeutics committee created pursuant to section 271 of the public health law. In addition, if a non-preferred drug is prescribed and does not meet the criteria for approval of a non-preferred drug under subdivision 3 of section 273 of the public health law, after providing a reasonable opportunity for the prescriber to reasonably present his or her justification for prior authorization, prior authorization will be denied if the preferred drug program determines that the use of the non-preferred is not warranted. Provided, however, if this chapter appropriates sufficient additional funds to allow the medicaid program to pay for non-preferred drugs which have been prescribed but whose use the preferred drug program has determined to be unwarranted, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, for persons eligible for medical assistance who are also beneficiaries under part D of title XVIII of the federal social security act, the following categories of drugs shall not be exempt from the definition of "covered part D drugs" and shall be subject to the medical assistance exclusion of coverage for "covered part D drugs": atypical anti-psychotics, anti-depressants, anti-retrovirals used in the treatment of HIV/AIDS, and anti-rejection drugs used for the treatment of organ and tissue transplants. Provided, however, that if this chapter appropriates sufficient additional funds to continue to exempt such drugs from the definition of "covered part D drugs", then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the following drugs shall not be exempt from inclusion in the preferred drug program established pursuant to section 272 of the public health law: atypical anti-psychotics; anti-depressants; anti-retrovirals used in the treatment of HIV/AIDS; and anti-rejection drugs used for the treatment of organ and tissue transplants. Provided, however, if this chapter appropriates sufficient additional funds to allow such

drugs to continue to be exempt from the prior authorization requirements of the preferred drug program, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011 82,339,000

For services and expenses of the medical assistance program including transportation services 137,733,000

For services and expenses of the medical assistance program including dental services 98,731,000

For services and expenses of the medical assistance program including non-institutional and other spending.

Notwithstanding any inconsistent provision of law, the money hereby appropriated may be available for payments to school districts, and to any city with a population of over 2,000,000 associated with additional claims for school supportive health services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. 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 85, 87 or 88 of the education law for medical care, services and supplies, including related special education services and special transportation, furnished to children with handicapping conditions. In addition, 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.
2. Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, or section 142 of the economic development law, or any other law, the commissioner of health is authorized to enter into a contract or contracts referenced in paragraph one without a competitive bid or request for proposal process; provided, however, that the department of health shall post on its website, for a period of no less than thirty days: a description of the proposed services to be provided pursuant to the contract or contracts; the criteria for selection of a contractor or contractors; 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 the manner by which a prospective contractor may seek such selection, which may include submission by electronic means. All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioner of health. 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.

3. The commissioner of health shall evaluate the results of the study or studies referenced in paragraph one to determine, after identification of actual direct and indirect costs incurred by public school districts, state operated/state supported schools, and counties, whether it is advisable to claim federal reimbursement for expenditures under sections 368-d and 368-e of the social services law 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 2,000,000, results in a decrease in the state share of annual expenditures pursuant to sections 368-d and 368-e of the social services law for such recipients, then to the extent that the amount of any such decrease exceeds \$50,000,000, 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 1 of part C of chapter 58 of the laws of 2005.
4. Provided, however, if this chapter appropriates sufficient additional funds to pay for costs incurred by public school districts, state operated/state supported schools, and counties without claiming the actual direct and indirect costs incurred by such entities as certified public expenditures, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the medical assistance program shall provide coverage for medically necessary speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy and related rehabilitative services, and occupational therapy. Provided, however, that speech therapy,

physical therapy, and occupational therapy each shall be limited to coverage of twenty visits per year, with such limitation not applying to persons with developmental disabilities. Provided, however, if this chapter appropriates sufficient additional funds to allow the medical assistance program to cover such medically necessary services without a limitation on the number of visits paid for, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the estate of a medical assistance recipient, for purposes of making any recoveries of the cost of such assistance otherwise authorized by law, shall include any real and personal property in which the medical assistance recipient had 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, whichever is less. Provided, however, if this chapter appropriates sufficient additional funds to permit limiting recoveries to real and personal property and other assets passing under the terms of a valid will or by intestacy, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011 1,661,670,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to pharmacy best practices initiatives including prior authorizations and prior approvals 13,600,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to utilization review activities including but not limited to utilization management for radiology and transportation management services 21,000,000

Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any

available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to education of medicaid eligibles and recipients regarding the medicare part D program and recipient and provider notification and other program information as determined necessary by the commissioner of health. Subject to the approval of the director of the budget, a portion of this appropriation may be suballocated to other state agencies 5,000,000

Notwithstanding any inconsistent provision of law, subject to the approval of a plan by the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to making improvements in the long-term care system including long-term care restructuring, the nursing home transition and diversion waiver, and point-of-entry initiatives for the purpose of expanding and promoting a more coordinated level of care for the delivery of quality services in the community 3,500,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account for services and expenses related to required criminal background checks for non-licensed long-term care employees including employees of nursing homes, certified home health agencies, long term home health care providers, AIDS home care providers, and licensed home care service agencies 23,410,000

Notwithstanding any inconsistent provision of section 112 or 163 of the state finance law or any other contrary provision of the state finance law or any other contrary provision of law, the commissioner of health may, without a competitive bid or request for proposal process, enter into contracts with one or more certified public accounting firms for the purpose of conducting audits of disproportionate share hospital payments made by the state of New York to general hospitals and for the purpose of conducting audits of hospital cost reports as submitted to the state of New York in accordance with article 28 of the public health law. Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein, together with any available federal matching funds, may be transferred to the general fund - state purposes account 4,600,000

Notwithstanding any inconsistent provision of law, subject to a plan developed by the commissioner of health and approved by the

director of the budget, up to the amount appropriated herein, together with any available federal matching funds, will be available for demonstrations that develop and evaluate interventions targeted at medicaid beneficiaries who are otherwise exempt or excluded from mandatory Medicaid managed care and who have multiple comorbidities.

Notwithstanding section 112 and section 163 of the state finance law, for chronic illness demonstration projects authorized by section 364-1 of the social services law, the commissioner of health may allocate up to \$2,500,000 of the amount appropriated for contracts without a request for proposal process or any other competitive process 12,000,000

Notwithstanding any other provision of law, the money herein appropriated, together with any available federal matching funds, is available for transfer or suballocation to the state university of New York and its subsidiaries, or to contract without competition for services with the state university of New York research foundation, to provide support for the administration of the medical assistance program including activities such as dental prior approval, retrospective and prospective drug utilization review, development of evidence based utilization thresholds, data analysis, clinical consultation and peer review, clinical support for the pharmacy and therapeutic committee, and other activities related to utilization management and for health information technology support for the medicaid program 12,000,000

For grants to the civil service employees association, Local 1000, AFSCME, AFL-CIO to contribute to the union's cost of purchasing health insurance coverage under the family health plus (FHPlus) buy-in for child care providers represented by the union who do not otherwise qualify for coverage under FHPlus 13,600,000

For grants to the United Federation of Teachers, Local 2, AFT, AFL-CIO to contribute to the union's cost of purchasing health insurance coverage under the family health plus (FHPlus) buy-in for child care providers represented by the union who do not otherwise qualify for coverage under FHPlus 18,000,000

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, moneys appropriated herein may be transferred to the general fund, state purposes account for services and expenses related to the independent audit of the internal controls of the school and preschool supportive health services programs as required by the New

York state school supportive health services program compliance agreement with the centers for medicare and medicaid services.

Notwithstanding any inconsistent provision of law, subject to the approval of the director of the budget, the amount appropriated herein may be increased or decreased by interchange with any appropriation of the department of health 800,000

For services and expenses of the medical assistance program including medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services 8,500,000,000

Program account subtotal 27,582,824,000

Special Revenue Funds - Federal
Federal Health and Human Services Fund
Medicaid Direct Account

For services and expenses for the medical assistance program, including administrative expenses for local social services districts, pursuant to title XIX of the federal social security act or its successor program.

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the following schedule: 50.90 percent for the period April 1, 2011 to March 31, 2012; 49.10 percent for the period April 1, 2012 to March 31, 2013.

The moneys hereby appropriated are to be available for payment of aid heretofore accrued to municipalities, and to providers of medical services pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and to providers of family care where payment systems through the fiscal intermediaries are not operational, shall be available to the department net of disallowances, refunds, reimbursements, and credits.

Notwithstanding any other provision of law, the money hereby appropriated may be increased or decreased by interchange, with any appropriation of the department of health and the office of medicaid inspector general and may be increased or decreased by transfer or suballocation between these appropriated amounts and appropriations of the office of mental health, office for people with developmental disabilities, the office of alcoholism and substance abuse services, the department of family assistance office of temporary and disability assistance,

office of children and family services, and state office for the aging with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

Notwithstanding any inconsistent provision of law, in lieu of payments authorized by the social services law, or payments of federal funds otherwise due to the local social services districts for programs provided under the federal social security act or the federal food stamp act, funds herein appropriated, in amounts certified by the state commissioner of temporary and disability assistance or the state commissioner of health as due from local social services districts each month as their share of payments made pursuant to section 367-b of the social services law may be set aside by the state comptroller in an interest-bearing account in order to ensure the orderly and prompt payment of providers under section 367-b of the social services law pursuant to an estimate provided by the commissioner of health of each local social services district's share of payments made pursuant to section 367-b of the social services law.

Notwithstanding any other provision of law, rule or regulation, to the contrary, for the period April 1, 2011 through March 31, 2013, all medicaid payments made for services provided on and after April 1, 2011, shall, except as hereinafter provided, be subject to a uniform 2 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 payment or other reductions provided that any method selected achieves no less than \$702,000,000 in medicaid state share savings, except as hereinafter provided, for services provided on and after April 1, 2011 through March 31, 2013.

The following 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.

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.

Provided, however, if this chapter appropriates sufficient additional funds to support medicaid payments or medicaid rates of payments, the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding paragraph (c) of subdivision 10 of section 2807-c of the public health law, section 21 of chapter 1 of the laws of 1999, or any other contrary provision of law, in determining rates of payments by state governmental agencies effective for services provided for the period April 1, 2011 through March 31, 2013, for inpatient and outpatient services provided by general hospitals, for inpatient services and adult day health care outpatient services provided by residential health care facilities pursuant to article 28 of the public health law, for home health care services provided pursuant to article 36 of the public health law by certified home health agencies, long term home health care programs and AIDS home care programs, for personal care services provided pursuant to section 365-a of the social services law, hospice services provided pursuant to article 40 of the public health law, foster care services provided pursuant to article 6 of the social services law, the commissioner of health shall apply no greater than zero trend factors attributable to calendar years on and after 2011 in accordance with paragraph (c) of subdivision 10 of section 2807-c of the public health law, provided, however, that such no greater than zero trend factors for such calendar years shall also be applied to rates of payment for personal care services for such period provided in those local social service districts, including New York city, whose rates of payment for such services are established by such local social service

districts pursuant to a rate-setting exemption issued by the commissioner of health to such local social service districts in accordance with applicable regulations, and provided further, however, that for rates of payment for assisted living program services provided for the period April 1, 2011 through March 31, 2013, trend factors attributable to such calendar years shall be established at no greater than zero percent, provided, however, that if this chapter provides sufficient additional funding to cover the cost of trend factor adjustments to the rates enumerated in this section, then provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any provision of law to the contrary and subject to the availability of federal financial participation, for the period April 1, 2011 through March 31, 2013, 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. Provided, however if this chapter provides sufficient additional funding to cover the cost of

targeted medical reimbursement rate reductions enumerated in this section, then the provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, 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: establish, in accordance with applicable federal law and regulations, standards for the provision of health home services to enrollees with chronic conditions in the program of medical assistance for needy persons; 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; establish the criteria under which such an enrollee will be designated as being eligible to receive health home services; and assign any enrollee designated as an eligible individual to a provider of health home services. Until such time as the commissioner of health obtains necessary waivers of the federal social security act, enrollees assigned to providers of health home services will be allowed to opt out of such services. In addition to such payments made for health home services, the commissioner of health is authorized to pay additional amounts to providers of health home services that meet process or outcome standards specified by the commissioner. Payment for such health home services and such additional payments 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. The commissioner of health 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. Notwithstanding any limitations imposed by section 364 - 1 of the social services law, the commissioner is authorized to allow entities participating in demonstration projects established pursuant to such section to provide health home services. Notwithstanding any law, rule, or regulation to the contrary, the

commissioners of the department of health, the office of mental health, 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 can demonstrate experience in the delivery of health, and mental health and/or alcohol and substance abuse services and the capacity to offer integrated delivery in each location approved by the commissioner, and meet the standards for providing and receiving payment for health home services. 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, 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 integrated delivery of services in a rational and efficient manner. Provided, however, if this chapter appropriates sufficient additional funds to provide coverage for persons with chronic conditions under the program of medical assistance for needy persons without the savings to be achieved through the provision of health home services, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013: coverage under the Medicaid program for enteral formula therapy is limited to coverage only for nasogastric, jejunostomy, or gastrostomy tube feeding or for treatment of an inborn error of metabolism, and no other nutritional or dietary supplements are covered; coverage under the Medicaid program for prescription footwear and inserts is 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; coverage under the Medicaid program for compression and support stockings is limited to coverage only for pregnancy or treatment of venous stasis ulcers; and the commissioner of health is authorized to require prior authorization for prescriptions of opioid analgesics in excess of four prescriptions in a thirty-day period. Provided, however, if this chapter appropriates sufficient additional funds to allow Medicaid coverage of such services without imposing such

limitations, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, when medicaid eligible persons are also beneficiaries under part B of title XVIII of the federal social security act and payment under part B would exceed the amount that would be paid by medicaid if the person were not eligible under part B or a qualified medicare beneficiary, the amount payable for services covered under the medicaid program for hospital outpatient services or diagnostic and treatment center services pursuant to article 28 of the public health law shall be 20 percent of the amount of any coinsurance liability of such eligible person pursuant to federal law if they were not eligible for medicaid or were not a qualified medicare beneficiary; provided however that in no event shall the amount payable for services covered under the medicaid program for such eligible person exceed the approved medical assistance payment level less the amount payable under part B.

Provided, however, if this chapter appropriates sufficient additional funds to provide medical assistance payments under paragraph (d) of subdivision 1 of section 367-a of the social services law for hospital outpatient services or diagnostic and treatment center services in situations where payment under part B of title XVIII of the federal social security act would exceed the amount that otherwise would be paid by medicaid if the person were not eligible under part B or a qualified medicare beneficiary, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the maximum co-payment chargeable to a recipient of medicaid for non-institutional services shall be as follows: where the state's payment for the service is \$10 or less, the maximum co-payment shall be \$.60; where the state's payment for the service is from \$10.01 to \$25.00, the maximum co-payment shall be \$1.15; where the state's payment for the service is from \$25.01 to \$50.00, the maximum co-payment shall be \$2.30; where the state's payment for the service is \$50.01 or more, the maximum co-payment shall be \$3.40. The co-payment chargeable to a medicaid recipient for each discharge for inpatient care shall be

\$30.00. The co-payment charged for each generic prescription drug dispensed shall be \$1.15 and for each brand name prescription drug dispensed shall be \$3.40; provided, however, that the co-payment charged for each brand name prescription drug on the preferred drug list established pursuant to section 272 of the public health law and the co-payment charged for each brand name prescription drug reimbursed pursuant to subparagraph (ii) of paragraph (a-1) of subdivision 4 of section 365-a of the social services law shall be \$1.15. Co-payments shall apply to the following services in addition to those listed in paragraph (d) of subdivision 6 of section 367-a of the social services law: vision care; dental services; audiology services; physician services; nurse practitioner services; and rehabilitation services including occupational therapy, physical therapy and speech therapy. In the year commencing April 1, 2011 and for each year thereafter, no recipient shall be required to pay more than a total of \$300.00 in co-payments nor shall reductions in Medicaid payments as a result of such co-payments exceed \$300.00 for any recipient. In both the medicaid and family health plus programs, the co-payment for emergency room services provided for non-urgent or non-emergency medical care shall be \$6.40; provided however that co-payments shall not be required with respect to emergency services or family planning services and supplies. The co-payment for nurse practitioner services in the family health plus program shall be \$5.00. Provided, however, if this chapter appropriates sufficient additional funds to allow the medicaid and family health plus programs to pay for services without the savings to be achieved by increasing the amount or scope of required co-payments, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, 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 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 behavioral health services with other services available under the medical assistance program, for recipients of

medical assistance who are not enrolled in managed care, and for approval, coordination, and integration of behavioral health services that are not provided through managed care programs under the medical assistance program 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. 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.

Notwithstanding any inconsistent provision of sections 112 and 163 of the state finance law, or section 142 of the economic development law, or any other law, commissioners of the office of mental health and the office of alcoholism and substance abuse services are authorized to enter into such contract or contracts without a competitive bid or request for proposal process; provided, however, that 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: a description of the proposed services to be provided pursuant to the contractor contracts; the criteria for selection of a contractor or contractors; 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 the manner by which a prospective contractor may seek such selection, which may include submission by electronic means. All reasonable and responsive submissions that are received from prospective contractors in timely fashion shall be reviewed by the commissioners of the office of mental health and the office of alcoholism and substance abuse services. 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, are best suited to provide the required services.

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 governmental unit, as such term is defined in the mental hygiene law, and its local social services district, and with the prior 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 1, 2013, 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 112 and 163 of the state finance law, and section 142 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 governmental unit, as such term is defined in the mental hygiene law, and its local social services district.

Provided, however, if this chapter appropriates sufficient additional funds to provide coverage for behavioral health care and services under the program of medical assistance for needy persons

without the savings to be achieved by contracting for the prior authorization of such services, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

For services and expenses of the medical assistance program including hospital inpatient services.

Notwithstanding any contrary provision of law, in determining rates of payments for general hospital inpatient services by state governmental agencies effective for services provided for the period April 1, 2011 through March 31, 2013, the commissioner of health shall make such adjustments to such rates as are necessary and not inconsistent with otherwise directly applicable regulations, to reduce reimbursement with regard to services provided to hospital inpatients as a result, as determined by the commissioner of health, of potentially preventable conditions, hospital acquired conditions, injuries sustained while a hospital inpatient and the inappropriate use of certain medical procedures, including cesarean deliveries, coronary artery grafts and percutaneous coronary interventions 8,674,990,000

For services and expenses of the medical assistance program including hospital outpatient and emergency room services ... 2,232,942,000

For services and expenses of the medical assistance program including clinic services 1,583,477,000

For services and expenses of the medical assistance program including nursing home services.

Notwithstanding any contrary provision of law, for the period April 1, 2011 through March 31, 2013, with regard to adjustments to inpatient rates of payment made pursuant to section 2808 of the public health law for inpatient services provided by residential health care facilities for the period April 1, 2010 through March 31, 2012 and the period April 1, 2012 through March 31, 2013, the commissioner of health and the director of the budget shall, upon a determination by such commissioner and such director that such rate adjustments shall, prior to the application of any applicable adjustment for inflation, result in an aggregate increase in total medicaid rates of payment for such services for either such state fiscal year, including payments made pursuant to subparagraph (i) of paragraph (d) of subdivision 2-c of section 2808 of the public health law, make such proportional adjustments to such rates as are necessary to reduce such total aggregate rate adjustments within each such year such that the aggregate total for each such year reflects no such

increase or decrease, and provided further, however, that adjustments made pursuant to this paragraph shall not be subject to subsequent correction or reconciliation, and provided further, however, that if this chapter provides sufficient additional funding to cover the cost of such rate adjustments to the rates enumerated in this paragraph, then provisions of this paragraph shall be deemed null and void as of March 31, 2011.

Notwithstanding any contrary provision of law, rule or regulation, for the period April 1, 2011 through March 31, 2013, 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, and provided further, however, that for that period no adjustment to rates of payment shall be made pursuant to paragraph (d) of subdivision 20 of section 2808 of the public health law as in effect on March 31, 2011, provided, however, that if this chapter provides sufficient additional funding to cover the cost of the adjustments to the rates enumerated in this section, then provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health shall not be required to revise certified rates of payment established pursuant to the public health law prior to April 1, 2013, based on consideration of rate appeals filed by residential health care facilities pursuant to section 2808 of the public health law or based upon adjustments to capital cost reimbursement as a result of approval by the commissioner of health of an application for construction under section 2802 of the public health law, in excess of aggregate amount of \$80,000,000 per state fiscal year, provided, however, that in revising such rates within such fiscal limits the commissioner of health may prioritize rate appeals for facilities which the commissioner of health determines are facing significant financial hardship and, further, the commissioner of health is authorized to enter into agreements with such facilities 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 of health, including, but not limited to, amounts owed pursuant to section 2807-d of the public health law, provided further, however, that such rate adjustment made pursuant to this section remain fully

subject to approval by the director of the budget in accordance with the provisions of subdivision two of section 2807 of the public health law.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, payments under the medicaid program to reserve a bed in a residential health care facility while a medicaid recipient is temporarily hospitalized or on leave of absence from the facility shall be made as follows: payments for reserved bed days shall be made at 95 percent of the medicaid rate otherwise payable to the facility for services provided on behalf of such recipient; payment for reserved bed days during temporary hospitalizations may not exceed fourteen days in any twelve month period; payment for reserved bed days for non-hospitalization leaves of absence may not exceed ten days in any twelve month period; and payments for reserved bed days for temporary hospitalizations shall only be made to a residential health care facility if at least 50 percent of the facility's residents eligible to participate in a medicare managed care plan are enrolled in such a plan. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payments for reserved bed days without regard to the percentage of a residential health care facility's residents that are enrolled in a medicare managed care plan, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

7,315,443,000

For services and expenses of the medical assistance program including other long term care services.

Notwithstanding any inconsistent provision of law or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, for participating providers, meaning certified home health agencies, long term home health agencies and personal care providers with total medicaid reimbursements exceeding \$50,000,000 per calendar year, 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 provided that the verification organization shall declare each service or item to be verified or unverified and provided that each participating provider shall receive and maintain reports for the verification organization which shall contain data on verified items or services including whether a service appeared on a conflict or exception report before verification

and how that conflict or exception was resolved and items or services that were not verified, including conflict and exception report data for these services and provided that 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 provided that the verification organization shall declare each service or item to be verified or unverified. Provided, however, if this chapter appropriates sufficient additional funds to support participating providers of medical assistance program items subject to preclaim review otherwise provided for in the public health law, than the provisions of this section shall be deemed null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The amount of personal care services covered by the medicaid program shall not exceed eight hours per week for individuals whose needs are limited to nutritional and environmental support functions.
2. The commissioner of health is authorized to adopt standards for the provision and management of personal care services covered by the medicaid program for individuals whose need for such services exceeds a specified level to be determined by the commissioner of health.
3. The commissioner of health is authorized to provide assistance to persons receiving personal care services covered by the medicaid program who are transitioning to receiving care from a managed long term care plan certified pursuant to section 4403-f of the public health law.
4. Provided, however, if this chapter appropriates sufficient additional funds to allow for the payment of personal care services at the level provided for in paragraph (e) of subdivision 2 of section 365-a of the social services law, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation,

- (a) for the period April 1, 2011 through March 31, 2013, 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, shall reflect ceiling

limitations determined in accordance with this section, provided, however, that at the discretion of the commissioner such ceilings may, as an alternative, be applied to payments for services provided for the period April 1, 2011 through March 31, 2012, except for such services provided to children and other discrete groups as may be determined by the commissioner. 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 2009 average per patient medicaid claims, weighted at a percentage as determined by the commissioner, and; (ii) the 2009 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 1, 2011 through March 31, 2012. An interim payment or rate of payment adjustment effective April 1, 2011, 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 subdivision (a) of this section 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 2009 average per patient medicaid claims adjusted by the percentage of increase or decrease in such agency's patient case mix from the 2009 calendar year to the annual period April 1, 2011 through March 31, 2012, weighted at a percentage as determined by the commissioner; and (ii) the 2009 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 1, 2011 through March 31, 2012, 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 1, 2011 through March 31, 2012. 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), 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 section shall be based on medicaid paid claims, as determined by the commissioner, for services provided by agencies in the base year 2009. 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 2009 and medicaid paid claims, as determined by the commissioner, for services provided by agencies in the reconciliation period April 1, 2011 through March 31, 2012. 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 section.
- (e) Payments or rate of payment adjustments determined pursuant to this section shall, for the period April 1, 2011 through March 31, 2012, be retroactively reconciled utilizing the methodology in paragraph (b) of this section and utilizing actual paid claims from such period.
- (f) Notwithstanding any inconsistent provision of this section, payments or rate of payment adjustments made pursuant to this section shall not result in an aggregate annual decrease in medicaid payments to providers subject to this section that is in excess of \$200,000,000, 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.

Notwithstanding any inconsistent provision of law or regulation and subject to the availability of federal financial participation, for the period April 1, 2012 through March 31, 2013, 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, 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. 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 2009. The commissioner may require agencies to collect and submit any data required to implement this subdivision.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, benefits under the medical assistance program shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative 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 6 of article 3 of the social services law and other applicable provisions of law. Provided, however, if this chapter appropriates sufficient additional funds to allow medical assistance to be furnished in situations in which a responsible relative who is not absent from the household fails or refuses to provide necessary care and assistance, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any contrary law, rule or regulation, for the period April 1, 2011 through March 31, 2013 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, to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall reflect no separate payment for home care nursing services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The commissioner of health is authorized to submit the appropriate waivers, including but not limited to those authorized pursuant to sections 1115 and 1915 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 120 days, to receive such services through a managed long term care plan certified pursuant to section 4403-f of the public health law or other care coordination program specified by the commissioner.

2. With respect to persons in receipt of long term care services prior to enrollment, the commissioner of health shall require the managed long term care plan to contract with agencies currently providing such services, in order to promote continuity of care.

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 in to managed long term care plans and other care coordination models.

3. An entity shall not need a designation by the majority leader of the senate, the speaker of the assembly, or the commissioner of health in order to apply for a certificate of authority as a managed long term care plan.

4. Managed long term care plans may be authorized by the department of health to cover primary care and acute care.

5. Managed long term care enrollment applications will be processed by the department of health or its designee, and not by local departments of social services.

6. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payment for services on a fee-for-service basis without the savings to be achieved by requiring enrollment of medicaid recipients in managed long term care plans or other care coordination models, and by streamlining the process for enrolling participants in managed long term care plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

5,643,636,000

For services and expenses of the medical assistance program including managed care services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013:

1. The following medicaid recipients shall not be required to participate in a managed care program established pursuant to section 364-j of the social services law: (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 Native Americans.
2. The following medicaid recipients shall not be eligible to participate in a managed care program established pursuant to section 364-j of the social services law: (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 2 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 costs 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 11 of paragraph (a) of subdivision 1 of section 366 of the social services law; (viii) a person who is eligible for medical assistance pursuant to paragraph (v) of subdivision 4 of section 366 of the social services law; and (ix) a person who is Medicare/Medicaid dually eligible and who is not enrolled in a medicare managed care plan.
3. The following categories of medicaid recipients may be required to enroll with a managed care program when program features and reimbursement rates are approved by the commissioner of health and, as appropriate, the commissioner of mental health: (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 4 of this section): (ii) an individual eligible for supplemental security income; (iii) HIV positive individuals; (iv) persons with serious mental illness and children and adolescents with serious emotional disturbances, as defined in section 4401 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 1915 (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 12 or subparagraph 13 of paragraph (a) of subdivision 1 of section 366 of the social services law; (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.

4. Applicants for medicaid and pregnant women applying for presumptive eligibility under the medicaid program shall be required to choose a managed care provider at the time of application; if the participant does not choose such a provider, the commissioner of health shall assign the applicant to a managed care provider in accordance with subparagraphs (ii) through (v) of paragraph (f) of subdivision 4 of section 364-j of the social services law. Individuals already in receipt of medicaid shall have no less than thirty days from the date selected by

their social services district to enroll in the managed care program to select a managed care provider, and as appropriate, a mental health special needs plan.

5. The department of health is authorized to contract with an entity offering a comprehensive health services plan, including an entity that has received a certificate of authority pursuant to sections 4403, 4403-a or 4408-a of the public health law (as added by chapter 639 of the laws of 1996) or a health maintenance organization authorized under article 43 of the insurance law, to eligible individuals residing in the geographic area served by such entity. Cities with a population of over 2,000,000 shall not be authorized to enter into medicaid managed care contracts with comprehensive health services plans. Such contracts may provide for medicaid payments on a capitated basis for nursing facility, home care or other long term care services of a duration and scope determined by the commissioner of health.

6. Provided, however, if this chapter appropriates sufficient additional funds to allow medicaid payment for services on a fee-for-service basis without the savings to be achieved by expanding the populations allowed or required to participate in medicaid managed care, or by streamlining the process for enrolling participants in medicaid managed care plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

10,023,265,000

For services and expenses of the medical assistance program including pharmacy services.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, payments for drugs which may not be dispensed without a prescription as required by section 6810 of the education law and for which payment is authorized under the medical assistance program pursuant to subdivision 2 of section 365-a of the social services law or under the family health plus program pursuant to subparagraph (v) of paragraph (e) of subdivision 1 of section 369-ee of the social services law may be included in the capitation payment for services or supplies provided to medical assistance or family health plus recipients by managed care organizations or other entities which are certified under article 44 of the public health law or licensed pursuant to article 43 of the insurance law or otherwise authorized by law to offer comprehensive health services plans to medical assistance or family health plus recipients. Provided, however, if this

chapter appropriates sufficient additional funds to allow such drugs to continue to be excluded as a benefit available to medical assistance and family health plus recipients through such comprehensive health services plans, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health is authorized to designate some or all of the drugs manufactured or marketed by a pharmaceutical manufacturer as non-preferred drugs under the preferred drug program established pursuant to section 272 of the public health law if: the commissioner of health has previously designated such pharmaceutical manufacturer as one with whom the commissioner is negotiating a manufacturer agreement, and included the drugs it manufactures or markets on the preferred drug list; and the commissioner has not reached a manufacturer agreement with such manufacturer. Provided, however, if this chapter appropriates sufficient additional funds to require the commissioner of health to designate as non-preferred all of the drugs manufactured or marketed by a manufacturer with whom the commissioner has been unable to reach a manufacturer agreement, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, for those drugs which may not be dispensed without a prescription as required by section 6810 of the education law and for which payment is authorized under the medical assistance program pursuant to subdivision 2 of section 365-a of the social services law, payments for such drugs and dispensing fees shall be limited to amounts established by the commissioner of health. Provided, however, if this chapter appropriates sufficient additional funds to allow the medical assistance program to continue to pay for drugs and dispensing fees in the amounts described in subdivision 9 of section 367-a of the social services law, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the commissioner of health may designate therapeutic

classes of drugs or individual drugs as preferred drugs in the medicaid preferred drug program established pursuant to section 272 of the public health law prior to any review that may be conducted by the pharmacy and therapeutics committee created pursuant to section 271 of the public health law. In addition, if a non-preferred drug is prescribed and does not meet the criteria for approval of a non-preferred drug under subdivision 3 of section 273 of the public health law, after providing a reasonable opportunity for the prescriber to reasonably present his or her justification for prior authorization, prior authorization will be denied if the preferred drug program determines that the use of the non-preferred is not warranted. Provided, however, if this chapter appropriates sufficient additional funds to allow the medicaid program to pay for non-preferred drugs which have been prescribed but whose use the preferred drug program has determined to be unwarranted, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the following drugs shall not be exempt from inclusion in the preferred drug program established pursuant to section 272 of the public health law: atypical anti-psychotics; anti-depressants; anti-retrovirals used in the treatment of HIV/AIDS; and anti-rejection drugs used for the treatment of organ and tissue transplants. Provided, however, if this chapter appropriates sufficient additional funds to allow such drugs to continue to be exempt from the prior authorization requirements of the preferred drug program, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011 3,968,930,000

For services and expenses of the medical assistance program including transportation services 349,464,000

For services and expenses of the medical assistance program including dental services 280,432,000

For services and expenses of the medical assistance program including noninstitutional and other spending.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the medical assistance program shall provide coverage for medically necessary speech therapy, and when provided at the direction of a physician or nurse practitioner, physical therapy and related rehabilitative

services, and occupational therapy. Provided, however, that speech therapy, physical therapy, and occupational therapy each shall be limited to coverage of twenty visits per year, with such limitation not applying to persons with developmental disabilities. Provided, however, if this chapter appropriates sufficient additional funds to allow the medical assistance program to cover such medically necessary services without a limitation on the number of visits paid for, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011.

Notwithstanding any inconsistent provision of law, rule or regulation to the contrary, for the period April 1, 2011 through March 31, 2013, the estate of a medical assistance recipient, for purposes of making any recoveries of the cost of such assistance otherwise authorized by law, shall include any real and personal property in which the medical assistance recipient had 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, whichever is less. Provided, however, if this chapter appropriates sufficient additional funds to permit limiting recoveries to real and personal property and other assets passing under the terms of a valid will or by intestacy, then the provisions of this paragraph shall not apply and shall be considered null and void as of March 31, 2011

8,417,449,000

For services and expenses of the medical assistance program including a series of targeted chronic illness demonstration projects.

Notwithstanding section 112 and section 163 of the state finance law, for chronic illness demonstration projects authorized by section 364-1 of the social services law, the commissioner of health may allocate up to \$2,500,000 of the amount appropriated for contracts without a request for proposal process or any other competitive process

12,000,000

Notwithstanding any other provision of law, the money herein appropriated, is available for transfer or suballocation to the state university of New York and its subsidiaries, or to contract without competition for services with the state university of New York research foundation, to provide support for the administration of the medical assistance program including activities such as dental prior

approval, retrospective and prospective drug utilization review, development of evidence based utilization thresholds, data analysis, clinical consultation and peer review, clinical support for the pharmacy and therapeutic committee, and other activities related to utilization management and for health information technology support for the medicaid program 12,000,000

Notwithstanding any inconsistent provision of section 112 or 163 of the state finance law or any other contrary provision of the state finance law or any other contrary provision of law, the commissioner of health may, without a competitive bid or request for proposal process, enter into contracts with one or more certified public accounting firms for the purpose of conducting audits of disproportionate share hospital payments made by the state of New York to general hospitals and for the purpose of conducting audits of hospital cost reports as submitted to the state of New York in accordance with article 28 of the public health law. Notwithstanding any inconsistent provisions of law, subject to the approval of the director of the budget, up to the amount appropriated herein 4,600,000

For services and expenses of the medical assistance program including medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services 8,500,000,000

For services and expenses of the medical assistance program including hospital inpatient, hospital outpatient and emergency room, clinic, nursing home, other long term care, managed care, pharmacy, transportation, dental, non-institutional and other spending, medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and for any other medical assistance services resulting from an increase in the federal medical assistance percentage pursuant to the American Recovery and Reinvestment Act. Funds appropriated herein shall be subject to all applicable reporting and accountability requirements contained in such act 1,204,000,000

Program account subtotal 58,322,628,000

Special Revenue Funds - Other
HCRA Resources Fund
Indigent Care Account

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the following schedule: 50 percent for the period April 1, 2011 to March 31, 2012; 50 percent for the period April 1, 2012 to March 31, 2013.

Notwithstanding section 40 of the state finance law or any provision of law to the contrary, subject to federal approval, department of health state funds medicaid spending, excluding payments for medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and further excluding any payments which are not appropriated within the department of health, in the aggregate, for the period April 1, 2011 through March 31, 2012, shall not exceed \$15,109,236,000 except as provided below and state share medicaid spending, in the aggregate, for the period April 1, 2012 through March 31, 2013, shall not exceed \$15,710,743,000, but in no event shall department of health state funds medicaid spending for the period April 1, 2011 through March 31, 2013 exceed \$30,819,979,000 provided, however, such aggregate limits 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, increases in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund, pursuant to a chapter establishing such fund. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected medicaid expenditures incurred both prior to and subsequent to such assessment for each such period, and if the director of the budget determines that such expenditures are expected to cause medicaid spending for such period to exceed the aggregate limit specified herein for such period, the state medicaid director, in consultation with the director of the budget and the commissioner of health, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit specified herein for such period.

Such medicaid savings allocation plan shall be designed, to reduce the expenditures 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, 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 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.

In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid spending 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).

For the purpose of making payments to providers of medical care pursuant to section 367-b of the social services law, and for payment of state aid to municipalities where payment systems through fiscal intermediaries are not operational, to reimburse such providers for costs attributable to the provision of care to patients eligible for medical assistance. Payments from this appropriation to general hospitals related to indigent care pursuant to article 28 of the public health law respectively, when combined with federal funds for services and expenses for the medical assistance program pursuant to title XIX of the federal social security act or its successor program, shall equal the amount of the funds received related to health care reform act allowances and surcharges pursuant to article 28 of the public health law and deposited to this account less any such amounts withheld pursuant to subdivision 21 of section 2807-c of the public health law. Notwithstanding any inconsistent provision of law, the moneys hereby appropriated may be increased or decreased by interchange or transfer with any appropriation of the department of health with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committ..... 1,583,000,000

Program account subtotal 1,583,000,000

Special Revenue Funds - Other
HCRA Resources Fund
Medical Assistance Account

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the

following schedule: 45.60 percent for the period April 1, 2011 to March 31, 2012; 54.40 percent for the period April 1, 2012 to March 31, 2013.

Notwithstanding section 40 of the state finance law or any provision of law to the contrary, subject to federal approval, department of health state funds medicaid spending, excluding payments for medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and further excluding any payments which are not appropriated within the department of health, in the aggregate, for the period April 1, 2011 through March 31, 2012, shall not exceed \$15,109,236,000 except as provided below and state share medicaid spending, in the aggregate, for the period April 1, 2012 through March 31, 2013, shall not exceed \$15,710,743,000, but in no event shall department of health state funds medicaid spending for the period April 1, 2011 through March 31, 2013 exceed \$30,819,979,000 provided, however, such aggregate limits 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, increases in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund, pursuant to a chapter establishing such fund. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected medicaid expenditures incurred both prior to and subsequent to such assessment for each such period, and if the director of the budget determines that such expenditures are expected to cause medicaid spending for such period to exceed the aggregate limit specified herein for such period, the state medicaid director, in consultation with the director of the budget and the commissioner of health, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit specified herein for such period.

Such medicaid savings allocation plan shall be designed, to reduce the expenditures 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, 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 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.

In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid spending 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).

For the purpose of making payments, the money hereby appropriated is available for payment of aid heretofore accrued or hereafter accrued, to providers of medical care pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and the federal government where payment systems through fiscal intermediaries are not operational, to reimburse such providers for costs attributable to the provision of care to patients eligible for medical assistance. Notwithstanding any inconsistent provision of law, the moneys hereby appropriated may be increased or decreased by interchange or transfer with any appropriation of the department of health with the approval of the director of the budget, who shall file such approval with the department of audit and control and copies thereof with the chairman of the senate finance committee and the chairman of the assembly ways and means committee.

For services and expenses related to the medical assistance program	292,800,000
For services and expenses of the medical assistance program related to the treatment of breast and cervical cancer	4,200,000
For services and expenses of the medical assistance program related to primary care case management. All or a portion of this appropriation may be transferred to state operations appropriations	4,000,000
For services and expenses of the medical assistance program related to disabled persons	47,000,000
For services and expenses of the medical assistance program related to physician services	170,400,000
For services and expenses of the medical assistance program related, but not limited to, pharmacy, inpatient, and nursing home services	5,337,510,000
For services and expenses of the medical assistance program related to the city of New York	249,400,000
For services and expenses of the medical assistance program related to providing distributions for supplemental medical insurance for medicare part B premiums, physician services, outpatient services, medical equipment, supplies and other health services	136,000,000
For services and expenses of the medical assistance program related to the family health plus program	1,278,800,000
For services and expenses of the medical assistance program related to providing financial assistance to residential health care facilities	30,000,000

For services and expenses of the medical assistance program related to supporting workforce recruitment and retention of personal care services or any worker with direct patient care responsibility for local social service districts which include a city with a population of over one million persons	272,000,000
For services and expenses of the medical assistance program related to supporting workforce recruitment and retention of personal care services for local social service districts that do not include a city with a population of over one million persons	22,400,000
For services and expenses of the medical assistance program related to supporting rate increases for certified home health agencies, long term home health care programs, AIDS home care programs, hospice programs, managed long term care plans and approved managed long term care operating demonstrations for recruitment and retention of health care workers	100,000,000

Program account subtotal	7,944,510,000

Special Revenue Funds - Other
 Miscellaneous Special Revenue Fund
 Medical Assistance Account

Notwithstanding section 40 of state finance law or any other law to the contrary, all medical assistance appropriations made from this account shall remain in full force and effect in accordance with the following schedule: 50 percent for the period April 1, 2011 to March 31, 2012; 50 percent for the period April 1, 2012 to March 31, 2013.

Notwithstanding section 40 of the state finance law or any provision of law to the contrary, subject to federal approval, department of health state funds medicaid spending, excluding payments for medical services provided at state facilities operated by the office of mental health, the office for people with developmental disabilities and the office of alcoholism and substance abuse services and further excluding any payments which are not appropriated within the department of health, in the aggregate, for the period April 1, 2011 through March 31, 2012, shall not exceed \$15,109,236,000 except as provided below and state share medicaid spending, in the aggregate, for the period April 1, 2012 through March 31, 2013, shall not exceed \$15,710,743,000, but in no event shall department of health state funds medicaid spending for the period April 1, 2011 through March 31, 2013 exceed \$30,819,979,000 provided, however, such aggregate limits 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, increases in provider revenues, and beginning April 1, 2012 the operational costs of the New York state medical indemnity fund, pursuant to a chapter establishing such fund. The director of the budget, in consultation with the commissioner of health, shall periodically assess known and projected medicaid expenditures incurred both prior to and subsequent to such assessment for each such period, and if the director of the budget determines that such expenditures are expected to cause medicaid spending for such period to exceed the aggregate limit specified herein for such period, the state medicaid director, in consultation with the director of the budget and the commissioner of health, shall develop a medicaid savings allocation plan to limit such spending to the aggregate limit specified herein for such period.

Such medicaid savings allocation plan shall be designed, to reduce the expenditures 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, 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 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.

In accordance with the medicaid savings allocation plan, the commissioner of the department of health shall reduce department of health state funds medicaid spending 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).

For the purpose of making payments to providers of medical care pursuant to section 367-b of the social services law, and for payment of state aid to municipalities and the federal government where payment systems through fiscal intermediaries are not operational, to reimburse the provision of care to patients eligible for medical assistance.

For services and expenses of the medical assistance program including nursing home, personal care, certified home health agency, long term home health care program and hospital services 1,499,600,000

Program account subtotal 1,499,600,000

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