

NYS Elder Law



ENACTMENT OF CHAPTER OF THE CONSOLIDATED LAWS

AN ACT relating to constituting chapter 35-A of the consolidated laws in relation to the elderly; to amend the elder law, in relation to long term care ombudsmen and tax abatements for rental properties occupied by senior citizens; to amend the criminal procedure law, in relation to the coordination of police services to elderly persons; to amend the private housing finance law, in relation to tax exemptions and senior citizen facilities; to amend the public health law, in relation to respite projects and funding for the elderly pharmaceutical insurance coverage program; to repeal certain provisions of the executive law relating to programs and services for the elderly; and providing for the repeal of certain provisions of the elder law upon expiration thereof

Became a law October 26, 2004, with the approval of the Governor.

Passed by a majority vote, three-fifths being present.

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

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Article I. Short Title

§ 101. Short title

This chapter shall be known as the "Elder Law".

Article II. Programs for the Elderly

Title 1. State Office for the Aging

§ 201. Office for the aging; director

1. There is hereby created within the executive department an office for the aging.
2. The head of such office shall be a director, who shall be appointed by the governor, by and with the advice and consent of the senate, and shall hold office during the pleasure of the governor. The director shall receive an annual salary to be fixed by the governor within the amount available therefor by appropriation. The director shall also be entitled to receive reimbursement for expenses actually and necessarily incurred by him or her in the performance of his or her duties.
3. The director may appoint such officers, employees, agents, consultants and special committees as he or she may deem necessary, prescribe their duties, fix their compensation and provide for reimbursement of their expenses within the amounts available therefor by appropriation. The director, with the advice of the advisory committee for the aging, may promulgate, adopt, amend or rescind rules and regulations necessary to carry out the provisions of this article.
4. In carrying out its powers and duties under this title, the office is organized and operated to have as a primary purpose informing and instructing the public, especially the elderly themselves, on subjects beneficial to the community which relate to the needs, abilities, resources, opportunities, rights, entitlements, and other issues affecting older people in New York state.
5. For the purposes of this chapter, "office" shall refer to the state office for the aging created pursuant to this section, and "director" shall refer to the director of the state office for the aging established by this section.

§ 202. General powers and duties of office

The office shall have the following powers and duties:

1. to advise and assist the governor in developing policies designed to help meet the needs of the aging and to encourage the full participation of the aging in society;
2. to coordinate state programs and activities relating to the aging;
3. to stimulate community interest in the problems of the aging;
4. to promote public awareness of resources available for the aging, and to refer the public to the appropriate departments and agencies of the state and federal governments for advice, assistance and available services in connection with particular problems;
5. to cooperate with and assist political subdivisions of the state in the development of local programs for the aging;
6. to consult and cooperate with universities, colleges and institutions in the state for the development of courses of study for persons engaged in public and private programs for the aging;

7. to make such studies of needs of the aging as the director may deem appropriate or as may be requested by the governor;
8. to foster and support studies, research and education relating to problems of and services for the aging;
9. to serve as a clearinghouse for information relating to the needs of the aging;
10. to sponsor conferences relating to problems of and services for the aging;
11. to enter into contracts, within the amount available by appropriation therefor, with individuals, organizations and institutions, in the exercise of any of its powers or the performance of any of its duties.
12. to make recommendations to the governor for the presentation of an annual award to a senior citizen for outstanding and unusual contribution to his or her community.
13. to conduct a program of education and information on age discrimination and the preparation and filing of complaints relating to persons sixty years of age or older.
- 14.[As amended by L.2010, c.319] to, in cooperation with the department of state:
 - (a) prepare or cause to be prepared and made available to cities, towns and villages model zoning and planning guidelines that foster age-integrated communities including provisions to allow for accessory senior citizen units in areas zoned for single family residences and for mixed-use development accommodating senior residential housing; and
 - (b) make recommendations, in consultation with the division of housing and community renewal, to the governor and legislature for assisting mixed-use age-integrated housing development or redevelopment demonstration projects in urban, suburban and rural areas of the state. The director of the office for the aging and secretary of state shall establish an advisory committee for purposes of this subdivision. Such committee shall include, but not be limited to, top representatives of local government, senior citizen organizations, developers, senior service providers and planners.

§ 203. Programs for the aging

1. The office shall submit to the federal department of health, education and welfare a state plan for purposes of the federal older Americans act of 1965 and subsequent amendments thereto. The office shall be the single state agency for supervising the administration of such plan and shall be primarily responsible for coordination of state programs for the aging for purposes of such federal act. The office shall act for the state in any negotiations relative to the submission and approval of such plan and may make such arrangements, not inconsistent with law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such federal act.
2. In addition to the powers and duties contained in section two hundred two of this title, the office is hereby authorized, to the extent appropriations are available therefor, to establish, operate and maintain, or to contract with counties, cities, towns, villages, school districts or public or private nonprofit corporations, associations, institutions, or agencies concerned with the aging, for the operation and maintenance of programs for the aging. Pursuant to the rules and regulations of the office, such programs may include, but need not be limited to, the following:
 - (a) coordination and community planning;
 - (b) information services;
 - (c) counselling services;

- (d) home care and protection services;
- (e) operation of multi-service centers; and
- (f) retired senior volunteer programs.

3. The director, with the advice of the advisory committee for the aging, shall make appropriate rules and regulations governing the submission and approval of applications for the operation of programs for the aging pursuant to subdivision two of this section. If an application is disapproved, the applicant, upon request, shall be afforded a hearing before the director or his or her designee.

4. (a) As required by the office, each county, city, town, village, school district or public or private nonprofit corporation, association, institution or agency operating a program for the aging pursuant to subdivision two of this section shall submit to the office (1) a quarterly estimate of anticipated expenditures for operation and maintenance of such program, including rental of buildings, purchase of equipment, administrative expenses, miscellaneous personal expenses of older persons incurred in the provision of volunteer services, and approved expenditures for minor alterations or repairs, not less than thirty days before the first day of the months of April, July, October and January, and (2) a verified accounting of the financial operations of such program during the preceding calendar quarter, together with a claim for reimbursement as provided in this title, on or before the thirtieth day of April, July, October and January. The director may permit the submission of such accountings with respect to periods exceeding three months, but not exceeding one year.

(b) After receipt of a satisfactory quarterly estimate and verified accounting pursuant to paragraph (a) of this subdivision, the director shall certify to the comptroller, for payment by the state to each such county, city, town, village, school district or public or private nonprofit corporation, association, institution or agency, the expenditures thereof, approved by the office, as follows:

- (i) the amount of federal funds, if any, properly received for such expenditures; and
- (ii) up to fifty percentum of such expenditures, after first deducting therefrom any federal funds properly received with respect to such expenditures.

5. Notwithstanding the provisions of subdivision four of this section, but subject to and in the manner specified in this subdivision, the office, in its discretion, may entertain and approve applications for interim payments.

(a) Such an application may be approved by the office, upon being satisfied that the requirement for filing a verified accounting of the financial operation of a program during the preceding calendar quarter before a claim for reimbursement based on the expenditures for such quarter may be made, is likely to cause a financial hardship to the applicant.

(b) Such an application may be made at the time of filing the quarterly estimate of anticipated expenditures as specified in subdivision four of this section or at such other time as the office shall specify.

(c) After receipt of a satisfactory quarterly estimate, the office may direct the director to certify to the comptroller for payment an interim payment in such amount as the office shall specify.

(d) The amount of the interim payment which the office may authorize shall not exceed an amount equal to one-third of the amount which the applicant may reasonably be entitled to receive in accordance with the provisions of subdivision four of this section, for the three month period for which a satisfactory quarterly statement has been filed, based on such satisfactory quarterly estimate. The amount of an interim payment received by the applicant shall be subtracted from the amount payable to the applicant for such three-month period.

6. The director is hereby authorized, within amounts appropriated therefor, to make grants-in-aid to existing foster grandparent grantee agencies for the engagement of foster grandparents in qualified residential group homes for neglected and disadvantaged children, in private homes, day care centers, special education classes in public schools, or other public or private nonprofit institutions or agencies providing care for neglected and disadvantaged

children who lack close personal relationships. Up to twenty percent of such grants-in-aid may be expended for the administrative purposes of such grantee agencies, with the approval of the office. Such grants shall be for a period of twelve months or less, shall not be used to match other state funds, shall not be used as a substitute for federal allocations, and shall be made in a manner which does not conflict with federal law, rule or regulation pursuant to title II of the United States domestic volunteer services act of nineteen hundred seventy-three, as amended. Grants may be used to match federal funds but must be used for expansion of existing federal programs, not as a substitute for presently required non-federal shares. Each grantee shall file reports at such time and containing such information as the office shall require. For the purpose of administering such grants-in-aid the office may make such agreements with other public agencies as are deemed necessary.

7. The director is hereby authorized, within amounts appropriated therefor, to make grants-in-aid to retired and senior volunteer programs for the engagement of individuals fifty-five years of age or over to serve as volunteers for the betterment of their community and themselves. Such volunteer activities may include but shall not be limited to assisting with the preparation of meals at nutrition sites; leading activities at child care centers; delivering meals to homebound elderly; providing telephone reassurance and/or friendly visits to the frail elderly; tutoring adults or children; assisting with services for the homeless and assisting school districts which request volunteers for the purpose of notifying a person in parental relation to any elementary school pupil when such pupil is deemed absent from required attendance at his or her designated school. The services of these volunteers will be performed in the community where such individuals reside or in nearby communities. Up to ten percent of such grants-in-aid may be expended for the administrative purposes of such programs, with the approval of the office. Such grants shall be for a period of twelve months or less, shall not be used to match other state funds, shall not be used as a substitute for federal allocations, and shall be made in a manner which does not conflict with federal law, rule or regulation pursuant to title II of the United States domestic volunteer services act of nineteen hundred seventy-three, as amended. Grants may be used to match federal funds, but not as a substitute for presently required non-federal shares. Each grantee shall file reports at such time and containing such information as the office shall require. For the purpose of administering such grants-in-aid the office may make such agreements with other public agencies as are deemed necessary.

8. [As added by L.2007, c. 48, § 1. See, also, subd. 8, below.] The director of the office for the aging is hereby authorized, to the extent appropriations are available therefor, to establish, operate and maintain, under the control of the office for the aging or in conjunction with an association, institution, agency, or other public or private entity, or community program engaged in the care of animals, one or more senior pet companionship programs. The purpose and intent of a senior pet companionship program shall be to match seniors who have limited social contact with pets, including cats and dogs and other small animals, to improve the lives of such seniors by enhancing their emotional and mental well-being through such companionship.

8. [As added by L.2007, c. 58, pt. B, § 18. See, also, subd. 8, above.] The director, in consultation with the commissioner of health, shall establish a program to be known as the NY Connects: Choices for Long Term Care. The purpose of this initiative is to provide consistent, comprehensive, locally-based information and assistance on long term care services to consumers, caregivers and families to help them make educated choices. This program shall provide individuals, caregivers, and families with objective information and assistance about home, community-based and institutional long term care services. NY Connects will be available on a voluntary basis to consumers, caregivers and their families. There shall be an on-going education and outreach campaign to educate the public about long term care services available in their community and to assist consumers in preparing for their long term care needs.

§ 204. Records of available space

1. The office shall have the responsibility to compile and maintain an inventory of space available for placing eligible aged citizens in facilities under the jurisdiction of the dormitory authority; the office shall also take whatever action necessary to locate those aged citizens of New York, who, according to standards to be promulgated by the office, are available for residence in facilities under the jurisdiction of the dormitory authority; the office shall initiate, assist, coordinate, supervise, and approve the plan of relocation of such aged citizens, in facilities under the jurisdiction of the dormitory authority, by any not-for-profit corporation or political subdivision of the state or the state, or in the absence of the foregoing entities, by the office itself; in addition, the office shall carry out the purposes of the public authorities law pertaining to the use of dormitory authority facilities for the aged.

2. In carrying out the duties and responsibilities under this title, the office shall periodically review existing aged residents' use of dormitory authority facilities, and to establish and enforce such rules and regulations as may be necessary to assure the office that the needs of aged residents, as determined by the office, are being met.

§ 205. Exclusion from mandatory retirement

Notwithstanding any other provision of law, an employee of the office or an employee of a local public agency whose position is in whole or in part funded through the office, or the federal older Americans act of 1965 as amended, shall not be subject to any mandatory retirement provision based on the age of such employee.

§ 206. Informal caregiver training

1. The director is hereby authorized and directed, to the extent appropriations are available therefor, to develop, establish and operate training and technical assistance programs, including caregiver resource centers, caregiver networks, and other support activities, for informal caregivers throughout the state for the purposes of assisting such caregivers and improving the quality of care provided to frail and disabled persons. The director shall also make available and encourage the utilization of such training programs in consultation with the commissioner of health, the commissioner of the office of children and family services, the commissioner of mental health, and the commissioner of mental retardation and developmental disabilities.

2. Definitions. For the purposes of this section: (a) "Informal caregiver" shall mean the family member or other natural person who normally provides the daily care or supervision of a frail or disabled person, or any family member or other natural person who contributes to and is involved in the caretaking responsibilities for such frail or disabled person. Such informal caregiver may, but need not, reside in the same household as the frail or disabled person.

(b) "Frail or disabled person" shall mean any person who is unable to attend to his or her daily needs without the assistance or regular supervision of an informal caregiver due to mental or physical impairment. Such definition shall not exclude persons under eighteen years of age who suffer from mental or physical impairment.

(c) "Program" shall mean the program of informal caregiver training and technical assistance established by this section.

(d) "Caregiver resource center" shall mean a project funded pursuant to this section which provides services and activities which are responsive to the needs and contracts of informal caregivers in regard to their caregiving responsibilities.

(e) "Caregiver networks" shall mean local coalitions which develop, coordinate, and implement action plans to identify and mobilize resources to address the unmet needs of frail and disabled persons and their caregivers.

3. (a) The duties of the director pursuant to this section shall include, but not be limited to:

(1) developing and make available or approve a curriculum for informal caregiver training which considers and is easily adapted to an array of personal needs and disabilities, and which is sensitive to ethnic and community characteristics;

(2) providing technical assistance and training to appropriate organizations and groups, including caregiver resource centers and caregiver networks, which, in turn, shall provide training and assistance to informal caregivers; and

(3) providing grants to appropriate organizations and groups, including caregiver resource centers and caregiver networks, to develop and make available approved curricula for informal caregiver training as well as disseminate information regarding the curriculum.

(b) Training and technical assistance shall include, but not be limited to:

- (1) knowledge of major health problems and diseases, mental and physical disabilities, and the aging process;
- (2) practical skills required in providing personal care and support;
- (3) stress awareness and methods of dealing with stress caused by providing care;
- (4) financial management; and
- (5) identification and utilization of available resources, including benefits, entitlements, and other programs and assistance.

4. The director shall:

- (a) Promulgate any rules and regulations necessary to carry out the provisions of this section.
- (b) On or before the first day of January every other year, submit a report to the governor, the temporary president of the senate and the speaker of the assembly, which shall include, but not be limited to:
 - (1) a financial report of the program's operation;
 - (2) a profile of persons or groups receiving training and technical assistance pursuant to this section; and
 - (3) an analysis of the program's success in assisting informal caregivers and improving the quality of care provided by such persons.

§ 207. Foster grandparents program for vulnerable infants and children

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

- (a) "Qualified area agencies on aging" shall mean those agencies which operate a foster grandparent program for the care of vulnerable infants and children and for the assistance of high risk mothers.
- (b) "Foster grandparents program" shall mean those activities for which grants may be provided pursuant to subdivision six of section two hundred three of this title, and shall include, but not be limited to, (1) visiting participating hospitals or other interim care facilities for a specified number of hours and providing care, love and stimulation to one or more vulnerable infants and children; and (2) visiting high risk mothers in their homes for a specified number of hours in order to assist such mothers in developing parenting skills and in providing a safe and suitable home for their children.
- (c) "Vulnerable infants and children" shall mean infants or children who reside in hospitals or other interim care facilities because no suitable foster home or other appropriate placement is available.
- (d) "High risk mothers" shall mean single young women for whom the teaching of parenting skills is necessary either to prevent family breakdown or to enable them to assume responsibility for their own child or children who are in or awaiting foster care.

2. The director, in consultation with the commissioner of the office of children and family services, is hereby authorized and directed, within appropriations which are available therefor, to award grants to qualified area agencies on aging to operate foster grandparent programs for the care of vulnerable infants and children and for the assistance of high risk mothers.

3. The duties of the director shall include, but not be limited to:

(a) the selection of qualified area agencies on aging to receive grants for the operation of foster grandparent programs for the care of vulnerable infants and children and for the assistance of high risk mothers, which programs have been approved pursuant to this subdivision. Applications for such grants shall demonstrate to the extent possible: the need within the jurisdiction of the qualified area agency to provide services to infants and children left in hospitals beyond medical necessity and the need to provide services to infants and children placed in interim care facilities, the experience of such agency in providing such services to this or related populations, the capacity of such agency in providing such services to effectively operate and administer such program, the capacity of such agency to coordinate its services with hospitals which provide social work counseling and home visit assessments by social work staff to high risk mothers; and

(b) the reviewing of foster grandparent programs for the care of vulnerable infants and children and for the assistance of high risk mothers conducted by qualified area agencies on aging and the approval of such programs for funding pursuant to paragraph (a) of this subdivision.

4. The director may promulgate such rules and regulations as he or she deems necessary to effectuate the purposes of this section.

§ 208. Respite program

1. The director is hereby authorized to establish and monitor respite projects for the purposes of encouraging the initiation and expansion of respite, evaluating the effectiveness of respite in deterring and/or delaying institutionalization, evaluating the demand for respite and of the cost of utilization of different service modes.

2. For the purposes of this section:

(a) "Respite" shall mean the provision of infrequent and temporary substitute care or supervision of frail or disabled adults on behalf of and in the absence of the care-giver, for the purpose of providing relief from the stresses or responsibilities concomitant with providing care, so as to enable the care-giver to maintain a normal routine. Respite shall not exceed one hundred days in any calendar year for any individual. Respite may be provided by any service or combination of services supplied by individuals, a public agency, a public corporation or a private not-for-profit corporation or any proprietary provider.

(b) "Care-giver" shall mean the family member or other natural person who normally provides the daily care or supervision of a frail or disabled adult. Such care-giver may, but need not, reside in the same household as the frail or disabled adult.

(c) "Provider" shall mean any entity enumerated in paragraph (a) of this subdivision which is the supplier of services providing respite.

(d) "Sponsor" shall mean the provider, public agency or community group approved by the director which establishes a contractual relationship with the office for the purposes of a project pursuant to this section, and which is responsible for the recruitment of providers, the coordination and arrangement of provider services in a manner which meets client needs, the general supervision of the local program, and the submission of such information or reports as may be required by the director.

(e) "Frail or disabled adult" shall mean any adult who is unable to attend to his or her daily needs without the assistance or regular supervision of a care-giver due to mental or physical impairment and who is otherwise eligible for services on the basis of his or her level of impairment. Priority shall be given in all cases to frail or disabled adults sixty years of age or older.

3. (a) Notwithstanding any inconsistent provision of law to the contrary, entities qualifying as providers or sponsors pursuant to the provisions of paragraphs (a), (c) and (d) of subdivision two of this section are hereby authorized to conduct or participate in respite projects as approved and extended by the director.

(b) The director shall publicize the existence of, and make available, application forms for such projects seeking the

advice and counsel of the advisory committee for the aging established pursuant to section two hundred ten of this title.

(c) Such application forms shall require the submission of such information as the director deems necessary for the evaluation of such proposed projects. This information shall include, but not be limited to:

- (1) the identity and qualifications of the sponsor;
- (2) the identity and qualifications of the provider or providers and a plan for the coordination of their services;
- (3) an assessment of the community need for respite services including documentation;
- (4) plans for the coordination and arrangement of provider services in a manner which meets client needs;
- (5) a fiscal plan, including specific provisions for the utilization of existing reimbursement and funding sources and the development of local financial support;
- (6) plans for publicizing the purpose of the project and the services to be provided, including the identities, services and charges of each participating provider;
- (7) indications of broad-based community support and participation; and
- (8) identification of the unserved or underserved population to be served.

(d) The director shall review, require any necessary modifications, and upon such modification, approve a number of applications and, within the amounts appropriated therefor, award grants for the operation of respite projects. Such an approved application shall constitute a plan of service which may be rendered only in the manner and for the period for which such plan has been approved or from time to time extended by the director. The director shall ensure that each such plan of service is coordinated with the "designated agency" as defined in section two hundred fourteen of this title, the local social services district or districts, and the local public health agency or agencies in which the services are to be provided in order to help ensure that every effort will be made to utilize existing funding sources for eligible individuals and to avoid unnecessary duplication of services.

(e) Within the amounts appropriated therefor, the director shall give first priority to the six existing respite projects established under the provisions of the respite demonstration program authorized pursuant to chapter seven hundred sixty-seven of the laws of nineteen hundred eighty-one.

(f) Further consideration shall be given to proposals that:

- (1) develop new or expand existing respite care projects/programs to provide care to one or more target populations that are currently unserved or underserved in the community;
- (2) provide for respite in a geographical area of the state that is currently without community-based respite care services;
- (3) provide services that are responsive to the individual's needs and circumstances in the targeted area;
- (4) show utilization of existing services, coordination of services with other agencies/resources; and utilization of various service components, such as personal emergency response systems, adult day services, and nutrition services, where appropriate.

4. (a) The director in consultation with the commissioner of the office of children and family services may apply for the appropriate waivers under federal law and regulation and may, subject to the approval of the director of the budget, waive any provision of the social services law or regulation of the office of children and family services as may be necessary to make funds which are available pursuant to the provisions of title XIX or XX of the federal social security act, the emergency assistance for families program or the emergency assistance for adults program

available to eligible providers if the recipients of such services are otherwise eligible to receive benefits or services pursuant to the provisions of such programs.

(b) In the event that waivers under federal law and regulation are not received, nothing contained in this section shall be construed to require the expenditure of funds by the state or any locality in an amount greater than if such waivers had been received.

5. Nothing contained in this section shall be construed to limit, modify or otherwise affect the provision of care and services of a long-term home health care program pursuant to article thirty-six of the public health law.

6. For purposes of determining the eligibility for benefits pursuant to this chapter, when applicable, only the financial eligibility of the frail or disabled adult shall be taken into consideration.

7. In addition, the director, within appropriations provided, may establish a training program for respite workers. The six existing respite projects established pursuant to chapter seven hundred sixty-seven of the laws of nineteen hundred eighty-one shall, insofar as they are able, assist in providing such a training program.

The director may also enter into contracts with boards of cooperative educational services pursuant to sections nineteen hundred fifty and forty-six hundred two of the education law to provide courses in training for respite care workers. This training program shall be optional for existing programs.

8. Every two years beginning on January first, two thousand five, the director shall submit a report to the governor, the temporary president of the senate and the speaker of the assembly which shall include, but not be limited to:

- (a) A financial report for each project;
- (b) A qualitative and quantitative profile of sponsors, providers, care-givers, and frail or disabled adults participating in the project;
- (c) A comparative assessment of the costs and effectiveness of each type of service or combinations of services provided;
- (d) An assessment of the nature and extent of the demand for services which provide respite and an evaluation of the success of such projects in meeting this demand;
- (e) Specific identification of any factors which significantly enhance or inhibit the successful provision of respite;
- (f) A review of the extent to which priority has been given to persons aged sixty and over;
- (g) The coordination of the projects with other agencies, facilities and institutions providing similar services as well as the utilization and networking with case management programs;
- (h) The ability of the projects to provide service at various economic levels;
- (i) The adherence of the program to its original or amended respite proposal; and
- (j) An assessment of the extent of the demand for the services the project provides.

§ 209. Naturally occurring retirement community supportive service program

1. [As amended by L.2010 c. 58 §41 and L.2010 c.348] As used in this section:

(a) “Advisory committee” or “committee” shall mean the advisory committee convened by the director for the purposes specified in this section. Such committee shall be broadly representative of housing and senior citizen groups, and all geographic areas of the state.

- (b) "Older adults" shall mean persons who are sixty years of age or older.
- (c) "Eligible applicant" shall mean a not-for-profit agency specializing in housing, health or other human services which serves or would serve the community within which a naturally occurring retirement community is located.
- (d) "Eligible services" shall mean services including, but not limited to: case management, care coordination, counseling, health assessment and monitoring, transportation, socialization activities, home care facilitation and monitoring, and other services designed to address the needs of residents of naturally occurring retirement communities by helping them extend their independence, improve their quality of life, and avoid unnecessary hospital and nursing home stays.
- (e) "Government assistance" shall mean and be broadly interpreted to mean any monetary assistance provided by the federal, the state or a local government, or any agency thereof, or any authority or public benefit corporation, in any form, including loans or loan subsidies, for the construction of an apartment building or housing complex for low and moderate income persons, as such term is defined by the United States Department of Housing and Urban Development.
- (f) "Naturally occurring retirement community" shall mean an apartment building or housing complex which:
- (1) was constructed with government assistance;
 - (2) was not originally built for older adults;
 - (3) does not restrict admissions solely to older adults;
 - (4) at least fifty percent of the units have an occupant who is an older adult or in which at least twenty-five hundred of the residents are older adults; and
 - (5) a majority of the older adults to be served are low or moderate income, as defined by the United States Department of Housing and Urban Development.
2. A naturally occurring retirement community supportive service program is established as a demonstration program to be administered by the director.
3. The director shall be assisted by the advisory committee in the development of appropriate criteria for the selection of grantees of funds provided pursuant to this section and programmatic issues as deemed appropriate by the director.
4. [As amended by L.2010 c.410 §1 eff. August 13, 2010] The criteria recommended by the committee and adopted by the director for the award of grants shall be consistent with the provisions of this section and shall include, at a minimum:
- (a) the number, size, type and location of the projects to be served; provided, that the committee and director shall make reasonable efforts to assure that geographic balance in the distribution of such projects is maintained, consistent with the needs to be addressed, funding available, applications for eligible applicants, other requirements of this section, and other criteria developed by the committee and director;
 - (b) the appropriate number and concentration of older adult residents to be served by an individual project; provided, that such criteria need not specify, in the case of a project which includes several buildings, the number of older adults to be served in any individual building;
 - (c) the demographic characteristics of the residents to be served;

- (d) the financial or in-kind support required to be provided to the project by the owners, managers and residents of the housing development; provided, however, that such criteria need not address whether the funding is public or private, or the source of such support;
- (e) the scope and intensity of the services to be provided, and their appropriateness for the residents proposed to be served. The criteria shall not require that the applicant agency be the sole provider of such services, but shall require that the applicant at a minimum actively manage the provision of such services;
- (f) the experience and financial stability of the applicant agency, provided that the criteria shall require that priority be given to programs already in operation, including those projects participating in the resident advisor program administered by the office, and enriched housing programs which meet the requirements of this section and which have demonstrated to the satisfaction of the director and the committee their fiscal and managerial stability and programmatic success in serving residents;
- (g) the nature and extent of requirements proposed to be established for active, meaningful participation for residents proposed to be served in project design, implementation, monitoring, evaluation and governance;
- (h) an agreement by the applicant to participate in the data collection and evaluation project necessary to complete the report required by this section;
- (i) the policy and program roles of the applicant agency and any other agencies involved in the provision of services or the management of the project, including the housing development governing body, or other owners or managers of the apartment buildings and housing complexes and the residents of such apartment buildings and housing complexes. The criteria shall require a clear delineation of such policy and program roles;
- (j) a requirement that each eligible agency document the need for the project and financial commitments to it from such sources as the committee and the director shall deem appropriate given the character and nature of the proposed project, and written evidence of support from the appropriate housing development governing body or other owners or managers of the apartment buildings and housing complexes. The purpose of such documentation shall be to demonstrate the need for the project, support for it in the areas to be served, and the financial and managerial ability to sustain the project;
- (k) a requirement that any aid provided pursuant to this section be matched by an equal amount, in-kind support of equal value, or some combination thereof from other sources, provided that such in-kind support to be utilized only upon approval from the director and only to the extent matching funds are not available, and that at least twenty-five percent of such amount be contributed by the housing development governing body or other owners or managers and residents of the apartment buildings and housing complexes in which the project is proposed; and
- (l) the circumstances under which the director may waive all or part of the requirement for provision of an equal amount of funding from other sources required pursuant to paragraph (k) of this subdivision, provided that such criteria shall include provision for waiver at the discretion of the director upon a finding by the director that the program will serve a low income or hardship community, and that such waiver is required to assure that such community receive a fair share of the funding available. The committee shall develop appropriate criteria for determining whether a community is a low income or hardship community.

5. Within amounts specifically appropriated therefor and consistent with the criteria developed and required pursuant to this section the director shall approve grants to eligible applicants in amounts not to exceed one hundred fifty thousand dollars for a project in any twelve month period. The director shall not approve more than ten grants in the first twelve month period after the effective date of this section.

5-a. [As amended L.2010 c. 410 §2 eff. August 13, 2010]The director may, in addition recognize neighborhood naturally occurring retirement communities, or Neighborhood NORCs, and provide program support within amounts specifically available by appropriation therefor, which shall be subject to the requirements, rules and regulations of this section, provided however that:

(a) the term Neighborhood NORC as used in this subdivision shall mean and refer to a residential dwelling or group of residential dwellings in a geographically defined neighborhood of a municipality containing not more than two thousand persons who are older adults reside in at least forty percent of the units and which is made up of low-rise buildings six stories or less in height and/or single and multifamily homes and which area was not originally developed for older adults, and which does not restrict admission strictly to the older adults;

(b) grants to an eligible Neighborhood NORC shall be no less than sixty thousand dollars for any twelve-month period;

(c) the director shall be assisted by the advisory committee in the development of criteria for the selection of grants provided pursuant to this section and programmatic issues as deemed appropriate by the director. The criteria recommended by the committee and adopted by the director for the award of grants shall be consistent with the provisions of this subdivision and shall include, at a minimum, the following requirements or items of information using such criteria as the advisory committee and the director shall approve:

(1) the number, size, type and location of residential dwellings or group of residential dwellings selected as candidates for neighborhood NORCs funding. The director shall make reasonable efforts to assure that geographic balance in the distribution of such grants is maintained, consistent with the needs to be addressed, funding available, applications from eligible applicants, ability to coordinate services and other requirements of this section;

(2) the appropriate number and concentration of older adult residents to be served by an individual Neighborhood NORC. The criteria need not specify the number of older adults to be served in any individual building;

(3) the demographic characteristics of the residents to be served;

(4) a requirement that the applicant demonstrate the development or intent to develop community wide support from residents, neighborhood associations, community groups, nonprofit organizations and others;

(5) a requirement that the boundaries of the geographic area to be served are clear and coherent and create an identifiable program and supportive community;

(6) a requirement that the applicant commit to raising matching funds, in-kind support, or some combination thereof from non-state sources provided that such in-kind support be utilized only upon approval from the director and only to the extent matching funds are not available, equal to fifteen percent of the state grant in the second year after the program is approved, twenty-five percent in the third year, forty percent in the fourth year, and fifty percent in the fifth year, and further commit that in each year, twenty-five percent of such required matching funds, in-kind support, or combination thereof be raised within the community served. Such local community matching funds, in-kind support, or combination thereof shall include but not be limited to: dues, fees for service, individual and community contributions, and such other funds as the advisory committee and the director shall deem appropriate;

(7) a requirement that the applicant demonstrate experience and financial stability;

(8) a requirement that priority in selection be given to programs in existence prior to the effective date of this subdivision which, except for designation and funding requirements established herein, would have otherwise generally qualified as a Neighborhood NORC;

(9) a requirement that the applicant conduct or have conducted a needs assessment on the basis of which such applicant shall establish the nature and extent of services to be provided; and further that such services shall provide a mix of appropriate services that provide active and meaningful participation for residents;

(10) a requirement that residents to be served shall be involved in design, implementation, monitoring, evaluation and governance of the Neighborhood NORC;

(11) an agreement by the applicant that it will participate in the data collection and evaluation necessary to complete the reporting requirements as established by the director;

(12) the policy and program roles of the applicant agency and any other agencies involved in the provision of services or the management of the Neighborhood NORC, provided that the criteria shall require a clear delineation of such policy and program roles;

(13) a requirement that each applicant document the need for the grant and financial commitments to it from such sources as the advisory committee and the director shall deem appropriate given the character and nature of the proposed Neighborhood NORC and written evidence of support from the community;

(14) the circumstances under which the director may waive all or part of the requirement for provision of an equal amount of funding from other sources required pursuant to this subdivision, provided that such criteria shall include provision for waiver at the discretion of the director upon a finding by the director that the Neighborhood NORC will serve a low income or hardship community, and that such waiver is required to assure that such community receive a fair share of the funding available. For purposes of this paragraph, a hardship community may be one that has developed a successful model but which needs additional time to raise matching funds required herein. An applicant applying for a hardship exception shall submit a written plan in a form and manner determined by the director detailing its plans to meet the matching funds requirement in the succeeding year;

(15) a requirement that any proposed Neighborhood NORC in a geographically defined neighborhood of a municipality containing more than two thousand older adults shall require the review and recommendation by the advisory committee before being approved by the director;

(d) on or before March first, two thousand eight, the director shall report to the governor and the fiscal and aging committees of the senate and the assembly concerning the effectiveness of Neighborhood NORCs in achieving the objectives set forth by this subdivision. Such report shall address each of the items required for Neighborhood NORCs in achieving the objectives set forth in this section and such other items of information as the director shall deem appropriate, including recommendations concerning continuation or modification of the program, and any recommendations from the advisory committee.

(e) in providing program support for Neighborhood NORCs as authorized by this subdivision, the director shall in no event divert or transfer funding for grants or program support from any naturally occurring retirement community supportive service programs authorized pursuant to other provisions of this section.

6. The director may allow services provided by a naturally occurring retirement community supportive service program or by a neighborhood naturally occurring retirement community to also include services to residents who live in neighborhoods contiguous to the boundaries of the geographic area served by such programs if: (a) the persons served are older adults; (b) the services affect the health and welfare of such persons; and (c) the services are provided on a one-time basis in the year in which they are provided, and not in a manner which is said or intended to be continuous. The director may also consent to the provision of such services by such program if the program has received a grant which requires services to be provided beyond the geographic boundaries of the program. The director shall establish procedures under which a program may request the ability to provide such services.

7. The director shall promulgate rules and regulations as necessary to carry out the provisions of this section.

8. On or before March first, two thousand five, the director shall report to the governor and the finance committee of the senate and the ways and means committee of the assembly concerning the effectiveness of the naturally occurring retirement community supportive services program, other than Neighborhood NORCs, as defined in subdivision five-a of this section, in achieving the objectives set forth by this section, which include helping to address the needs of residents in such naturally occurring retirement communities, assuring access to a continuum of necessary services, increasing private, philanthropic and other public funding for programs, and preventing unnecessary hospital and nursing home stays. The report shall also include recommendations concerning continuation or modification of the program from the director and the committee, and shall note any divergence between the recommendations of the director and the committee. The director shall provide the required information and any other information deemed appropriate to the report in such form and detail as will be helpful to the legislature and the governor in determining to extend, eliminate or modify the program including, but not limited to, the following:

- (a) the number, size, type and location of the projects developed and funded, including the number, kinds and functions of staff in each program;
- (b) the number, size, type and location of the projects proposed but not funded, and the reasons for denial of funding for such projects;
- (c) the age, sex, religion and other appropriate demographic information concerning the residents served;
- (d) the services provided to residents, reported in such manner as to allow comparison of services by demographic group and region;
- (e) a listing of the services provided by eligible applicants, including the number, kind and intensity of such services; and
- (f) a listing of other organizations providing services, the number, kind and intensity of such services, the number of referrals to such organizations and, to the extent practicable, the outcomes of such referrals.

§ 210. Advisory committee

1. [As amended by L.2010 c. 58 §42 eff. September 1, 2010] There shall be within the office an advisory committee for the aging, consisting of not more than thirty-five members, appointed by the governor. In making such appointments, the governor shall give due consideration to representation from the major regions of the state. One member of the advisory committee shall be designated as chairperson by the governor and shall serve as chairperson at the pleasure of the governor. The advisory committee shall meet from time to time at the call of such chairperson or the director. The director shall seek the advice of the advisory committee with respect to the needs of the aging and, if so requested by the director, such committee shall make particular studies relating to the aging.
2. The members of the advisory committee shall serve without salary, but each member shall be entitled to reimbursement for his or her actual and necessary expenses incurred in the performance of his or her official duties.
3. All members of the advisory committee shall be appointed for terms of three years provided, however, that of the members first appointed, one-third shall be appointed for one-year terms, and one-third shall be appointed for two-year terms. Any member chosen to fill a vacancy created otherwise than by expiration of term shall be appointed for the unexpired term of the member he or she is to succeed.
4. Sixty percent of the members of the advisory committee appointed on and after the effective date of this subdivision shall be sixty years of age or over.

§ 211. Assistance of other agencies

To effectuate the purposes of this title, the director may request from any department, division, board, bureau, commission or other agency of the state or of any political subdivision thereof, and the same are authorized to provide, such facilities, assistance and data, as will enable the office properly to exercise its powers and perform its duties hereunder.

§ 212. Grants or gifts

The director, with the approval of the governor, may accept as agent of the state any gift, grant, devise or bequest, whether conditional or unconditional (notwithstanding the provisions of section eleven of the state finance law), and including federal grants, for any of the purposes of this article. Any moneys so received may be expended by the office to effectuate any purpose of this title, subject to the same limitations as to approval of expenditures and audit as are prescribed for state moneys appropriated for the purposes of this title.

§ 213. Reports

1. The office shall from time to time report to the governor, and shall make an annual report to the governor and legislature.

2. Such annual report shall:

(a) Describe the progress, problems and other matters related to the provision of services to older persons by programs administered by the office including, but not limited to the federal older Americans act of 1965, the community services for the aging program and the recreation program for the elderly;

(b) Assess the effectiveness of the community services for aging program pursuant to section two hundred fourteen of this title in coordinating and improving the local delivery of services to the elderly; and

(c) Include recommendation for expanding or replicating service programs that have been determined effective in helping needy elderly remain in the community and to avoid institutional care.

3. Such annual report shall also present in quantitative, as well as in qualitative, terms, a report on the quality of life of the aged in our state, including:

(a) A report on the impact of inflation on the aged.

(b) A report on mortality trends in the upper age brackets, including chronic disease trends among older persons.

(c) A report on crime trends impacting on the aged.

(d) A report on the numbers of elderly living in substandard housing, numbers of new housing facilities for the aged in public, non-profit or limited profit housing.

(e) A report on coverage of the aged in the state by various public social security programs, pension plans, private retirement plans, and assistance programs.

(f) A report on unemployment and employment of older persons, including prevalence of age discrimination in the labor market and efforts to provide education, information, and recommendations for legislation, trends toward early or later retirement, duration of unemployment by age groupings, self-employment and partial employment of older persons.

(g) A report on the hot meal program within the state, including costs per meal, number of aged served, as well as a report on the meals-on-wheels program.

(h) A report on the recreational services for the aged, including numbers of senior centers and clubs, membership and programming provided.

(i) A report on the extent to which the aged are provided adult education courses in public schools or are attending college courses.

(j) A report on institutionalization of aged, including trends in mental hospitals, skilled nursing homes, health related facilities, adult homes, including length of stay, costs, occupancy rates, extent to which local communities are providing care for institutionally released aged.

4. The legislature hereby declares that, as a matter of state policy, caring services and programs for seniors should be shaped by the principles of strengthening independence, affirming dignity, and maximizing choice, and a recognition that seniors and their families and intimates provide a vast potential source of social, cultural, historic,

and spiritual enrichment and leadership.

The office shall enunciate these principles in the form of a bill of rights for seniors, and shall, in addition to any other report required by this section, report annually, not later than June first of each year, on the progress being made in their advancement by state agencies and local governments in the development and operation of programs for seniors. Such report shall discuss progress in the following principles with respect to programs for seniors:

(a) Seniors needing long term care in an institution or in an appropriate community-based alternative should be able to obtain such care at an affordable cost in a timely manner from reliable and responsible providers who can provide choices that meet the preferences of these seniors, and who have the capacity to provide a smooth transition to other forms of long term care when appropriate. Such programs should, whenever possible, provide a continuum of quality health care, either within a single institution, or through a consortium of providers.

(b) Public policy should affirm seniors' desire to maintain a high quality of life by living with dignity in their own communities, by supporting the efforts of informal caregivers such as family, friends and neighbors who provide eighty percent of all personal care and assistance to seniors.

(c) A goal of policy and programs in New York should be to help seniors obtain or maintain affordable and secure housing that allows them to age in place in their own communities with supportive assistance and access to health related services in a manner that ameliorates problems of income, changes in family structure, health, threats to personal safety, and architectural and structural inadequacies.

(d) Programs intended to offset excessive health care and prescription drug costs for seniors, and to make health care, particularly wellness and prevention programs, more affordable, should be designed to expand choice and promote ease of access for seniors rather than to simply provide ease of management and control for bureaucrats and program managers.

(e) State and local policies and program guidelines should support the most creative and flexible approaches to providing care for seniors, so as to promote and sustain the autonomy and mobility of seniors, and to tap their potential to enrich their communities.

(f) Seniors should be able to continue their productive lives in the community of New York without fear of discrimination based on age, and public policy should seek means of increasing opportunities for contribution from these respected members of our community by supporting and encouraging a healthy social environment that enables seniors to continue their productive lives if they wish, that affirms and encourages their ability to achieve financial security, and that works to preserve their dignity, safety, and independence.

(g) Public programs should promote personal security for seniors, encourage personal responsibility of their families and intimates, and recognize and build on the interdependence of all generations and the diversity of our population.

(h) Public investment in programs providing health care and other social help for seniors should be provided at a level which supports public mandates with respect to these programs.

(i) No declaratory relief, injunctive remedy or monetary liability against the state of New York or any political subdivision thereof, or any public or private entity, domiciled or doing business in the state of New York, or any employee or officer thereof, shall be created or granted based upon the principles set forth in this subdivision, or upon the enunciation of said principles to be made by the office pursuant thereto. No claim for contribution or indemnification shall be created based upon this subdivision. No assignment of claim shall be prosecuted based upon this subdivision.

(j) Existing powers of the office for the aging shall not be changed by this subdivision.

5. Every state department, bureau, or agency or office shall cooperate to the fullest extent possible in providing such data as the office may need to assemble such reports, including recommendations by the director to the governor and legislature.

§ 214. Community services for the elderly

1. Definitions. As used in this section, the following words shall have the following meanings:

(a) "Designated agency" shall mean an agency which is designated by the chief executive officer of the county if there be one, or otherwise the governing board of such county, or the chief executive officer of the city of New York, or the governing board of an Indian tribal council; which is either a unit of county government or the city of New York or an Indian tribal organization or a private non-profit agency, and which is the area agency on aging created pursuant to the federal older Americans act of 1965.

(b) "Elderly person" shall mean a person sixty years of age or older.

(c) "County" shall mean a county, as defined in section three of the county law, except that the city of New York shall be considered one county.

(d) "Base year expenditures" and "base year services" shall mean the level of expenditures and services in the year prior to the first year for which a county plan is submitted or in such county's two thousand five fiscal year, whichever is greater.

(e) "Community services" shall mean services for elderly persons which are provided by a public or governmental agency or non-profit agency, and which are provided in the home of an elderly person or in community settings such as senior citizens centers, housing projects, or agency offices. Such services shall not include any services provided pursuant to the public health law other than home care services.

(f) "Community service projects" shall mean community services financed pursuant to paragraph (b) of subdivision four of this section.

(g) "County plan" shall mean a plan for community services prepared by a county pursuant to this section.

(h) "Non-profit agency" shall mean a corporation organized or existing pursuant to the not-for-profit corporation law.

(i) "Program year" shall mean the period from April first through March thirty-first of the following calendar year.

(j) "First program year" for a county shall mean the initial year for which the county has received approval for its county plan.

2. County plans for improving the availability of community services to the elderly. (a) Counties with a designated agency are required to submit a county plan for a two-, three-, or four-year period determined by the director, with an annual update containing a budget request for the forthcoming program year and such other information as shall be required by the director, for improving the delivery of community services for elderly persons in the format prescribed by the director. The plan for the city of New York shall specifically address the needs of each county within such city. Such plan shall be a comprehensive description of the manner in which the county intends to address the needs of elderly persons living in the county through improved coordination of existing community services and by the development of any new or expanded community service projects which will improve the delivery of services to the elderly. Such plan shall contain:

(1) a statement of goals and objectives for addressing the needs of elderly persons in the county, an assessment of the needs of elderly persons residing in the county, a description of public and private resources that currently provide community services to elderly persons within the county, a description of intended actions to consolidate and coordinate existing community services administered by county government, a description of the intended actions to coordinate congregate services programs for the elderly operated within the county pursuant to section two hundred seventeen of this title with other community services for the elderly, a description of the means to coordinate other community services for elderly persons in the county with those administered by county government, and a statement of the priorities for the provision of community services during the program period covered by such plan;

(2) an identification of community service projects to be developed to improve the delivery of services, a budget request for approval for the forthcoming year which individually identifies each community service project to be funded pursuant to paragraph (b) of subdivision four of this section, letters of comment from the appropriate local agencies on the relationship and expected impact of the proposed community service projects, assurances that community service projects will provide services to those most in need, an indication of fee schedules by which elderly persons participating in community service projects may contribute to the costs of such projects, and an indication of how the effectiveness of such community service projects will be evaluated;

(3) an identification of planning, coordination, and administrative activities necessary to achieve the goals and objectives of the plan, together with a budget request for such activities for approval for the forthcoming year to be funded pursuant to paragraph (a) of subdivision four of this section, and assurances by the county that it will comply with the requirements of state and federal law; and

(4) such other components as may be required pursuant to regulations promulgated by the director.

(b) Such county plan for community services or annual update shall be prepared by the designated agency and approved by the chief executive officer of the county, if there be one, or otherwise the governing board of the county, or the chief executive of the city of New York and submitted to the director no later than ninety days prior to the beginning of the program period covered by such plan or annual update. Prior to a submission of a county plan or annual update to the director for approval, the designated agency shall conduct such public hearings as may be required by regulations of the director, provided that there shall be at least one such hearing, and one in each county contained within the city of New York.

(c) The director shall review such county plan and may approve or disapprove such plan, or any part, program, or project within such plan, and shall propose such modifications and conditions as are deemed appropriate and necessary. Compliance with paragraphs (a) and (b) of this subdivision shall be the basis for approval of a county plan. The director shall establish by regulation the dates for notifying the designated agency of approval or disapproval of a county plan. In the event the director shall disapprove the proposed county plan, the county submitting such application shall be afforded an opportunity for an adjudicatory hearing, as prescribed by article three of the state administrative procedure act.

(d) Notwithstanding any provision of this section, nothing contained in this section shall give the director or a designated agency any administrative, fiscal, supervisory, or other authority whatsoever over any plans, programs or expenditures authorized pursuant to titles eighteen, nineteen and twenty of the federal social security act, or over any unit of state or local government.

(e) Counties with a designated agency may submit to the director a letter of intent, in the form and by the date prescribed by the director with the approval of the director of the budget, evidencing the commitment of the county to develop a county home care plan for functionally impaired elderly.

(f) Within the amounts appropriated therefor, counties submitting an approved letter of intent pursuant to paragraph (e) of this subdivision shall be eligible for reimbursement of one hundred percent of the approved expenditures for preparing a county home care plan for functionally impaired elderly. Such a grant-in-aid shall be available to a county only once and shall be limited to one-half the amount available to such county pursuant to subparagraph one of paragraph (a) of subdivision four of this section; provided however that in either of the two years immediately following its first submission of a home care plan for functionally impaired elderly, a county which does not receive state aid during such year for expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to paragraph (j) of subdivision four of this section, may apply for reimbursement of one hundred percent of the approved expenditures for revising such home care plan, limited to one-quarter the amount available to such county pursuant to subparagraph one of paragraph (a) of subdivision four of this section.

(g) County home care plans for functionally impaired elderly prepared pursuant to this subdivision shall include a comprehensive description of all aspects of home care, non-institutional respite, case management, and ancillary services available to elderly persons in the county; a description of intended actions to coordinate such home care,

non-institutional respite, case management, and ancillary services to functionally impaired elderly persons in their county provided under this section with other services to elderly persons; a proposal for expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services for functionally impaired elderly persons with unmet needs to support such persons' continued residence in their homes; and such other components as may be required pursuant to regulations promulgated by the director, including how the proposed expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services will be delivered to unserved or underserved populations.

(h) Such county home care plan for functionally impaired elderly shall be prepared by the designated agency after consultation with the social services district and the local public health agency, and shall be approved by the chief executive officer of the county, if there be one, or otherwise the governing board of the county, or the chief executive of the city of New York, and submitted to the director for approval by such date as may be specified by regulation. The director shall not approve such county home care plan for functionally impaired elderly unless it complies with the standards and regulations issued pursuant to this section.

3. Community service projects. (a) The director may authorize a county which has an approved county plan pursuant to this section to provide one or more community service projects included in such approved plan which are designed to make community services and entitlement programs more available and accessible to older persons through the improved coordination and delivery of services for the elderly. As necessary to meet project goals and objectives, such projects may provide new services not previously provided within the county, expand services provided during the base year, and establish new mechanisms to coordinate all existing and new services.

(b) Counties having an approved plan which includes one or more community service projects shall be eligible for state aid, as provided in subdivision four of this section, for the provision of such projects identified in such plan.

(c) Each community service project included in a county plan shall clearly specify the intended goals and objectives of such project, shall describe the elderly population the project intends to serve, shall specify a timetable not to exceed three years to achieve and evaluate such goals and objectives, and shall specify proposed methods to evaluate the effectiveness of such project.

(d) The director, with the advice of the advisory committee for the aging, shall promulgate regulations and issue guidelines for evaluating the effectiveness and achievements of such community service projects, shall require periodic evaluations of each project, and shall make available such evaluations to appropriate agencies, the governor and the legislature.

(e) No project funded pursuant to this section shall continue beyond three years, unless approved by the director after the director is satisfied that the project effectively improves the delivery of services to the elderly based upon periodic evaluations of the project.

4. State aid. (a) County plans for improving the availability of community services to the elderly:

(1) within the amounts appropriated therefor, counties with an approved county plan shall be eligible for reimbursement of one hundred percent of the annual approved expenditures for the preparation and revision of such county plan, evaluation of projects contained within such county plan, execution of interagency agreements necessary to carry out the plan, actions to consolidate, combine or collocate services within the county, and such other costs of the designated agency necessary to implement such county plan, provided that the total annual amount payable to a county pursuant to this subparagraph shall not exceed the sum of one dollar for each elderly person residing in the county, or seventy-five thousand dollars, whichever is less, and further provided that for the city of New York such amount shall not exceed one dollar for each elderly person residing in the city or three hundred seventy-five thousand dollars, whichever is less. Notwithstanding the foregoing limitations, counties with a population of less than twenty thousand elderly persons shall be eligible for reimbursement of one hundred percent of such annual approved expenditures provided that the total annual amount of such reimbursement per county shall not exceed twenty thousand dollars.

(2) within the amounts appropriated therefor, a county may receive a grant-in-aid of up to twenty-five per centum of the total annual amount that such county is eligible to receive pursuant to subparagraph one of this paragraph for the

cost of preparing an initial county plan in accordance with this section. Such a grant-in-aid shall be available to a county only once and shall be in addition to the reimbursement received by the county pursuant to subparagraph one of this paragraph for the first program year. A request for such a grant-in-aid shall be accompanied by a letter of intent in the form prescribed by the director evidencing the commitment of the county to develop a county plan for community services and shall be submitted to the director at least six months prior to the beginning of the first program year.

(b) Community service projects:

(1) within the amounts appropriated therefor, counties having an approved county plan shall be eligible for reimbursement by the state for expenditures for approved community service projects pursuant to this section. Such state reimbursement shall not exceed thirty-three thousand six hundred dollars or four dollars twenty cents for each elderly person residing in the county, whichever is greater. The annual state reimbursement eligibility shall be at a rate of seventy-five percent of the total annual expenditures for such approved programs.

(2) the director shall provide by regulation that certain non-county moneys and in-kind equivalents may be used to comprise the county share of such total annual approved expenditures, provided that such county share shall not include cost-sharing received from elderly persons receiving expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to paragraph (k) of this subdivision or moneys received from the federal government for services for the elderly allocated to the states or local governments according to population or other such non-competitive basis.

(3) the director shall provide by regulation the requirements for any participant contributions and fee schedules used for community service projects and the manner for the accounting and use of any such revenue.

(c) Reimbursement pursuant to this section shall not be available for expenditures for base year services otherwise provided without cost, or to replace base year expenditures made by the county or any other service provider irrespective of the source of funds for such services.

(d) Reimbursement shall not be available to community services projects funded pursuant to paragraph (b) of this subdivision or to expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services funded pursuant to paragraph (j) of this subdivision for services provided to elderly persons who are eligible for or are receiving services to meet their needs pursuant to titles eighteen, nineteen or twenty of the federal social security act or any other governmental programs or for services provided to residents in adult residential care facilities which had previously been provided by the facility or which are required by law to be provided by such facility.

(e) For the purpose of determining the amount of state reimbursement for which a county is eligible pursuant to this section, the last preceding federal census or other census data approved by the comptroller shall be used. Funds appropriated by the state for the purpose of reimbursement for community services pursuant to this section shall be apportioned among the counties pursuant to the formula set forth in paragraph (b) of this subdivision by the director. Funds appropriated by the state for the purpose of reimbursement for expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to this section shall be apportioned among the counties by the director pursuant to the formula set forth in paragraph (j) of this subdivision.

(f) The comptroller may withhold the payment of state aid to any county in the event that such county alters or discontinues the operations approved by the director pursuant to this section or otherwise fails to comply with the regulations or requirements of the director.

(g) Counties shall submit claims for reimbursement after the end of each month or each quarter as required by and in accordance with procedures prescribed by the director. Reimbursement shall be available for approved expenditures incurred in accordance with an approved county plan for community services.

(h) Reimbursement pursuant to subparagraph one of paragraph (b) or paragraph (j) of this subdivision shall not be available for expenditures for community or expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services to elderly persons in the city of New York unless

expenditures for such services are apportioned for services in each of the counties contained within such city in a manner which the director has determined by regulation substantially reflects the proportion that the number of elderly persons in that county bears to the total number of elderly persons in the city as a whole. In determining whether reimbursement shall be available under paragraph (g) of this subdivision, the director shall ensure that expenditures were apportioned in accordance with the provisions of this paragraph.

(i) The director, within the amounts appropriated therefor and with the approval of the director of the budget, may authorize a county which has an approved home care plan for functionally impaired elderly to provide expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to such plan. Such services shall be limited to those services necessary to meet otherwise unmet needs and which support such elderly persons' continued residence in their homes. Needs will be determined pursuant to a standardized evaluation of functional impairment, available resources and such other relevant factors specified pursuant to regulations promulgated by the director. No expanded non-medical in-home services, non-institutional respite services, or ancillary services shall be provided to any individual pursuant to this section unless such expanded non-medical in-home services, non-institutional respite services, or ancillary services are accompanied by ongoing case management services in accordance with regulations promulgated by the director.

(j) Within the amounts appropriated therefor, counties authorized to provide expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to paragraph (i) of this subdivision shall be eligible for reimbursement by the state of up to seventy- five percent of allowable expenditures for approved services pursuant to this section up to the level authorized by the director. The director shall not authorize a level of state reimbursement pursuant to this paragraph which exceeds the sum of ninety-one thousand two hundred fifty dollars or seven dollars thirty cents for each elderly person residing in the county, whichever is greater, and shall proportionately reduce such sum for each county in any years for which appropriations are not sufficient to fully fund approved expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services for functionally impaired elderly in all counties with approved home care plans; provided however that in state fiscal years beginning on or after the first day of April, two thousand five, the director, with the approval of the director of the budget, may authorize state reimbursement in excess of these levels to the extent appropriations are available therefor.

(k) The director, with the approval of the director of the budget, shall provide by regulation the extent of cost-sharing to be required of elderly persons receiving expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to this section, which shall reflect such recipients' means to pay for such services and which will not affect their ability to remain in their homes; provided however that the director shall not authorize or direct the withholding of state aid pursuant to paragraph (f) of this subdivision prior to the first day of April, two thousand five, based on any county's failure or inability to comply with regulations promulgated pursuant to this paragraph. The full amount of cost-sharing actually received by any county from elderly persons receiving expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services shall be used by such county to expand either such county's program of community services or such county's program of expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to this section.

(l) Reimbursement pursuant to paragraph (j) of this subdivision shall not be available for expenditures for base year services otherwise provided without cost, or to replace base year expenditures made by the county or any other service provider irrespective of the source of funds, or to replace community services expenditures pursuant to paragraph (b) of this subdivision.

(m) Counties shall submit claims for reimbursement for expanded in-home services, non-institutional respite services, case management services, and ancillary services to functionally impaired elderly as required by and in accordance with procedures prescribed by the director. Reimbursement shall be available for approved expenditures incurred in accordance with an approved county home care plan for functionally impaired elderly to the extent the director has authorized state aid for such services pursuant to paragraph (i) of this subdivision.

(n) The director shall provide by regulation that certain non-county moneys and in-kind equivalents may be used in part to compose the county share of total allowable expenditures pursuant to paragraph (j) of this subdivision, provided that such county share shall not include cost-sharing received from elderly persons receiving expanded

non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to paragraph (k) of this subdivision or moneys received from the federal government for services for the elderly allocated to the states or local governments according to population or other such non-competitive basis.

5. Contracts for services. (a) For the purposes of this section, counties are authorized to contract with public agencies, municipalities, non-profit agencies, or such other entities as the director may authorize. Contracts for nursing services, home health aide services, nutritional services (other than the delivery of meals), physical, speech, and occupational therapy, and medical social services provided pursuant to this section shall only be with certified home health agencies as defined in article thirty-six of the public health law.

(b) Community services provided pursuant to this section shall not be provided directly by the designated agency unless approval is granted by the director. Such approval may not be given by the director unless the designated agency directly provided the service prior to approval of the annual county plan by the director, or unless it can be shown that the direct provision of a community service by the designated agency is necessary due to the absence of an existing suitable provider to assure an adequate supply of such service, or to ensure the quality of the service provided.

(c) Pursuant to an agreement, two or more counties may join together for the purposes of this section. Such agreements shall make provision for the proportionate cost to be borne by each county, the employment of personnel, the receipt and disbursement of funds, and any other matters deemed necessary by the director. Claims for reimbursement pursuant to subdivision four of this section shall be paid to each county and shall be limited to the amount to which each county would be entitled pursuant to such subdivision.

6. Implementation of home care plans. Within the amounts appropriated therefor, counties authorized to provide expanded non-medical in-home services, non-institutional respite services, case management services, and ancillary services pursuant to paragraph (i) of subdivision four of this section shall be eligible for reimbursement by the state of one hundred percent of allowable expenditures for implementing the approved county home care plan for functionally impaired elderly, limited to a sum equivalent to the amount available to such county pursuant to subparagraph one of paragraph (a) of subdivision four of this section.

7. For the purposes of obtaining state aid within the amounts appropriated therefor under this section, a designated agency of an Indian tribal organization shall qualify as though it were a designated agency for a county.

§ 215. Social model adult day services programs

1. Definitions. As used in this section:

(a) "Advisory committee for the aging" shall mean the advisory committee for the aging established pursuant to section two hundred ten of this title.

(b) "Social adult day services" shall mean a program providing a variety of long term care services to a group of individuals, possessing functional impairments, whether due to physical or cognitive impairments, in a congregate setting and pursuant to an individualized plan of care.

(c) "Designated agency" shall mean any agency which is either a unit of county government, the city of New York, or the governing body or council of an Indian tribal reservation, or a private not-for-profit agency organized or existing pursuant to the not-for-profit corporation law, which has been designated as an area agency on aging by the state office for the aging pursuant to the federal older Americans act of 1965, as amended.

(d) "Functionally impaired" shall mean a person who needs the assistance of another person in at least one of the following activities of daily living: toileting, mobility, transferring, or eating; or who needs supervision due to cognitive and/or psycho-social impairment.

(e) "Social adult day care" shall mean a program providing a variety of comprehensive services to functionally impaired elderly persons as defined in regulations established by the director.

2. Duties of the director. (a) The director is authorized and directed to promulgate rules and regulations, establishing standards and requirements with regard to the operation of all social adult day care programs receiving funding pursuant to this article. Such standards and requirements shall include, but not be limited to:

- (1) services to be provided;
- (2) admission criteria;
- (3) participant cost-sharing;
- (4) assessment and enrollment;
- (5) staffing;
- (6) monitoring and evaluation of programs; and
- (7) any other standards or requirements which the director determines to be appropriate.

(b) Rules and regulations promulgated by the director pursuant to this subdivision shall also direct how social adult day care will be included in the planning currently required of designated agencies.

3. Funding for social adult day care programs.

(a) Beginning with amounts appropriated in the two thousand five fiscal year, the director shall, within amounts appropriated therefor, make grants available on a competitive basis to not-for-profit or local government operated social adult day care programs for functionally impaired elderly persons, with consideration of regional needs and a broad array of models. Such grants shall equal seventy-five percent of allowable expenditures for approved services pursuant to this section; provided however that the director may accept certain in-kind equivalents to comprise the required twenty-five percent match; and provided further, in the case of providers which can demonstrate financial need, the director may make grants of up to one hundred percent of allowable expenditures pursuant to this section.

(b) Beginning with the first year that the annual increase in amounts appropriated for the purposes of this section shall equal at least five million dollars, for that increase and all increases thereafter, the director shall distribute such increases to designated agencies for the provision of social adult day care programs for functionally impaired elderly persons based on a formula developed by the office which shall consider at least the following: the number of elderly persons in the area; and the number of functionally impaired elderly persons in the area as determined by the office. Base funding established under paragraph (a) of this subdivision shall continue to be distributed as provided in paragraph (a) of this subdivision. Within the amounts appropriated therefor, designated agencies authorized to provide social adult day care under this section shall be eligible for reimbursement from the state for seventy-five percent of allowable expenditures for approved social adult day care services pursuant to this section up to a level authorized by the director; provided however, that certain in-kind equivalents may comprise the twenty-five percent match.

(c) The office may use up to three percent of the total of any funding appropriated pursuant to this section for administration.

(d) The designated agency may use up to three percent of the total of any funds provided to the designated agency pursuant to this section for administration.

4. Funding eligibility. Funding pursuant to this section shall not be available to social adult day care programs for services provided to elderly persons who are eligible for or receiving comparable services to those defined in this section pursuant to title eighteen, nineteen or twenty of the federal social security act, or any other government program. In addition, funding pursuant to this section shall not supplant any existing public or private funding for social adult day care programs.

5. Report of director. The director, after consultation with his or her advisory committee, affected state agencies, any affected municipal agencies and persons involved in providing social adult day care services, shall make a report, on or before December thirty-first, two thousand five, to the governor, the temporary president of the senate, the speaker of the assembly, the chair of the senate standing committee on aging and the chair of the assembly standing committee on aging on the projected costs and benefits of establishing uniform standards and requirements with regard to operation of social adult day care services in the state. The report shall include the director's findings, recommendations and estimate of the fiscal implications of regulating social adult day care services in the state.

§ 215-a. Senior vision services program

1. Definitions. As used in this section:

(a) "Senior vision services" shall mean the provision of non-vocational services to elderly persons who have a functional visual impairment. These services may include, but not be limited to, client assessment, information and referral, client and family counseling, referrals for ophthalmological, optometric or other health care services, technical assistance and training for human services personnel to serve persons who are blind or visually impaired, and low vision screening.

(b) "Functional visual impairment" shall mean an impairment of sight that substantially interferes with an elderly person's ability to perform specific daily living skills and tasks. Persons who are not regarded as legally blind, pursuant to this section, but who experience such an impairment of sight, shall be deemed eligible for senior vision services pursuant to this section.

(c) "Elderly" shall mean an individual over sixty years of age.

(d) "Director" shall mean the director of the office for the aging.

2. The director, in consultation with the New York state commission for the blind and visually handicapped, is hereby authorized and directed, subject to the availability of appropriations, to establish a program of senior vision services grants to assist in the provision of vision services to elderly persons with functional visual impairments.

3. The director, in consultation with the New York state commission for the blind and visually handicapped, shall award senior vision services grants to not-for-profit corporations which demonstrate:

(a) the ability to provide senior vision services;

(b) a commitment to provide such services to visually impaired persons or specialized training in providing such services to persons who are blind or visually impaired; and

(c) other such factors as may be determined by the director in consultation with the state commission for the blind and visually handicapped.

4. Grant awards shall take into consideration the lack of non-traditional and non-vocational services for elderly persons in need of senior vision services and the ability of such senior vision services grants to establish or to expand existing blind or visually impaired services currently provided or available in the county or region served by the not-for-profit corporation or through another source.

5. The director shall ensure that in awarding the grants pursuant to this section that due consideration is given to the geographic and existing service demands for senior vision services within a county or region of the state.

6. The director shall promulgate any rules and regulations necessary to carry out the provisions of this section. Additionally, the director shall submit a report to the governor, the temporary president of the senate and the speaker of the assembly, prior to, but in no event later than, December thirty-first, in the year following enactment of this section, and annually thereafter, which shall include, but not be limited to:

- (a) financial reports of the grant project operations established pursuant to this section;
- (b) an analysis of the grant project's ability to provide such senior vision services to elderly persons with functional visual impairments;
- (c) recommendations on the continuation of such grants and the need for program expansion, if appropriate;
- (d) a profile of the grant recipient; and
- (e) other information deemed necessary by the director.

§215-b. Enriched social adult day services demonstration project.

[Expired and is deemed repealed March 31, 2011, pursuant to L.2008, c. 58, pt. A, §32] 1. Legislative intent. Social adult day services programs are resources that can help communities maintain the independence of elderly residents. The level of services needed by some elderly persons exceeds the level of assistance currently available through social model adult day services programs but is not at the level of support provided in an adult day health care program. Social adult day services programs cannot enroll new participants whose needs exceed the services that can be provided in the current social adult day services programs. Additionally, these programs must discharge current participants when their needs cannot be met. Therefore, an enriched social adult day services project shall be established as a demonstration project for the purposes of maintaining elderly persons in the community by deterring or delaying institutionalization.

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

- (a) "Elderly" or "elderly persons" shall mean persons who are sixty years of age or older.
- (b) "Eligible participant" shall mean elderly or elderly persons as defined in this section, who are functionally impaired, as defined in section two hundred fifteen of this title, and in need of services that exceed the level of assistance currently available through social adult day services programs but not at the level of support provided by adult day health care programs.
- (c) "Eligible entity" shall mean any not-for-profit or government entity, including the governing body or council of an Indian tribal reservation, who has demonstrated to the office and the department of health, based on criteria developed by the director and the commissioner of health, that it can safely provide either directly or through a contract with a licensed health care practitioner or licensed home care provider as defined in section thirty-six hundred five of the public health law, social adult day care services as defined in section two hundred fifteen of this title, as well as additional allowable medical services as developed by the director and the commissioner of health, and optional services as defined in this section.
- (d) "Enriched social adult day services demonstration project" or "project" shall mean programs eligible under this section that provide all of the services currently required for social adult day services programs under section two hundred fifteen of this title in addition to enriched services, and may include optional services.
- (e) "Enriched services" shall include the provision of total assistance with toileting, mobility, transferring and eating; dispensing of medications by a registered nurse; health education; counseling; case management; restorative therapies lasting less than six months and maintenance therapies. Total assistance with toileting, mobility, transferring and eating shall be provided under the supervision of a licensed health care provider. Restorative and maintenance therapies shall be provided by an appropriately licensed health care provider.
- (f) "Optional services" shall mean other non-medical services approved by the director designed to improve the quality of life of eligible participants by extending their independence, avoiding unnecessary hospital and nursing home stays, and sustaining their informal supports.

3. Demonstration project. The director, in conjunction with the commissioner of health, is authorized and directed to establish an enriched social adult day services demonstration project for the purposes of testing innovative ways that

social adult day services programs can successfully enable eligible participants to remain independent in their communities by deterring or delaying institutionalization through the use of enriched services.

4. Duties of the director. (a) The director, in conjunction with the commissioner of health, may make up to twenty grants available on a competitive basis to eligible entities under this section. Such grants may be available for up to two hundred thousand dollars for each enriched social adult day services demonstration project and shall be for up to one hundred percent of allowable expenditures for approved services and expenses under this section.

(b) In making grants, the director, in conjunction with the commissioner of health, may consider:

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

(2) projects that effectively serve culturally diverse populations;

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

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

(5) any other criteria determined to be appropriate.

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

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

§ 216. Advisory council to the recreation program for the elderly created; functions, powers and duties

[Expired and deemed repealed as of April 1, 2010 pursuant to L. 2010 c.58 §§39 and 86] There is hereby created in the office an advisory council to the recreation program for the elderly to consist of seven members to be appointed by the director. The council shall have power to organize, elect a chairperson and secretary, and advise the director on regulations with respect to the furnishing of recreation programs for adults sixty years of age and over, such programs being established to assist such adults to prevent premature institutionalization as a result of physical or mental deterioration. The term of the members of such council shall be five years.

§ 217. Congregate services initiative for the elderly

1. Definitions. As used in this section, the following words shall have the following meanings:

(a) "Designated agency" shall mean an agency which is designated by the chief executive officer of the county if there be one, or otherwise the governing board of such county, or the chief executive officer of the city of New York, or the governing board of an Indian tribal council; which is either a unit of county government or the city of New York or an Indian tribal organization or a private non-profit agency, and which is the area agency on aging created pursuant to the federal older Americans act of 1965.

(b) "Elderly person" shall mean a person sixty years of age or older.

(c) "County" shall mean a county, as defined in section three of the county law, except that the city of New York shall be considered one county.

(d) "Congregate services" shall mean services for elderly persons which are provided by a public or a government agency or non-profit agency which are provided in community settings at which elderly people come together for services and activities that respond to their diverse needs and interests, enhance their dignity, support their independence, and encourage their involvement in and with the community and which seek to prevent the well elderly from requiring more intensive services such as those provided under expanded non-medical in-home services and non-institution respite service. Such services include but are not limited to:

- (1) Information and referral;
- (2) Transportation;
- (3) Nutrition-related services that deal with hunger among the elderly;
- (4) Socialization/companionship;
- (5) Educational and cultural opportunities;
- (6) Counseling;
- (7) Support services for families/caregivers;
- (8) Volunteer opportunities;
- (9) Employment services information; and
- (10) Health promotion and disease prevention services.

(e) "Non-profit agency" shall mean a corporation organized or existing pursuant to the not-for-profit corporation law.

2. Notwithstanding any provision of this section, nothing contained herein shall give the director or a designated agency any administrative, fiscal, supervisory, or other authority whatsoever over any plans, programs or expenditures authorized pursuant to titles eighteen, nineteen and twenty of the federal social security act, or over any unit of state or local government.

3. Funding. (a) The director shall, within the amounts appropriated therefor, make funds available to designated agencies for the provision of congregate services for elderly persons.

(b) The director shall distribute such funds based on a formula developed by the office which shall take into account the geographic distribution of elderly persons within the state and any other factors deemed appropriate by the director.

4. (a) Except as otherwise provided in paragraph (b) of this subdivision, the designated agency shall subcontract with public agencies, not-for-profit agencies, or other entities to provide congregate services.

(b) The designated agency may directly operate, with the approval of the director, congregate services.

(c) The designated agency may use up to five percent of the total of any funds provided to the designated agency pursuant to this section for administration.

5. Designated agencies qualifying for funds under this section must include in the current county plan, required under section two hundred fourteen of this title, a description of the planning, coordination, administrative and local

funding priorities and activities necessary to achieve the goals and objectives of this section.

6. Within the amounts appropriated therefor, counties authorized to provide congregate services pursuant to this section shall be eligible for reimbursement by the state of up to seventy-five percent of allowable expenditures for approved services pursuant to this section.

7. The comptroller may withhold the payment of state aid to any county in the event that such county alters or discontinues the operations approved by the director pursuant to this section or otherwise fails to comply with the regulations or requirements of the director.

8. Contracts for services. (a) For the purposes of this section, counties are authorized to contract with public agencies, municipalities, non-profit agencies, or such other entities as the director may authorize.

(b) Congregate services provided pursuant to this section shall not be provided directly by the designated agency unless approval is granted by the director. Such approval may not be given by the director unless the designated agency directly provided the service prior to approval of the annual county plan by the director, or unless it can be shown that the direct provision of a congregate service by the designated agency is necessary due to the absence of an existing suitable provider to assure an adequate supply of such service, or to ensure the quality of the service provided.

(c) Pursuant to an agreement, two or more counties may join together for the purposes of this section. Such agreements shall make provision for the proportionate cost to be borne by each county, the employment of personnel, the receipt and disbursement of funds, and any other matters deemed necessary by the director.

9. For the purposes of obtaining state aid within the amounts appropriated therefor under this section, a designated agency of an Indian tribal organization shall qualify as though it were a designated agency for a county.

10. On or before February first, two thousand five the office shall submit a report to the chairs of the assembly ways and means committee, the senate finance committee, and the director of the division of the budget which evaluates and makes recommendations on the congregate services initiative program. The report should include but not be limited to the following information:

(a) A description of grant recipients and amount of funds received through area offices on aging for the congregate services initiative. The description of grant recipients should include: the types of services offered at each site, the number of individuals served, and, to the extent practicable, a profile of the individuals served. The office should include a specific recommendation on whether a minimal set of services should be required of each program or if flexible service requirements should be maintained.

(b) A description of the benefits of the program, including any survey information obtainable from participants in the program, family members, or caregivers for whom the program may serve as respite. The description of benefits should also address the extent to which availability of the program helps to avoid unnecessary institutionalization of participants.

(c) A description of oversight and planning mechanisms built into the program and an assessment of the extent to which reconfiguration of the recreation program to the congregate services initiative has improved the delivery and/or oversight of services.

(d) A description of how providers of congregate services initiative services have coordinated with other agencies, providers, or counties, who offer similar services.

(e) A description of any known factors which have either contributed to successful service delivery or have hindered the congregate services initiative program.

(f) An assessment of the need for and/or demand for congregate initiative services and the extent to which the congregate services initiative or any other available services, are currently addressing those needs.

(g) Any other information the office for the aging deems relevant.

11. The executive department is authorized to collect any information necessary from grant recipients or area offices on aging necessary to complete this report.

12. With regard to direct grants to community based non-profit organizations for the provision of congregate services to persons sixty years of age or older to promote their health, independence and involvement in the community, congregate services shall be provided at community settings where eligible persons come together for services and activities and shall include, but are not limited to: information and referral; transportation; nutrition-related services; socialization; educational and cultural opportunities; counseling; support services for caregivers and families; volunteer opportunities; employment services information; and health promotion and disease prevention services.

§ 217-a. Long term care insurance education and outreach program

1. For the purposes of this section, the term "long term care insurance resource center" shall mean a project within an area agency on aging funded pursuant to this section that provides direct assistance to the general public in choosing and obtaining long term care insurance.

2. The commissioner of health, in consultation with the director of the office for the aging and the superintendent of insurance, is hereby authorized and directed, within amounts allocated therefor pursuant to paragraph (qq) of subdivision one of section twenty-eight hundred seven-v of the public health law, to establish a long term care insurance education and outreach program within the department of health for the purpose of informing and educating the general public about long term care insurance, including those policies that are available through the partnership for long term care program.

3. The commissioner of health, the superintendent of insurance and the director of the office for the aging shall appoint a state program coordinator to implement, administer and supervise the long term care insurance education and outreach program, and coordinate the development of the educational and informational materials. The state program coordinator shall be an employee of the office for the aging who shall be selected from among individuals with expertise and experience in the fields of long term care insurance, and with other qualifications determined by the commissioner of health, the superintendent of insurance and the director of the office for the aging to be appropriate for the position. The state program coordinator shall, within amounts available, personally or through authorized representatives, be responsible for training staff persons of the program, including staff persons of the long term care insurance resource centers, and shall provide for the collection and dissemination of timely and accurate long term care insurance information to said staff persons.

4. The long term care insurance education and outreach program shall, within amounts available, consist of the following elements which shall be provided by the office for the aging:

(a) educational and informational materials in print, audio, visual, electronic or other media;

(b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or presentations;

(c) establishment of a toll-free telephone hotline and electronic services to provide information; and

(d) establishment of long term care insurance resource centers within each area agency on aging.

5. Long term care insurance resource centers shall, within amounts available, provide the general public with the following items or services:

(a) educational and informational materials in print, audio, visual, electronic or other media;

(b) public service announcements, advertisements, media campaigns, workshops, mass mailings, conferences or

presentations; and

(c) counseling, information, referral services, and direct assistance in choosing and obtaining long term care insurance. Direct assistance shall, within amounts available, include but not be limited to assistance with the following:

- (i) planning for the financing of long term care;
- (ii) understanding policy options, benefits and appeal rights;
- (iii) obtaining the coverage needed and the appropriate benefits; and
- (iv) avoiding or reporting illegal billing, fraudulent practices or scams.

Each long term care insurance resource center shall be responsible, within amounts available, for providing a sufficient number of staff positions (including volunteers) necessary to provide and carry out the services of the long term care insurance education and outreach program, provided that at least one position shall be filled by an individual who is employed full time and paid by the area agency on aging. The long term care insurance resource center shall be responsible for ensuring that its staff persons have no conflict of interest in providing the services described in subdivision four of this section.

6. Annually, in order to receive funding, each area agency on aging shall submit a service plan and proposed budget for the operation of a long term care insurance resource center to the state program coordinator for approval. An area agency on aging shall be eligible to receive funds in an amount of up to fifty thousand dollars, except that an area agency on aging located within a city of one million or more shall be eligible to receive funds in an amount of up to one hundred thousand dollars.

7. [As amended by L.2009, c. 58, pt A. § 13, eff. April 7, 2009]The department of health shall produce, post on its website, make available to others for reproduction, or contract with others to develop such materials required by this section. The material produced pursuant to this section shall be culturally and linguistically appropriate for the communities served by the long term care insurance resource centers. These materials shall be made available to the public free of charge.

8. In exercising any of their powers under this section, the commissioner of health and/or the director of the office for the aging may consult with appropriate agencies, organizations, and consumers and providers of long term care insurance or organizations representing them.

9. In addition to state funds allocated for programs under this section, the commissioner of health and/or the director of the office for the aging may accept funding from public sources for these programs, and may undertake joint or cooperative programs with other public entities or a private not-for-profit corporation which is neither a provider or regulator of long term care insurance, or an affiliate or unit of such agency or corporation.

10. The commissioner of health, the director of the office for the aging and the superintendent of insurance shall issue an annual report to the governor, the speaker of the assembly, and the temporary president of the senate. Such report shall contain, at a minimum, the following information: the number of individuals who have received counseling and assistance by the long term care insurance education and outreach program, their ages and their occupations; whether these individuals have purchased a long term care insurance policy, and if so, the policy that was purchased; a description of all of the services, including counseling, education and outreach services, being provided by the long term care education and outreach program, broken down by county; the activities used to promote the partnership for long term care program; and a description of the long term care education and outreach program's funding sources and whether they are adequate. The report shall also contain recommendations for targeting specific age groups to buy long term care insurance, creating new methods of promoting the purchase of long term care insurance, and improving long term care insurance products.

11. An area agency on aging may use up to five percent of the total of any funds provided to an area agency on aging pursuant to this section for administration.

§ 218. Long term care ombudsman

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

(a) "Local ombudsman" shall mean an individual who is employed by the local entity designated pursuant to subdivision four of this section and who has been approved by the state ombudsman to perform or carry out the activities of the local long term care ombudsman program. The local ombudsman may be either a paid employee or volunteer of the local entity.

(b) [Expires and deemed repealed Dec. 31, 2015, pursuant to L.2004, c. 642, § 14. See, also, par. (b) below.] "Long term care facilities" shall mean residential health care facilities as defined in subdivision three of section twenty-eight hundred one of the public health law and adult care facilities as defined in subdivision twenty-one of section two of the social services law. Within the amounts appropriated therefor, "long term care facilities" shall also mean managed long term care plans and approved managed long term care or operating demonstrations as defined in section forty-four hundred three-f of the public health law and the term "resident", "residents", "patient" and "patients" shall also include enrollees of such plans.

(b) [Eff. Dec. 31, 2015, pursuant to L.2004, c. 642, § 14. See, also, par. (b) above.] "Long term care facilities" shall mean residential health care facilities as defined in subdivision three of section twenty-eight hundred one of the public health law and adult care facilities as defined in subdivision twenty-one of section two of the social services law.

(c) "State ombudsman" shall mean the state long term care ombudsman appointed by the director pursuant to subdivision three of this section.

2. Office established. There is hereby established within the office an office of the state long term care ombudsman for the purpose of receiving and resolving complaints affecting applicants, patients and residents in long term care facilities and, where appropriate, referring complaints to appropriate investigatory agencies and acting in concert with such agencies.

3. State long term care ombudsman. (a) The director shall appoint a full-time state long term care ombudsman to administer and supervise the office of the state long term care ombudsman.

(b) The state ombudsman shall be selected from among individuals with expertise and experience in the fields of long term care and advocacy, and with other qualifications determined by the director to be appropriate for the position.

(c) The state ombudsman shall, personally or through authorized representatives as provided for in paragraph (d) of this subdivision:

(1) identify, investigate and resolve complaints that are made by, or on behalf of, long term care residents in this state and that relate to actions, inactions or decisions that may adversely affect the health, safety and welfare or rights of such residents; provided, however, that the state ombudsman shall immediately refer to the appropriate investigatory agency information obtained during the investigation of a complaint which suggests the possible occurrence of physical abuse, mistreatment or neglect or Medicaid fraud, in accordance with procedures established by the state ombudsman. Such procedures shall include, but not be limited to, the reporting to the appropriate investigatory agency any reasonable information which suggests the possible occurrence of physical abuse, mistreatment or neglect as defined in section twenty-eight hundred three-d of the public health law. Nothing in this section shall be construed as authorizing the state ombudsman to impose a resolution unacceptable to either party involved in a complaint or to assume powers delegated to the commissioner of health or the department of health pursuant to article twenty-eight of the public health law or to the commissioner of the office of children and family services or the office of children and family services pursuant to the social services law; nor does it authorize the state ombudsman to investigate final administrative determinations made pursuant to law by such commissioners if such decisions become the subject of complaints to the state ombudsman;

(2) provide services to assist residents in protecting their health, safety, welfare and rights, including but not limited to representing the interests of residents before governmental agencies and seeking appropriate administrative, legal and other remedies to protect their welfare, safety, health and rights;

(3) inform the residents about means of obtaining services provided by public health, social services and veterans' affairs or other public agencies;

(4) analyze and monitor the development and implementation of federal, state and local laws, regulations or policies with respect to the adequacy of long term care facilities and services in the state;

(5) in consultation with the director, establish procedures for the training of the authorized representatives and of local ombudsmen and their staff which at a minimum shall specify the minimum hours of training and the content of the training, including, but not limited to, training relating to federal, state and local laws, regulations and policies with respect to long term care facilities in the state; and

(6) carry out such other activities as the director determines to be appropriate pursuant to the federal Older Americans Act of 1965 and other applicable federal and state laws and related regulations as may, from time to time, be amended.

(d)(1) The state ombudsman, with the approval of the director, may appoint one or more authorized representatives to assist the state ombudsman in the performance of his or her duties under this section.

(2) The state ombudsman shall appoint only those individuals who have been certified as having completed the training program developed pursuant to paragraph (c) of this subdivision.

(e) No state ombudsman, authorized representative, local ombudsman or immediate family member of such person shall:

(1) have a direct involvement in the licensing or certification of a long term care facility or of a provider of a long term care service;

(2) have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long term care facility or a long term care service;

(3) be employed by, or participate in the management of, a long term care facility; and

(4) receive remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long term care facility.

(f) The state ombudsman shall establish written procedures to identify and remove conflicts of interest set out in paragraph (e) of this subdivision and shall include actions that the director may require an individual ombudsman or immediate family member to take to remove such conflicts of interest.

(g) [Expires and is deemed repealed Dec. 31, 2015, pursuant to L.2004, c. 642, § 14.] Within the amounts appropriated therefor, the state ombudsman program shall include services specifically designed to serve persons enrolled in managed long term care plans or approved managed long term care or operating demonstrations authorized under section forty-four hundred three-f of the public health law, and shall also review and respond to complaints relating to marketing practices by such plans and demonstrations.

4. Local long term care ombudsman program. (a) The state ombudsman, with the approval of the director, may designate an entity to operate a local long term care ombudsman program for one or more counties.

(b) The designated entity shall be an area agency on aging, a public agency or a private not-for-profit corporation which is neither a provider or regulator of long term care facilities, or an affiliate or unit of such agency or corporation.

(c)(1) Each local long term care ombudsman program shall be directed by a qualified individual who is employed and paid by the local entity and who shall have the duties and responsibilities as provided in regulations, consistent with the provisions of this section and of Title VII of the federal older Americans act of 1965, as amended. In addition, upon designation, the entity is responsible for providing for adequate and qualified staff, which may include trained volunteers to perform the functions of the local long term care ombudsman program.

(2) No local program staff, including the supervisor and any volunteers, shall perform or carry out the activities on behalf of the local long term care ombudsman program unless such staff has received the training pursuant to paragraph (c) of subdivision three of this section and has been approved by the state ombudsman as qualified to carry out the activities on behalf of the local program.

(d) The director, in consultation with the state ombudsman, shall establish in regulations standards for the operation of a local long term care ombudsman program.

(e) When the state ombudsman determines that a local long term care ombudsman program does not meet the standards set forth in this section and in any related regulations, the state ombudsman shall with the approval of the director withdraw the designation of the local program. Prior to taking such action, the state ombudsman shall send to the affected local program a notice of intention to withdraw the designation, which notice shall also inform the local program of its right to an administrative hearing prior to the director's final determination. Such administrative hearing shall be conducted in accordance with procedures set forth in regulations.

5. Review of complaint. (a) Upon receipt of a complaint, the ombudsman shall determine immediately whether there are reasonable grounds for an investigation. Such investigation shall be conducted in a manner prescribed in regulations. The state ombudsman, or the local ombudsman, whoever is appropriate, shall immediately refer to the appropriate investigatory agency information obtained during the investigation of a complaint which suggests the possible occurrence of physical abuse, mistreatment or neglect or Medicaid fraud, in accordance with procedures established by the state ombudsman. Such procedures shall include, but not be limited to, the reporting to the appropriate investigatory agency if there is reasonable cause to believe the occurrence of physical abuse, mistreatment or neglect as defined in section twenty-eight hundred three-d of the public health law.

(b) If the referral is made by the local ombudsman, a copy of the referral, together with copies of any relevant information or records, shall be sent forthwith to the state ombudsman.

6. Retaliatory discrimination prohibited. (a) No person shall discriminate against any resident of a long term care facility because such resident or any person acting on behalf of the resident has brought or caused to be brought any complaint to the state or local long term care ombudsman for investigation, or against any resident or employee of a long term care facility or any other person because such resident or employee or any other person has given or provided or is to give or provide any statements, testimony, other evidence or cooperation for the purposes of any such complaint.

(b) Any resident who has reason to believe that he or she may have been discriminated against in violation of this subdivision may, within thirty days after such alleged violation occurs, file a complaint with the commissioner of health pursuant to subdivision ten of section twenty-eight hundred one-d of the public health law.

7. Record access. (a)(1) The state ombudsman, with the approval of the director, may approve and certify one or more previously designated local ombudsmen or state representatives as a records access ombudsman upon their having completed the training program for records access ombudsman set out in paragraph (b) of this subdivision; and

(2) A records access ombudsman shall be an employee of the office of the state ombudsman or of the local entity designated to carry out a local ombudsman program, except that the state ombudsman may certify as a records access ombudsman a volunteer under the direct supervision of the state ombudsman or of the supervisor of the local program, whichever is appropriate, if such volunteer is licensed in a medical, legal, or social work profession, or whose experience and training demonstrate equivalent competency in medical and personal records review.

(b) Except as otherwise provided by law, no person, including the state ombudsman, his or her authorized representatives, or any local ombudsman, shall be authorized to have access to or review the medical or personal records of a patient or resident pursuant to section twenty-eight hundred three-c of the public health law and section four hundred sixty-one-a of the social services law or pursuant to written consent to such access by the patient or resident, or his or her legal representative unless such person has been:

(1) Certified as having satisfactorily completed a training program prescribed by the office and designed, among other purposes, to (A) impress upon the participant the value, purpose, and confidentiality of medical and personal records, (B) familiarize the participant with the operational aspects of long term care facilities, and (C) deal with the medical and psycho-social needs of patients or residents in such facilities; and

(2) Certified as a records access ombudsman by the state ombudsman.

(c) No ombudsman shall disclose the identity of the resident or complainant that made a complaint to the ombudsman unless:

(1) the complainant or resident or his or her legal representative gives written consent to the ombudsman, except that written consent shall also include the resident or complainant giving oral consent that is documented contemporaneously in a writing made by the ombudsman with the agreement of the complainant or resident and in accordance with requirements established by the director; or

(2) pursuant to a court order.

(d) No ombudsman shall disclose to any person outside of the ombudsman program any information obtained from a patient's or resident's records without the approval of the state ombudsman or his or her designee, in accordance with procedures for disclosure established by the director in consultation with the state ombudsman. Such approval is not required for suspected instances of physical abuse, mistreatment or neglect or Medicaid fraud and, subject to withholding identifying information of a non-consenting complainant or resident under paragraph (c) of this subdivision, a local ombudsman or state representative shall provide needed file information to the appropriate state and federal regulatory authorities and cooperate with them to help further their investigation.

(e) No records access or other ombudsman who directly or indirectly obtains access to a patient's or resident's medical or personal records pursuant to section twenty-eight hundred three-c of the public health law shall disclose to such patient or resident or to any other person outside of the ombudsman program the content of any such records to which such patient, resident or other person had not previously had the right of access, provided that this restriction shall not prevent such ombudsman from advising such patient or resident of the status or progress of an investigation or complaint process initiated at the request of such patient or resident or from referring such complaint, together with the relevant records, to appropriate investigatory agencies. Any person who intentionally violates the provisions of this subdivision shall be guilty of a misdemeanor. Nothing contained in this section shall be construed to limit or abridge any right of access to records, including financial records, otherwise available to ombudsmen, patients or residents, or any other person.

8. Failure to cooperate. Any long term care facility which refuses to permit the state ombudsman, his or her authorized representative, or any local ombudsman entry into such facility or refuses to cooperate with the state ombudsman, his or her authorized representative, or any local ombudsman in the carrying out of their mandated duties and responsibilities set forth in this section and any regulations promulgated pursuant thereto, or refuses to permit patients or staff to communicate freely and privately with the state ombudsman, his or her authorized representative, or any local ombudsman shall be subject to the appropriate sanction or penalties of the state agency that licenses the facility.

9. Civil immunity. Notwithstanding any other provision of law, ombudsmen designated under this section or who are also records access ombudsmen functioning in accordance with this section shall be included within the definition of employee as set forth in section seventeen of the public officers law and shall be defended and indemnified in accordance with the provisions of article two of such law.

10. Regulations. The director is authorized to promulgate regulations to implement the provisions of this section.

11. Annual report. On or before March thirty-first, two thousand five, and annually thereafter, the state ombudsman shall submit to the governor, commissioner of the administration on aging, speaker of the assembly, temporary president of the senate, director of the state office for the aging, commissioner of the department of health, and the commissioner of children and family services a report and make such report available to the public:

(a) describing the activities carried out by the office of the state long term care ombudsman during the prior calendar year;

(b) containing and analyzing data relating to complaints and conditions in long term care facilities and to residents for the purpose of identifying and resolving significant problems;

(c) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(d) containing recommendations for:

(1) appropriate state legislation, rules and regulations and other action to improve the quality of the care and life of the residents; and

(2) protecting the health, safety and welfare and rights of the residents;

(e) any other matters as the state ombudsman, in consultation with the director, determines to be appropriate.

§ 219. Elderly abuse education and outreach program

1. Definitions. For the purposes of this section, the terms "designated agency" and "elderly person" shall have the same meaning as ascribed to them in section two hundred fourteen of this title.

2. The director, within the amounts appropriated therefor, shall, in conjunction with the office of children and family services, establish an elderly abuse education and outreach program for the purpose of providing education and outreach to the general public, including elderly persons and their families and caregivers, to identify and prevent elderly abuse, neglect and exploitation.

3. (a) As part of the program, the director may award grants to qualified designated agencies to establish local elderly abuse education and outreach programs. Grants may also be awarded to expand or enhance existing programs.

(b) In making such grants, the director shall consider:

(1) the need within the jurisdiction of the designated agency for such education and outreach;

(2) the manner in which the designated agency proposes to provide such education and outreach;

(3) the capacity of the designated agency to coordinate its services with health, human service and law enforcement and public agencies which provide services or assistance to the elderly, including the local department of social services adult protective services unit; and

(4) any other criteria determined by the director to be appropriate.

4. (a) The office may use up to five percent of the total funds appropriated pursuant to this section for administration.

(b) A designated agency which has been awarded a grant pursuant to subdivision three of this section may use up to five percent of the total of any funds provided to a designated agency pursuant to this section for administration.

§ 220. Resident advisor program

1. Within amounts appropriated therefor, the office may establish or administer as necessary a resident advisor program in locales across the state and in such a manner that insures a wide geographic representation.
2. The director of the office is directed to work in cooperation with appropriate state and federal agencies to facilitate the successful operation of local resident advisor program sites.
3. In administering the resident advisor program, the director is directed to provide program sites with technical assistance to housing and supportive service providers; training of an ongoing nature for program sponsors; marketing materials and technical assistance aimed at obtaining resident acceptance to resident advisors; and assistance in developing necessary linkages between state, federal and local partners.

§ 221. Legislative findings and objectives

1. The legislature finds and declares that a significant percentage of the state's senior citizens live at or below the poverty level. In many cases, energy costs reach or exceed thirty percent of household income. These factors make energy conservation efforts on behalf of low income elderly crucial. The legislature further finds that energy conservation programs have been under-utilized by such citizens because of such factors as reduced mobility, social and physical isolation, and the complexity of the maze of services available.
2. The legislature therefore declares that a pilot program to assist such citizens to conserve energy should be implemented by the office in conjunction with county offices for the aging. The legislature further declares that such a program will further the energy conservation objectives of the state and should be partially supported by petroleum overcharge restitution funds.

§ 222. Senior citizen energy packaging pilot program

1. Within the amounts appropriated therefor, the office shall establish guidelines for and administer a senior citizen energy packaging pilot program to be carried out by county offices for the aging in the counties of Nassau, Suffolk, Broome, Erie and Tompkins and such other counties as funds may allow. Wherever possible, such program shall be coordinated with appropriate existing programs of public utilities, the state energy office and the department of state.
2. These appropriations shall be used specifically for the training of personnel within county offices for the aging to insure their thorough familiarity with state and federal energy conservation programs and benefits and their ability to facilitate receipt of such benefits by the client population. These appropriations shall also be used to provide salaries, appropriate benefits and expenses of such personnel in carrying out the purposes of the pilot program. Depending on the size of the client population to be served, no more than five of such personnel shall be trained and utilized in any county.
3. The client population shall consist of those senior citizens living at or below the poverty level. Whenever possible, priority shall be given to serving first those in greatest need of assistance, including but not limited to, home energy assistance program recipients.

§ 223. Economically sustainable transportation demonstration program

1. Definitions. As used in this section:
 - (a) "Economically sustainable transportation provider" shall mean a non-profit provider of transportation services that submits to the director and obtains approval of a plan demonstrating that the provider is capable of providing economically sustainable transportation services.

(b) "Economically sustainable transportation services" shall mean demand-responsive transportation services that are provided:

- (1) by automobile;
- (2) to qualified individuals;
- (3) twenty-four hours a day, seven days a week; and
- (4) by volunteer or paid drivers.

(c) "Qualified individual" shall mean an individual who is:

- (1) an older individual, as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002); or
- (2) an individual who is blind, within the meaning of the Rehabilitation Act of 1973 (29 U.S.C. 701 et seq.), an individual who has significant visual impairment described in section 751 of the Rehabilitation Act of 1973 (29 U.S.C. 796j), or an individual who is eligible for benefits under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq., 1381 et seq.) on the basis of blindness.

(d) "Qualified transportation account" shall mean an account established for a qualified individual for the purpose of acquiring transportation services from an economically sustainable transportation provider.

(e) "Director" shall mean the director of the New York state office for the aging.

(f) "Eligible entity" shall mean a private non-profit organization with experience in establishing and replicating the independent transportation network to provide economically sustainable transportation services for qualified individuals.

2. The director shall establish the economically sustainable transportation demonstration program for the purpose of enabling seniors to remain independent and mobile in their community. The program would provide an on demand transit service for seniors that would use automobiles driven by volunteer and paid drivers to transport seniors to where they need and want to go. After a period of five years, the program would no longer be eligible for state funding and would be completely self-sustaining, relying on consumer fares and voluntary community support to remain operational.

3. Before carrying out the economically sustainable transportation demonstration program, the director shall enter into a contract or a cooperative agreement with an eligible entity to provide recommendations and support to the director regarding the administration of such a program.

(a) The eligible entity that enters into a contract or agreement under subdivision three of this section shall:

- (1) Provide initial and ongoing technical assistance and support to the director for the administration of the sustainable transportation demonstration program.
- (2) Provide initial and ongoing technical assistance to economically sustainable transportation providers.
- (3) Provide recommendation to the director about the establishment of, and requirements concerning locations where the economically sustainable transportation services will be provided in the state.
- (4) Provide recommendations to the director for the creation and use of qualified transportation accounts for the transportation services, including the provisions that such an account:

(i) may be funded with credits or funds equal to the value of a vehicle traded to an economically sustainable transportation provider by, or on behalf of, a qualified individual, or by other means;

(ii) shall be used only to provide transportation services to the qualified individual;

(iii) shall have a designated beneficiary; and

(iv) shall be transferable to an individual other than the qualified individual.

(5) Provide recommendations to the director regarding participation in any federal grant program for an economically sustainable transportation program.

4. After receiving the recommendations and support described in subdivision three of this section, the director shall develop a request for proposal to carry out the economically sustainable demonstration program.

5. Copyrights and trademarks. Nothing in this section shall affect the rights of the eligible entity under the copyright or trademark laws of the United States. Nothing in this section shall require the disclosure of information to which Federal law relating to trade secrets (including section 552(b)(4) of title 5, United States Code) applies. In entering into a contract or cooperative agreement under this section, the director shall not establish any conditions that affect such rights or require such disclosure.

6. Within amounts appropriated, the director shall make grants available to qualified economically sustainable transportation providers of no less than fifty-five thousand dollars per grantee in the first year of the operation of the program. Such providers shall be eligible to receive funding under this section annually for up to five years. After such time, providers must be able to provide economically sustainable transportation services without receiving further public financial assistance for operating or capital expenses.

7. To be eligible to receive a grant under this section, an economically sustainable transportation provider shall commit to raising matching funds from non-state sources equal to fifty percent of the state grant. Up to ten percent of the provider match may be provided in-kind.

8. The office may use up to twelve percent of the total of any funding appropriated pursuant to this section for administration.

Article II. Programs for the Elderly

Title 3. Program for Elderly Pharmaceutical Insurance Coverage

§ 240. Short title

This title shall be known and may be cited as the "program for elderly pharmaceutical insurance coverage".

§ 241. Definitions

For purposes of this title, the terms:

For purposes of this title, the terms:

1. [Expires and is deemed repealed on and after June 15, 2012, pursuant to L.2005, c.58, pt. C, § 79. subd. 1. See, also, subd. 1 below.] "Covered drug" shall mean a drug dispensed subject to a legally authorized prescription pursuant to section sixty-eight hundred ten of the education law, and insulin, an insulin syringe, or an insulin needle. Such term shall not include: (a) any drug determined by the commissioner of the federal food and drug administration to be ineffective or unsafe; (b) any drug dispensed in a package, or form of dosage or administration, as to which the commissioner of health finally determines in accordance with the provisions of section two hundred fifty-two of this title that a less expensive package, or form of dosage or administration, is available that is pharmaceutically equivalent and equivalent in its therapeutic effect for the general health characteristics of the eligible program participant population; (c) any device for the aid or correction of vision; (d) any drug, including vitamins, which is generally available without a physician's prescription; and (e) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food and drug administration; and (f) a brand name drug for which a multi-source therapeutically and generically equivalent drug, as determined by the federal food and drug administration, is available, unless previously authorized by the elderly pharmaceutical insurance coverage program, provided, however, that the elderly pharmaceutical insurance coverage panel is authorized to exempt, for good cause shown, any brand name drug from such restriction, and provided further that such restriction shall not apply to any drug that is included on the preferred drug list under section two hundred seventy-two of the public health law or is in the clinical drug review program under section two hundred seventy-four of the public health law to the extent that the preferred drug program and the clinical drug review program are applied to the elderly pharmaceutical insurance coverage program pursuant to section two hundred seventy-five of the public health law, or to any drug covered under a program participant's Medicare part D or other primary insurance plan. Any of the drugs enumerated in the preceding sentence shall be considered a covered drug or a prescription drug for purposes of this article if it is added to the preferred drug list under article two-A of the public health law. For the purpose of this title, except as otherwise provided in this section, a covered drug shall be dispensed in quantities no greater than a thirty day supply or one hundred units, whichever is greater. In the case of a drug dispensed in a form of administration other than a tablet or capsule, the maximum allowed quantity shall be a thirty day supply; the panel is authorized to approve exceptions to these limits for specific products following consideration of recommendations from pharmaceutical or medical experts regarding commonly packaged quantities, unusual forms of administration, length of treatment or cost effectiveness. In the case of a drug prescribed pursuant to section thirty-three hundred thirty-two of the public health law to treat one of the conditions that have been enumerated by the commissioner of health pursuant to regulation as warranting the prescribing of greater than a thirty day supply, such drug shall be dispensed in quantities not to exceed a three month supply.

1. [Eff. June 15, 2012. See, also, subd. 1, above.] "Covered drug" shall mean a drug dispensed subject to a legally authorized prescription pursuant to section sixty-eight hundred ten of the education law, and insulin, an insulin syringe, or an insulin needle. Such term shall not include: (a) any drug determined by the commissioner of the federal food and drug administration to be ineffective or unsafe; (b) any drug dispensed in a package, or form of dosage or administration, as to which the commissioner of health finally determines in accordance with the provisions of section two hundred fifty-two of this title that a less expensive package, or form of dosage or administration, is available that is pharmaceutically equivalent and equivalent in its therapeutic effect for the general

health characteristics of the eligible program participant population; (c) any device for the aid or correction of vision, or any drug, including vitamins, which is generally available without a physician's prescription; and (d) drugs for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the federal food and drug administration. For the purpose of this title, except as otherwise provided in this section, a covered drug shall be dispensed in quantities no greater than a thirty day supply or one hundred units, whichever is greater. In the case of a drug dispensed in a form of administration other than a tablet or capsule, the maximum allowed quantity shall be a thirty day supply; the panel is authorized to approve exceptions to these limits for specific products following consideration of recommendations from pharmaceutical or medical experts regarding commonly packaged quantities, unusual forms of administration, length of treatment or cost effectiveness. In the case of a drug prescribed pursuant to section thirty-three hundred thirty-two of the public health law to treat one of the conditions that have been enumerated by the commissioner of health pursuant to regulation as warranting the prescribing of greater than a thirty day supply, such drug shall be dispensed in quantities not to exceed a three month supply.

2. "Provider pharmacy" shall mean a pharmacy registered in the state of New York pursuant to section sixty-eight hundred eight of the education law, a non-resident establishment registered pursuant to section sixty-eight hundred eight-b of the education law, or a pharmacy registered in a state bordering the state of New York when certified as necessary by the executive director pursuant to section two hundred fifty-three of this title, for which an agreement to provide pharmacy services for purposes of this program pursuant to section two hundred forty-nine of this title is in effect.

3. "Income" shall mean "household gross income" as defined in the real property tax circuit breaker credit program, pursuant to subparagraph (C) of paragraph one of subsection (e) of section six hundred six of the tax law, but only shall include the income of program applicants and spouses and shall exclude the income of other members of the household.

4. "Contractor" shall mean a private not-for-profit or proprietary corporation which has entered into a contractual arrangement with the state to carry out the provisions of section two hundred forty-three of this title.

5. "Resident" shall mean an individual legally domiciled within the state.

6. "Annual coverage period" shall mean the period of twelve consecutive calendar months for which an eligible program participant has met the application fee or deductible requirements, as the case may be, of sections two hundred forty-seven and two hundred forty-eight of this title.

7. "Program year" shall mean a year beginning on October first and ending the following September thirtieth.

§ 242. Program eligibility

1. Persons eligible for comprehensive coverage under section two hundred forty-seven of this title shall include:

(a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand five, is less than or equal to twenty thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

(b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person's spouse beginning on or after January first, two thousand one, is less than or equal to twenty-six thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

2. Persons eligible for catastrophic coverage under section two hundred forty-eight of this title shall include:

(a) any unmarried resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period beginning on or after January first, two thousand one, is more than twenty thousand and less than or equal to thirty-five thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months; and

(b) any married resident who is at least sixty-five years of age and whose income for the calendar year immediately preceding the effective date of the annual coverage period when combined with the income in the same calendar year of such married person's spouse beginning on or after January first, two thousand one, is more than twenty-six thousand dollars and less than or equal to fifty thousand dollars. After the initial determination of eligibility, each eligible individual must be redetermined eligible at least every twenty-four months.

3. (a) Eligibility for assistance under this title shall not be granted to any person who at the time an application is made is receiving medical assistance under section three hundred sixty-six of the social services law, or to any person receiving equivalent or better coverage from any other public or private third party payment source or insurance plan than those benefits provided for under this title.

(b) An individual who is determined eligible for assistance under this title whose prescription costs are covered in part by any public or private plan may receive reduced assistance under this title. In such cases, benefits provided through this title shall be considered payments of last resort.

(c) [Expires and is deemed repealed on and after October 1, 2010 pursuant to L. 2010 c. 109 §19, see also paragraph (c) below] The fact that some of an individual's prescription drug expenses are paid or reimbursable under the provisions of the medicare program shall not disqualify an individual, if he or she is otherwise eligible, from receiving assistance under this title. In such cases, the state shall pay the portion of the cost of those prescriptions for qualified drugs for which no payment or reimbursement is made by the medicare program or any federally funded prescription drug benefit, less the participant's co-payment required on the amount not paid by the medicare program. In addition, the participant registration fee charged to eligible program participants for comprehensive coverage pursuant to section two hundred forty-seven of this title shall be waived for the portion of the annual coverage period that the participant is also enrolled as a transitional assistance beneficiary in the medicare prescription drug discount card program, authorized pursuant to title XVIII of the federal social security act, provided that: (i) any sponsor of such drug discount card program has signed an agreement to complete coordination of benefit functions with EPIC, and has been endorsed by the EPIC panel; or (ii) any exclusive sponsor of such drug discount card program authorized pursuant to title XVIII of the federal social security act that limits the participants to the medicare prescription drug discount card program sponsored by such exclusive sponsor, shall coordinate benefits available under such discount card program with EPIC. The participant registration fee charged to eligible program participants for comprehensive coverage pursuant to section two hundred forty-seven of this title shall be waived for the portion of the annual coverage period that the participant is also enrolled as a full subsidy individual in a prescription drug or MA-PD plan under Part D of title XVIII of the federal social security act.

(c)(1) [Eff. October 1, 2010, see paragraph (c) above] The fact that some of an individual's prescription drug expenses are paid or reimbursable under the provisions of the medicare program shall not disqualify an individual, if he or she is otherwise eligible, from receiving assistance under this title. In such cases, the state shall pay the portion of the cost of those prescriptions for qualified drugs for which no payment or reimbursement is made by the medicare program or any federally funded prescription drug benefit, less the participant's copayment required on the amount not paid by the medicare program.

(2) Coverage under this paragraph shall be available only after the participant has first exhausted the first two levels of appeal available under Part D of title XVIII of the federal social security act and the appeal has been denied. During the coverage determination and appeal period, the elderly pharmaceutical insurance coverage program shall provide up to a ninety day supply of the prescribed medication, or such lesser supply as specified on the prescription, if: (i) the pharmacist notifies the prescriber that the participant's Medicare Part D plan and the elderly pharmaceutical insurance coverage program have denied payment for the prescribed medication and that if the prescriber does not choose to change the prescription to a drug that is covered by the participant's Medicare Part D plan, a Medicare Part D appeal must be pursued; and (ii) the prescriber notifies the elderly pharmaceutical insurance coverage program of the prescriber's intent to provide necessary information and cooperation in the pursuit of the

Medicare Part D appeal. In instances where the pharmacist is unable to immediately reach the prescriber, the elderly pharmaceutical insurance coverage program shall, upon the request of the pharmacist, authorize a three day emergency supply of the prescribed medication. The elderly pharmaceutical insurance coverage program shall authorize such additional ninety day supplies of the prescribed medication, or such lesser supply as specified on the prescription, and such additional three day emergency supplies as required to ensure coverage of the prescribed medication during the pendency of the Medicare Part D appeal.

(d) The elderly pharmaceutical insurance coverage program is authorized to apply for transitional assistance under the medicare prescription drug discount program with a specific drug discount card under title XVIII of the federal social security act on behalf of applicants and eligible program participants under this title. The elderly pharmaceutical insurance coverage program shall provide applicants and eligible program participants with prior written notice of, and the opportunity to decline, such automatic enrollment.

(e) As a condition of continued eligibility for benefits under this title, if a program participant's income indicates that the participant could be eligible for an income-related subsidy under section 1860D-14 of the federal social security act by either applying for such subsidy or by enrolling in a medicare savings program as a qualified medicare beneficiary (QMB), a specified low-income medicare beneficiary (SLMB), or a qualifying individual (QI), a program participant is required to provide, and to authorize the elderly pharmaceutical insurance coverage program to obtain, any information or documentation required to establish the participant's eligibility for such subsidy, and to authorize the elderly pharmaceutical insurance coverage program to apply on behalf of the participant for the subsidy or the medicare savings program. The elderly pharmaceutical insurance coverage program shall make a reasonable effort to notify the program participant of his or her need to provide any of the above required information. After a reasonable effort has been made to contact the participant, a participant shall be notified in writing that he or she has sixty days to provide such required information. If such information is not provided within the sixty day period, the participant's coverage may be terminated.

(f) As a condition of continued eligibility for benefits under this title, if a program participant is eligible for Medicare part D drug coverage under section 1860D of the federal social security act, the participant is required to enroll in Medicare part D at the first available enrollment period and to maintain such enrollment. This requirement shall be waived if such enrollment would result in significant additional financial liability by the participant, including, but not limited to, individuals in a Medicare advantage plan whose cost sharing would be increased, or if such enrollment would result in the loss of any health coverage through a union or employer plan for the participant, the participant's spouse or other dependent. The elderly pharmaceutical insurance coverage program shall provide premium assistance for all participants enrolled in Medicare part D as follows:

(i) for participants with comprehensive coverage under section two hundred forty-seven of this title, the elderly pharmaceutical insurance coverage program shall pay for the portion of the part D monthly premium that is the responsibility of the participant. Such payment shall be limited to the low-income benchmark premium amount established by the federal centers for Medicare and Medicaid services and any other amount which such agency establishes under its de minimus premium policy, except that such payments made on behalf of participants enrolled in a Medicare advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

(ii) for participants with catastrophic coverage under section two hundred forty-eight of this title, the elderly pharmaceutical insurance coverage program shall credit the participant's annual personal covered drug expenditure amount required under this title by an amount equal to the annual low-income benchmark premium amount established by the centers for Medicare and Medicaid services, prorated for the remaining portion of the participant's elderly pharmaceutical insurance coverage program coverage period. The elderly pharmaceutical insurance coverage program shall, at appropriate times, notify participants with catastrophic coverage under section two hundred forty-seven of this title of their right to coordinate the annual coverage period with that of Medicare part D, along with the possible advantages and disadvantages of doing so.

(g) The elderly pharmaceutical insurance coverage program is authorized and directed to conduct an enrollment program to facilitate, in as prompt and streamlined a fashion as possible, the enrollment into Medicare part D of program participants who are required by the provisions of this section to enroll in part D. Provided, however, that a

participant shall not be prevented from receiving his or her drugs immediately at the pharmacy under the elderly pharmaceutical insurance coverage program as a result of such participant's enrollment in Medicare part D.

(h) In order to maximize prescription drug coverage under Medicare part D, the elderly pharmaceutical insurance coverage program is authorized to represent program participants under this title in the pursuit of such coverage. Such representation shall not result in any additional financial liability on behalf of such program participants and shall include, but not be limited to, the following actions:

(i) application for the premium and cost-sharing subsidies on behalf of eligible program participants;

(ii) enrollment in a prescription drug plan or MA-PD plan; the elderly pharmaceutical insurance coverage program shall provide program participants with prior written notice of, and the opportunity to decline such facilitated enrollment subject, however, to the provisions of paragraph (f) of this subdivision;

(iii) pursuit of appeals, grievances, or coverage determinations.

§ 243. Pharmaceutical insurance contract

1. The elderly pharmaceutical insurance coverage panel, established pursuant to section two hundred forty-four of this title shall, subject to the approval of the director of the budget, enter into a contract with one or more contractors to assist in carrying out the provisions of this title. Such contractual arrangements shall be made subject to a competitive process pursuant to the state finance law and shall ensure that state payments for the contractor's necessary and legitimate expenses for the administration of this program are limited to the amount specified in advance, and that such payments shall not exceed the amount appropriated therefor in any fiscal year. The panel shall, at each of its regularly scheduled meetings, review the contract pricing provisions to assure that the level of contract payments are in the best interest of the state, giving consideration to the total level of participant enrollment achieved, the volume of claims processed, and such other factors as may be relevant in order to contain state expenditures. In the event that the panel determines that the contract payment provisions do not protect the interest of the state, the executive director shall initiate contract negotiations for the purpose of modifying contract payments and/or scope requirements.

2. The responsibilities of the contractor or contractors shall include, but need not be limited to:

(a) providing for a method of determining, on an annual basis and upon their application therefor, the eligibility of persons pursuant to section two hundred forty-two of this title within a reasonable period of time, including alternative methods for such determination of eligibility, such as through the mail or home visits, where reasonable and/or necessary, and for notifying applicants of such eligibility determinations;

(b) notifying each eligible program participant in writing upon the commencement of the annual coverage period of such participant's cost-sharing responsibilities pursuant to sections two hundred forty-seven and two hundred forty-eight of this title. The contractor shall also notify each eligible program participant of any adjustment of the co-payment schedule by mail no less than thirty days prior to the effective date of such adjustments and shall inform such eligible program participants of the date such adjustments shall take effect;

(c) issuing an identification card to each program participant who is eligible to purchase prescribed covered drugs for an amount specified pursuant to subdivision three of section two hundred forty-seven or subdivision three of section two hundred forty-eight of this title. The dates of the annual coverage period shall be imprinted on the card. When an eligible program participant meets the annual limits on point of sale co-payments set forth in subdivision four of section two hundred forty-seven or subdivision four of section two hundred forty-eight of this title, either new identification cards shall be issued to such participant indicating waiver of such co-payment requirements for the remainder of the annual coverage period or the contractor shall develop and implement an alternative method to permit the purchase of covered drugs without a co-payment requirement;

(d) developing and implementing the system for those individuals electing the deductible option to record their personal covered drug expenditures in accordance with subdivision three of section two hundred forty-eight of this

title. Such recordkeeping system shall be provided to each such participant at a nominal charge which shall be subject to the approval of the panel. The contractor shall also reimburse participants for personal covered drug expenditures made in excess of their deductible requirements, less the co-payments required by subdivision four of section two hundred forty-eight of this title, made prior to their receipt of an identification card issued in accordance with paragraph (c) of this subdivision;

(e) processing of claims for reimbursement to participating provider pharmacies pursuant to section two hundred fifty of this title;

(f) performing or causing to be performed utilization reviews for such purposes as may be required by the elderly pharmaceutical insurance coverage panel;

(g) conducting audits and surveys of participating provider pharmacies as specified pursuant to the terms and conditions of the contract; and

(h) coordinating coverage with insurance companies and other public and private organizations offering such coverage for those eligible program participants having partial coverage for covered drugs through third-party sources, and providing for recoupment of any duplicate reimbursement paid by the state on behalf of such eligible program participants.

3. The contractor or contractors shall be required to provide such reports as may be deemed necessary by the elderly pharmaceutical insurance coverage panel and shall maintain files in a manner and format approved by the executive director.

4. The contractor or contractors may contract with private not-for-profit or proprietary corporations, or with entities of local government within the state of New York, to perform such obligations of the contractor or contractors as the elderly pharmaceutical insurance coverage panel shall permit.

§ 244. Elderly pharmaceutical insurance coverage panel

1. There is hereby established within the executive department, a panel to be known as the elderly pharmaceutical insurance coverage panel hereinbefore or hereinafter referred to as the panel.

2. The panel shall consist of the commissioners of the departments of education and health, the superintendent of insurance, and the directors of the office for the aging and the division of the budget. Each panel member may designate an officer of his or her respective department, office, or division to represent and exercise all the powers of such panel member as the case may be at all meetings of the panel from which such panel member may be absent.

3. The director and the commissioner of health shall serve as co-chairs of the panel.

4. The panel shall meet at such times as may be requested by the co-chairs, provided that the panel shall meet at least four times a year.

5. The panel shall:

(a) subject to the approval of the director of the budget, promulgate program regulations pursuant to section two hundred forty-six of this title;

(b) determine the annual schedule of cost-sharing responsibilities of eligible program participants pursuant to sections two hundred forty-seven and two hundred forty-eight of this title;

(c) enter into contracts pursuant to section two hundred forty-three of this title;

(d) recommend and implement alternative program improvements for the efficient and effective operation of the program in accordance with the provisions of this title;

(e) establish or contract for a therapeutic drug monitoring program. Such program shall monitor therapeutic drug use of eligible program participants in an effort to prevent the incorrect or unnecessary consumption of such therapeutic drugs;

(f) develop and implement, in cooperation with area offices for the aging, an outreach program to inform the elderly of benefits they may be entitled to pursuant to this title, and to make available information concerning the program for elderly pharmaceutical insurance coverage and benefits to which they may be entitled through a prescription drug coverage program funded by the federal government;

(g) prepare an annual report and submit such report to the governor and the legislature no later than the first day of January of each year. The panel should include in the report a summary of the administrative cost containment initiatives completed during the year. Such report shall, at a minimum, contain annual statistical information regarding the number of persons enrolled in the program by marital status and income level, the total and per capita number of prescriptions filled and total state reimbursement and participant co-payment expenditures, by income levels, the total numbers of prescriptions filled with generic drugs, brand name drugs and sole source drugs, the authorization and substitution rate for the total numbers of prescriptions filled with generic, brand name and sole source drugs, the distribution of the top three hundred most commonly used drugs by volume and cost, a distribution of all prescriptions by volume and price, the annual percentage increase in the cost of these drugs, numbers of participating provider pharmacies, recipients and payments by county, the amount of cost recoveries for the period covered in the report, projections of program costs for the following two years, and an evaluation of the performance of the program contractor or contractors and of the cost effectiveness of all outreach efforts;

(h) prepare an evaluation report on the experience of the program for the governor and the legislature no later than November first, nineteen hundred ninety-five. Such report should include the recommendations of the panel concerning the continuation of the program beyond its expiration;

(i) establish policies and procedures to allow individuals who participate in the catastrophic deductible plan on December thirty-first, two thousand to continue to receive benefits under the provisions of section two-hundred forty-eight of this title in effect on December thirty-first, two thousand, if and for as long as the enrollee so chooses; and

(j) facilitate implementation of an expanded elderly pharmaceutical insurance coverage program on January first, two thousand one, by commencing no later than October first, two thousand, outreach activities, including but not limited to the dissemination of information to local governments and senior citizen provider advocacy groups regarding such expanded program. The panel shall make applications available for the expanded elderly pharmaceutical insurance coverage program on October first, two thousand.

(k) enter into an agreement with one or more sponsors of a drug discount card program or a prescription drug plan authorized under title XVIII of the federal social security act, to serve as an endorsed EPIC drug discount card program or prescription drug plan for the purposes of effective coordination of benefits.

(l) [Expires and is deemed repealed on and after June 15, 2012, pursuant to L.2005, c. 58, pt. C, § 79, subd. 1.] implement a preferred drug program and clinical drug review program in accordance with the provisions of article two-A of the public health law, including taking necessary actions consistent with this article to apply prior authorization under article two-A of the public health law to EPIC.

6. The panel members shall receive no compensation for their services as panel members.

7. There shall be an advisory committee to the panel comprised of twelve persons. Four members shall be appointed by the governor, three members shall be appointed by the temporary president of the senate, one member shall be appointed by the minority leader of the senate, three members shall be appointed by the speaker of the assembly and one member shall be appointed by the minority leader of the assembly. The committee members shall be representatives of consumers, pharmacists, pharmaceutical drug manufacturers and pharmaceutical wholesalers. No less than fifty percent of the committee membership shall represent the consumers. The executive director shall consult the advisory committee and consider its recommendations concerning the implementation of this program

and the policies governing the continued operation of this program. Committee members shall receive no compensation for their services but shall be allowed their actual and necessary expenses incurred in the performance of their duties.

§ 245. Executive director

Upon the recommendation of the co-chairs, the governor shall appoint an executive director of the elderly pharmaceutical insurance coverage panel hereinafter referred to as the executive director. The executive director shall receive an annual salary fixed by the governor within the amount available therefor by appropriation and shall be entitled to reimbursement for reasonable expenses incurred in connection with the performance of his or her duties. The executive director shall:

1. Monitor the provision of services pursuant to contractual arrangements entered into pursuant to section two hundred forty-three of this title and examine and review all documents and other information to assure compliance with all provisions of this article whether such documents or other information are under the control of a contractor or a participating provider pharmacy;
2. Appoint staff and request the assistance of any department or other agency of the state in performing such functions as may be necessary to carry out the provisions of this title;
3. Perform such other functions as may be specifically required by this title, as assigned by the panel, or necessary to ensure the efficient operation of the program; and
4. Establish procedures to prorate registration fees for any participant's annual coverage period which began after January first, two thousand and before January first, two thousand one. Such proration shall be calculated on a daily basis and ensure that program participants are afforded an equitable transition from the program established pursuant to this title to the revised program to go into effect on January first, two thousand one.

§ 246. Regulations

Program regulations shall:

1. Provide for a process of determining and redetermining eligibility for participation in this program including provisions for submission of proof of income, age, and residency and information on existing complete or partial coverage of prescription drug expenses under a third party assistance or insurance plan;
2. Provide for a fair hearing process pursuant to an agreement with the department of health for individuals and participating provider pharmacies to appeal determinations or actions of the contractors;
3. Establish procedures for the state to recover the value of benefits or payments made under this title, if any, that were based on applications or claims submitted in violation of any provision of this title; and
4. Establish procedures to ensure that all information obtained on persons pursuant to paragraph (a) of subdivision two of section two hundred forty-three of this title shall remain confidential and shall not be disclosed to persons or agencies other than those entitled to such information because such disclosure is necessary for the proper administration of the program established pursuant to this title.

§ 247. Cost-sharing responsibilities of eligible program participants for comprehensive coverage

1. Registration fee. Eligible individuals meeting the registration fee requirements of this section may purchase prescribed covered drugs for an amount specified by subdivision three of this section, subject to the limits on point of sale co-payments specified by subdivision four of this section.

2. Registration fee schedule. Eligible individuals electing to meet the requirements of this subdivision shall pay a quarterly registration fee in a manner and form determined by the executive director; at the option of the participant, the registration fee may be paid annually in a lump sum upon the beginning of the annual coverage period. No eligible individual electing to meet the requirements of this subdivision shall have his participation in the program lapse by virtue of non-payment of the applicable registration fee unless the contractor has provided notification of the amount and due date thereof, and more than thirty days have elapsed since the due date of the individual's registration fee. The registration fee to be charged to eligible program participants for comprehensive coverage under this option shall be in accordance with the following schedule:

(a) Quarterly registration fees for unmarried individual program participants:

individual income of \$5,000 or less	\$2.00
individual income of \$5,001 to \$6,000	\$2.00
individual income of \$6,001 to \$7,000	\$4.00
individual income of \$7,001 to \$8,000	\$5.50
individual income of \$8,001 to \$9,000	\$7.00
individual income of \$9,001 to \$10,000	\$9.00
individual income of \$10,001 to \$11,000	\$10.00
individual income of \$11,001 to \$12,000	\$11.50
individual income of \$12,001 to \$13,000	\$13.50
individual income of \$13,001 to \$14,000	\$15.00
individual income of \$14,001 to \$15,000	\$20.00
individual income of \$15,001 to \$16,000	\$27.50
individual income of \$16,001 to \$17,000	\$35.00
individual income of \$17,001 to \$18,000	\$42.50
individual income of \$18,001 to \$19,000	\$50.00
individual income of \$19,001 to \$20,000	\$57.50

(b) Quarterly registration fees for each married individual program participant:

joint income of \$5,000 or less	\$2.00
joint income of \$5,001 to \$6,000	\$2.00
joint income of \$6,001 to \$7,000	\$3.00
joint income of \$7,001 to \$8,000	\$4.00
joint income of \$8,001 to \$9,000	\$5.00
joint income of \$9,001 to \$10,000	\$6.00
joint income of \$10,001 to \$11,000	\$7.00
joint income of \$11,001 to \$12,000	\$8.00
joint income of \$12,001 to \$13,000	\$9.00
joint income of \$13,001 to \$14,000	\$10.00
joint income of \$14,001 to \$15,000	\$10.00
joint income of \$15,001 to \$16,000	\$21.00
joint income of \$16,001 to \$17,000	\$26.50
joint income of \$17,001 to \$18,000	\$31.50
joint income of \$18,001 to \$19,000	\$37.50
joint income of \$19,001 to \$20,000	\$43.00
joint income of \$20,001 to \$21,000	\$48.50
joint income of \$21,001 to \$22,000	\$54.00
joint income of \$22,001 to \$23,000	\$59.50
joint income of \$23,001 to \$24,000	\$65.00
joint income of \$24,001 to \$25,000	\$68.75
joint income of \$25,001 to \$26,000	\$75.00

(c) In the event that the state expenditures per participant meeting the registration fee requirements of this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, exceed such expenditures in the previous program year by a minimum of ten percent, the annual registration fees set forth in this subdivision may, unless otherwise provided by law, be increased, pro-rata, for the subsequent program year, provided that such increase shall not exceed 7.5 percent of the prior year registration fees as may have been adjusted in accordance with this paragraph.

(d) In the event that the state expenditures per such participant, incurred pursuant to this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, are less than such expenditures in the previous program year by a minimum of ten percent, the annual registration fees set forth in this subdivision may, unless otherwise provided by law, be decreased, pro-rata, for the subsequent program year, provided that such decrease shall not exceed 7.5 percent of the prior year registration fees as may have been adjusted in accordance with this paragraph.

(e) The determination to adjust annual registration fees set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments and changes in the consumer price index. The frequency of such adjustments shall not exceed once in any program year and such adjustments shall not become effective for individual program participants prior to the first day of the next annual coverage period for each participant.

3. Point of sale co-payment. (a) Upon satisfaction of the registration fee pursuant to this section an eligible program participant must pay a point of sale co-payment as set forth in paragraph (b) of this subdivision at the time of each purchase of a covered drug prescribed for such individual. Such co-payment shall not be waived or reduced in whole or in part, subject to the limits provided by subdivision four of this section.

(b) The point of sale co-payment amounts which are to be charged eligible program participants shall be in accordance with the following schedule:

For each prescription of covered drugs costing \$15.00 or less -	\$3.00
For each prescription of covered drugs costing \$15.01 to \$35.00 -	\$ 7.00
For each prescription of covered drugs costing \$35.01 to \$55.00 -	\$ 15.00
For each prescription of covered drugs costing \$55.01 or more -	\$ 20.00

(c) For the purposes of the foregoing schedule of point of sale co-payments, "costing" shall mean the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with section two hundred fifty of this title plus the point of sale copayment, calculated as of the date of sale.

4. Limits on point of sale co-payments. During each annual coverage period no point of sale co-payment as set forth in subdivision three of this section shall be required to be made for the remainder of such period by any eligible program participant who has already incurred co-payments in excess of the limits set forth in the following schedule:

(a) Limits on co-payments by unmarried individual eligible program participants:

individual income of \$5,000 or less	no more than \$340
individual income of \$5,001 to \$6,000	no more than \$408
individual income of \$6,001 to \$7,000	no more than \$476
individual income of \$7,001 to \$8,000	no more than \$544
individual income of \$8,001 to \$9,000	no more than \$612
individual income of \$9,001 to \$10,000	no more than \$700
individual income of \$10,001 to \$11,000	no more than \$720
individual income of \$11,001 to \$12,000	no more than \$827
individual income of \$12,001 to \$13,000	no more than \$896

individual income of \$13,001 to \$14,000	no more than \$964
individual income of \$14,001 to \$15,000	no more than \$1,016
individual income of \$15,001 to \$16,000	no more than \$1,034
individual income of \$16,001 to \$17,000	no more than \$1,052
individual income of \$17,001 to \$18,000	no more than \$1,070
individual income of \$18,001 to \$19,000	no more than \$1,088
individual income of \$19,001 to \$20,000	no more than \$1,160

(b) Limits on co-payments by each married individual eligible program participant:

joint income of \$5,000 or less	no more than \$291
joint income of \$5,001 to \$6,000	no more than \$342
joint income of \$6,001 to \$7,000	no more than \$399
joint income of \$7,001 to \$8,000	no more than \$456
joint income of \$8,001 to \$9,000	no more than \$513
joint income of \$9,001 to \$10,000	no more than \$570
joint income of \$10,001 to \$11,000	no more than \$622
joint income of \$11,001 to \$12,000	no more than \$641
joint income of \$12,001 to \$13,000	no more than \$660
joint income of \$13,001 to \$14,000	no more than \$684
joint income of \$14,001 to \$15,000	no more than \$710
joint income of \$15,001 to \$16,000	no more than \$826
joint income of \$16,001 to \$17,000	no more than \$877
joint income of \$17,001 to \$18,000	no more than \$928
joint income of \$18,001 to \$19,000	no more than \$980
joint income of \$19,001 to \$20,000	no more than \$990
joint income of \$20,001 to \$21,000	no more than \$1,008
joint income of \$21,001 to \$22,000	no more than \$1,026
joint income of \$22,001 to \$23,000	no more than \$1,044
joint income of \$23,001 to \$24,000	no more than \$1,062
joint income of \$24,001 to \$25,000	no more than \$1,080
joint income of \$25,001 to \$26,000	no more than \$1,150

(c) Effective October first, nineteen hundred eighty-eight, the limits on point of sale co-payments as set forth in this subdivision may be adjusted by the panel on the anniversary date of each program participant's annual coverage period, and such adjustment shall be in effect for the duration of that annual coverage period. Any such annual adjustment shall be made using a percentage adjustment factor which shall not exceed one-half of the difference between the year-to-year percentage increase in the consumer price index for all urban consumers, as published by the United States Department of Labor, and, if larger, the year-to-year percentage increase in the aggregate average cost of covered drugs purchased under this title, which year-to-year percentage increase in such cost shall be determined by comparison of such cost in the same month of each of the appropriate successive years; provided, however, that for any such adjustment based wholly on experience in the program year commencing October first, nineteen hundred eighty-seven, the year-to-year percentage increase in such cost shall be determined by comparison of such cost in each of two months no less than five months apart and within such program year, which comparison shall be annualized. Such percentage adjustment factor shall be the same as that used to determine any similar annual adjustment for the same annual coverage periods pursuant to the provisions of subdivision four of section two hundred forty-eight of this title.

(d) Such annual adjustments shall be calculated by multiplying the percentage adjustment factor by (1) ten percent and applying the resulting percentage to the upper income limitation of each income level for unmarried individuals contained in this subdivision, and by (2) seven and one-half percent and applying the resulting percentage to the upper income limitation of each income level for married individuals contained in this subdivision; each result of such calculations, minus any applicable registration fee increases made pursuant to subdivision two of this section

and plus the result of applying the percentage adjustment factor to the sum of any such annual adjustments applicable thereto for any prior annual coverage period, shall be the amount by which the limit on co-payments for each such income level may be adjusted, and such amount shall be in addition to any such amount or amounts applicable to prior annual coverage periods.

(e) The determination to adjust the limits on point of sale co-payments set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments.

§ 248. Cost-sharing responsibilities of eligible program participants for catastrophic coverage

1. Deductible. Eligible individuals meeting the deductible requirements of this section may purchase prescribed covered drugs for an amount specified by subdivision three of this section, subject to the limits on point of sale co-payments specified by subdivision four of this section.

2. Deductible schedule. Eligible individuals electing to meet the requirements of this subdivision shall incur an amount of personal covered drug expenditures during any annual coverage period which are not reimbursed by any other public or private third party payment source or insurance plan, and shall be deemed to have met their deductible requirements for the remainder of such annual coverage period. The amount of personal covered drug expenditures to be incurred by eligible program participants for catastrophic coverage under this option shall be in accordance with the following schedule:

(a) Annual personal covered drug expenditures for unmarried individual eligible program participants:

individual income of \$20,001 to \$21,000	.....	\$530
individual income of \$21,001 to \$22,000	.....	\$550
individual income of \$22,001 to \$23,000	.....	\$580
individual income of \$23,001 to \$24,000	.....	\$720
individual income of \$24,001 to \$25,000	.....	\$750
individual income of \$25,001 to \$26,000	.....	\$780
individual income of \$26,001 to \$27,000	.....	\$810
individual income of \$27,001 to \$28,000	.....	\$840
individual income of \$28,001 to \$29,000	.....	\$870
individual income of \$29,001 to \$30,000	.....	\$900
individual income of \$30,001 to \$31,000	.....	\$930
individual income of \$31,001 to \$32,000	.....	\$960
individual income of \$32,001 to \$33,000	.....	\$1,160
individual income of \$33,001 to \$34,000	.....	\$1,190
individual income of \$34,001 to \$35,000	.....	\$1,230

(b) Annual personal covered drug expenditures for each married individual eligible program participant:

joint income of \$26,001 to \$27,000	.....	\$650
joint income of \$27,001 to \$28,000	.....	\$675
joint income of \$28,001 to \$29,000	.....	\$700
joint income of \$29,001 to \$30,000	.....	\$725
joint income of \$30,001 to \$31,000	.....	\$900
joint income of \$31,001 to \$32,000	.....	\$930
joint income of \$32,001 to \$33,000	.....	\$960
joint income of \$33,001 to \$34,000	.....	\$990
joint income of \$34,001 to \$35,000	.....	\$1,020
joint income of \$35,001 to \$36,000	.....	\$1,050
joint income of \$36,001 to \$37,000	.....	\$1,080
joint income of \$37,001 to \$38,000	.....	\$1,110
joint income of \$38,001 to \$39,000	.....	\$1,140

joint income of \$39,001 to \$40,000	\$1,170
joint income of \$40,001 to \$41,000	\$1,200
joint income of \$41,001 to \$42,000	\$1,230
joint income of \$42,001 to \$43,000	\$1,260
joint income of \$43,001 to \$44,000	\$1,290
joint income of \$44,001 to \$45,000	\$1,320
joint income of \$45,001 to \$46,000	\$1,575
joint income of \$46,001 to \$47,000	\$1,610
joint income of \$47,001 to \$48,000	\$1,645
joint income of \$48,001 to \$49,000	\$1,680
joint income of \$49,001 to \$50,000	\$1,715

(c) In the event that the state expenditures per participant electing to meet the deductible requirements of this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, exceed such expenditures in the previous program year by a minimum of ten percent, the annual personal covered drug expenditures set forth in this subdivision may, unless otherwise provided by law, be increased, pro-rata, for the subsequent program year, provided that such increase shall not exceed eight percent of the prior year personal covered drug expenditures as may have been adjusted in accordance with this paragraph.

(d) In the event that the state expenditures per such participant, incurred pursuant to this subdivision, exclusive of expenditures for program administration, in the program year commencing October first, nineteen hundred eighty-eight, and in each program year thereafter, are less than such expenditures in the previous program year by a minimum of ten percent, the annual personal covered drug expenditures set forth in this subdivision may, unless otherwise provided by law, be decreased, pro-rata, for the subsequent program year, provided that such decrease shall not exceed eight percent of the prior year personal covered drug expenditures as may have been adjusted in accordance with this paragraph.

(e) The determination to adjust annual personal covered drug expenditures set forth in this subdivision, shall follow a review of such factors as the relative financial capacity of the state and such eligible program participants to support such adjustments and changes in the consumer price index. The frequency of such adjustments shall not exceed once in any twelve month period and such adjustments shall not become effective for individual program participants prior to the first day of the next annual coverage period for each participant.

3. Point of sale co-payment. (a) Upon satisfaction of the deductible requirements pursuant to subdivision two of this section, an eligible program participant shall pay a point of sale co-payment as set forth in paragraph (b) of this subdivision at the time of each purchase of a covered drug prescribed for such individual. Such co-payment shall not be waived or reduced in whole or in part, subject to the limits provided by subdivision four of this section.

(b) The point of sale co-payment amounts which are to be charged eligible program participants shall be in accordance with the following schedule:

For each prescription of covered drugs costing \$15.00 or less -	\$3.00
For each prescription of covered drugs costing \$15.01 to \$35.00 -	\$7.00
For each prescription of covered drugs costing \$35.01 to \$55.00 -	\$ 15.00
For each prescription of covered drugs costing \$55.01 or more -	\$ 20.00

(c) For the purposes of the foregoing schedule of point of sale co-payments, "costing" shall mean the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with section two hundred fifty of this title plus the point of sale co-payment, calculated as of the date of sale.

4. Annual limits on point of sale co-payments. During each annual coverage period, no point of sale co-payments as set forth in subdivision three of this section shall be required to be made for the remainder of such period by any eligible program participant meeting the personal covered drug expenditure requirements of subdivision two of this

section in excess of the limits set forth in the following schedule:

(a) Limits on co-payments by unmarried individual eligible program participants:

individual income of \$20,001 to \$21,000	no more than \$1,050
individual income of \$21,001 to \$22,000	no more than \$1,100
individual income of \$22,001 to \$23,000	no more than \$1,150
individual income of \$23,001 to \$24,000	no more than \$1,200
individual income of \$24,001 to \$25,000	no more than \$1,250
individual income of \$25,001 to \$26,000	no more than \$1,300
individual income of \$26,001 to \$27,000	no more than \$1,350
individual income of \$27,001 to \$28,000	no more than \$1,400
individual income of \$28,001 to \$29,000	no more than \$1,450
individual income of \$29,001 to \$30,000	no more than \$1,500
individual income of \$30,001 to \$31,000	no more than \$1,550
individual income of \$31,001 to \$32,000	no more than \$1,600
individual income of \$32,001 to \$33,000	no more than \$1,650
individual income of \$33,001 to \$34,000	no more than \$1,700
individual income of \$34,001 to \$35,000	no more than \$1,750

(b) Limits on co-payments by each married individual eligible program participant:

joint income of \$26,001 to \$27,000	no more than \$1,080
joint income of \$27,001 to \$28,000	no more than \$1,120
joint income of \$28,001 to \$29,000	no more than \$1,160
joint income of \$29,001 to \$30,000	no more than \$1,200
joint income of \$30,001 to \$31,000	no more than \$1,240
joint income of \$31,001 to \$32,000	no more than \$1,280
joint income of \$32,001 to \$33,000	no more than \$1,320
joint income of \$33,001 to \$34,000	no more than \$1,360
joint income of \$34,001 to \$35,000	no more than \$1,400
joint income of \$35,001 to \$36,000	no more than \$1,440
joint income of \$36,001 to \$37,000	no more than \$1,480
joint income of \$37,001 to \$38,000	no more than \$1,520
joint income of \$38,001 to \$39,000	no more than \$1,560
joint income of \$39,001 to \$40,000	no more than \$1,600
joint income of \$40,001 to \$41,000	no more than \$1,640
joint income of \$41,001 to \$42,000	no more than \$1,680
joint income of \$42,001 to \$43,000	no more than \$1,720
joint income of \$43,001 to \$44,000	no more than \$1,760
joint income of \$44,001 to \$45,000	no more than \$1,800
joint income of \$45,001 to \$46,000	no more than \$1,840
joint income of \$46,001 to \$47,000	no more than \$1,880
joint income of \$47,001 to \$48,000	no more than \$1,920
joint income of \$48,001 to \$49,000	no more than \$1,960
joint income of \$49,001 to \$50,000	no more than \$2,000

(c) Effective October first, nineteen hundred eighty-eight, the limits on point of sale co-payments as set forth in this subdivision may be adjusted by the panel on the anniversary date of each program participant's annual coverage period, and such adjustment shall be in effect for the duration of that annual coverage period. Any such annual adjustment shall be made using a percentage adjustment factor which shall not exceed one-half of the difference between the year-to-year percentage increase in the consumer price index for all urban consumers, as published by the United States Department of Labor, and, if larger, the year-to-year percentage increase in the aggregate average cost of covered drugs purchased under this title, which year-to-year percentage increase in such cost shall be determined by comparison of such cost in the same month of each of the appropriate successive years; provided,

however, that for any such adjustment based wholly on experience in the program year commencing October first, nineteen hundred eighty-seven, the year-to-year percentage increase in such cost shall be determined by comparison of such cost in each of two months no less than five months apart and within such program year, which comparison shall be annualized. Such percentage adjustment factor shall be the same as that used to determine any similar annual adjustment for the same annual coverage periods pursuant to the provisions of subdivision four of section two hundred forty-seven of this title. Such annual adjustments shall be calculated by multiplying the percentage adjustment factor by (1) ten percent and applying the resulting percentage to the upper income limitation of each income level for unmarried individuals contained in this subdivision, and by (2) seven and one-half percent and applying the resulting percentage to the upper income limitation of each income level for married individuals contained in this subdivision; each result of such calculations, minus any applicable deductible increases made pursuant to subdivision two of this section and plus the result of applying the percentage adjustment factor to the sum of any such annual adjustments applicable thereto for any prior annual coverage period, shall be the amount by which the limit on co-payments for each such income level may be adjusted, and such amount shall be in addition to any such amount or amounts applicable to prior annual coverage periods.

(d) The determination to adjust the limits on point of sale co-payments set forth in this subdivision shall follow a review of such factors as the relative financial capacity of the state and such eligible program participant to support such adjustments.

§ 249. Participating provider pharmacies

1. The state shall offer an opportunity to participate in this program to all provider pharmacies as defined in section two hundred forty-one of this title, provided, however, that the participation of pharmacies registered in the state pursuant to section sixty-eight hundred eight-b of the education law shall be limited to state assistance provided under this title for prescription drugs covered by a program participant's medicare or other drug plan.

2. To participate in this program, a pharmacy shall be required to enter into a provider agreement and shall abide by such terms and conditions as shall be prescribed in the agreement, including the release of financial information for the purpose of program audits and surveys.

§ 250. Reimbursement to participating provider pharmacies

1. The amount of reimbursement which shall be paid by the state to a participating provider pharmacy for any covered drug filled or refilled for any eligible program participant shall be equal to the allowed amount defined as follows, minus the point of sale co-payment as required by sections two hundred forty-seven and two hundred forty-eight of this title:

(a) Multiple source covered drugs. Except for brand name drugs that are required by the prescriber to be dispensed as written, the allowed amount for a multiple source covered drug shall equal the lower of:

(1) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase, or

(2) The upper limit, if any, set by the centers for medicare and medicaid services for such multiple source drug, or

(3) Average wholesale price discounted by twenty-five percent, or

(4) The maximum allowable cost, if any, established by the commissioner of health pursuant to paragraph (e) of subdivision nine of section three hundred sixty-seven-a of the social services law.

Plus a dispensing fee for drugs reimbursed pursuant to subparagraphs two, three, and four of this paragraph, as defined in paragraph (c) of this subdivision.

(b) Other covered drugs. The allowed amount for brand name drugs required by the prescriber to be dispensed as written and for covered drugs other than multiple source drugs shall be determined by applying the lower of:

(1) Average wholesale price discounted by sixteen and twenty-five one hundredths percent, plus a dispensing fee as defined in paragraph (c) of this subdivision, or

(2) The pharmacy's usual and customary charge to the general public, taking into consideration any quantity and promotional discounts to the general public at the time of purchase.

(c) As required by paragraphs (a) and (b) of this subdivision, a dispensing fee of four dollars fifty cents will apply to generic drugs and a dispensing fee of three dollars fifty cents will apply to brand name drugs.

2. For purposes of determining the amount of reimbursement which shall be paid to a participating provider pharmacy, the panel shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug that participating provider pharmacies buy most frequently. Using the result of this survey, the contractor shall update every thirty days the list of average wholesale prices upon which such reimbursement is determined using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is dispensed.

3. (a) Notwithstanding any inconsistent provision of law, the program for elderly pharmaceutical insurance coverage shall reimburse for covered drugs which are dispensed under the program by a provider pharmacy only pursuant to the terms of a rebate agreement between the program and the manufacturer (as defined under section 1927 of the federal social security act of such covered drugs; provided, however, that:

(1) any agreement between the program and a manufacturer entered into before August first, nineteen hundred ninety-one, shall be deemed to have been entered into on April first, nineteen hundred ninety-one; and provided further, that if a manufacturer has not entered into an agreement with the department before August first, nineteen hundred ninety-one, such agreement shall not be effective until April first, nineteen hundred ninety-two, unless such agreement provides that rebates will be retroactively calculated as if the agreement had been in effect on April first, nineteen hundred ninety-one; and

(2) the program may reimburse for any covered drugs pursuant to subdivisions one and two of this section, for which a rebate agreement does not exist and which are determined by the elderly pharmaceutical insurance coverage panel to be essential to the health of persons participating in the program; and likely to provide effective therapy or diagnosis for a disease not adequately treated or diagnosed by any other covered drug; and which are recommended for reimbursement by the panel and approved by the commissioner of health.

(b) The rebate agreement between such manufacturer and the program for elderly pharmaceutical insurance coverage shall utilize for covered drugs the identical formula used to determine the rebate for federal financial participation for drugs, pursuant to section 1927(c) of the federal social security act, to determine the amount of the rebate pursuant to this subdivision.

(c) The amount of rebate pursuant to paragraph (b) of this subdivision shall be calculated by multiplying the required rebate formulas by the total number of units of each dosage form and strength dispensed. The rebate agreement shall also provide for periodic payment of the rebate, provision of information to the program, audits, verification of data, damages to the program for any delay or non-production of necessary data by the manufacturer and for the confidentiality of information.

(d) The program in providing utilization data to a manufacturer (as provided for under section 1927 (b) of the federal social security act shall provide such data by zip code, if requested, for the top three hundred most commonly used drugs by volume covered under a rebate agreement.

(e) Any funds collected pursuant to any rebate agreements entered into with a manufacturer pursuant to this subdivision, shall be deposited into the elderly pharmaceutical insurance coverage program premium account.

4. Notwithstanding any other provision of law, entities which offer insurance coverage for provision of and/or reimbursement for pharmaceutical expenses, including but not limited to, entities licensed/certified pursuant to article thirty-two, forty-two, forty-three or forty-four of the insurance law (employees welfare funds) or article forty-four of the public health law, shall participate in a benefit recovery program with the elderly pharmaceutical insurance coverage (EPIC) program which includes, but is not limited to, a semi-annual match of EPIC's file of enrollees against the entity's file of insured to identify individuals enrolled in both plans with claims paid within the twenty-four months preceding the date the entity receives the match request information from EPIC. Such entity shall indicate if pharmaceutical coverage is available from the entity for the insured persons, list the copayment or other payment obligations of the insured persons applicable to the pharmaceutical coverage, and (after receiving necessary claim information from EPIC) list the amounts which the entity would have paid for the pharmaceutical claims for those identified individuals and the entity shall reimburse EPIC for pharmaceutical expenses paid by EPIC that are covered under the contract between the entity and its insured in only those instances where the entity has not already made payment of the claim. Reimbursement of the net amount payable (after rebates and discounts) that would have been paid under the coverage issued by the entity will be made by the entity to EPIC within sixty days of receipt from EPIC of the standard data in electronic format necessary for the entity to adjudicate the claim and if the standard data is provided to the entity by EPIC in paper format payment by the entity shall be made within one hundred eighty days. After completing at least one match process with EPIC in electronic format, an entity shall be entitled to elect a monthly or bi-monthly match process rather than a semi-annual match process.

5. Notwithstanding any other provision of law, the panel shall maximize the coordination of benefits for persons enrolled under Title XVIII of the federal social security act (medicare) and enrolled under this title in order to facilitate medicare payment of claims. The panel may select an independent contractor, through a request-for-proposal process, to implement a centralized coordination of benefits system under this subdivision for individuals qualified in both the elderly pharmaceutical insurance coverage (EPIC) program and medicare programs who receive medications or other covered products from a pharmacy provider currently enrolled in the elderly pharmaceutical insurance coverage (EPIC) program.

6. [Expires and is deemed repeal on and after October 1, 2010 pursuant to L.2010 c. 109 § 19-a(a); see subdivision 6 below]The EPIC program shall be the payor of last resort for individuals qualified in both the EPIC program and title XVIII of the federal social security act (Medicare). For such individuals, no reimbursement shall be available under EPIC for covered drug expenses except:

(i) where a prescription drug plan authorized by Part D of the federal social security act (referred to in this subdivision as a Medicare Part D plan) has approved coverage and EPIC has an obligation under this title to pay a portion of the participant's cost-sharing responsibility under Medicare Part D; or

(ii) where the provider pharmacy has certified that: (1) a Medicare Part D plan has denied coverage, and (2) either, after consultation with the prescriber, the prescriber has declined to revise the prescription to a drug that would be covered by the Medicare Part D plan, or the provider pharmacy has been unable to contact the prescriber.

(b) If the provider pharmacy certifies as set forth in subparagraph (ii) of paragraph (a) of this subdivision, the EPIC program shall pay for the drug as the primary payor. If determined by the EPIC program to be practical and cost-effective, the program, or its contractor, shall attempt to obtain Medicare Part D coverage of the drug by initiating a Medicare Part D appeal. If the initial appeal is denied by the Medicare Part D plan, the EPIC program shall pursue additional levels of Medicare Part D appeals when practical and cost-effective.

6. [Eff. October 1, 2010; see subdivision 6 above](a) The EPIC program shall be the payor of last resort for individuals qualified in both the EPIC program and title XVIII of the federal social security act (Medicare). For such individuals, no reimbursement shall be available under EPIC for covered drug expenses except:

(i) where a prescription drug plan authorized by Part D of the federal social security act (referred to in this subdivision as a Medicare Part D plan) has approved coverage and EPIC has an obligation under this title to pay a portion of the participant's cost-sharing responsibility under Medicare Part D; or

(ii) where the provider pharmacy has certified that a Medicare Part D plan has denied coverage

(b) If the provider pharmacy certifies as set forth in subparagraph (ii) of paragraph (a) of this subdivision, the EPIC program shall pay for the drug as the primary payor upon a showing of compliance with the notification and appeal provisions of subparagraph two of paragraph (c) of subdivision three of section two hundred forty-two of this title.

§ 251. Penalties for fraud and abuse

1. Any person who knowingly makes a false statement or representation, or who by deliberate concealment of any material fact, or by impersonation or other fraudulent device, obtains or attempts to obtain or aids or abets any person to obtain any benefit under this title to which he or she is not entitled, shall be guilty of a class A misdemeanor.
2. Any person who, having made application to receive any benefit under this title for the use and benefit of another and having received it, knowingly and willfully converts such benefit or any part thereof to a use other than for the use and benefit of such other person, shall be guilty of a class A misdemeanor.
3. Any person who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under this title, shall be guilty of a class A misdemeanor.

§ 252. Procedures for determinations relating to package, or form of dosage or administration, of certain drugs

1. If the department of health makes an initial determination that a particular package, or form of dosage or administration, of a drug shall be excluded in accordance with the provisions of paragraph (b) of subdivision one of section two hundred forty-one of this title, the executive department shall notify the manufacturer of such drug product that the executive department intends to seek the exclusion of such package, or form of dosage or administration, from the program and shall provide such manufacturer with the reasons therefor together with the facts which the department relies upon to support its initial determination. The manufacturer shall have fifteen days after receiving such exclusion notice to notify the executive department of an intent to appeal the decision. If the manufacturer fails to notify the executive department of an intent to appeal within the time specified in this section, the commissioner of health shall forthwith determine whether the package, or form of dosage or administration, shall be excluded from the program. If the manufacturer notifies the executive department of an intent to appeal, the manufacturer shall submit to the executive department within forty-five days of receiving such exclusion notice, the basis of the manufacturer's appeal. Within fifteen days of receiving such submission from the manufacturer, the executive department shall provide to the manufacturer any additional facts concerning the drug product that the department relies upon to support its initial determination. Within ten days of receiving such facts, the manufacturer may submit additional facts concerning the drug package, or form of dosage or administration. Based on the facts submitted pursuant to this section, the commissioner of health shall make a final determination, in accordance with the standard set forth in paragraph (b) of subdivision one of section two hundred forty-one of this title, as to whether the package, or form of dosage or administration, of the drug product shall constitute a covered drug for the purposes of this article. A determination to exclude the drug package, or form of dosage or administration, shall be subject to judicial review pursuant to article seventy-eight of the civil practice law and rules.
2. The commissioner of health shall establish by regulation an appropriate process allowing drug packages, or forms of dosage or administration, finally determined under this section not to be covered drugs for the purposes of this title to be dispensed to program participants for whom such drug packages, or forms of dosage or administration, are medically indicated as certified to by a physician treating such participant. Any such drug package, or form of dosage or administration, so certified as medically indicated for a specific participant in accordance with such regulations shall be a covered drug for the purpose of this title.

§ 253. Utilization of out-of-state provider pharmacies; necessity and convenience

1. In counties having a population of seventy-five thousand or less that are in proximity to the state boundary and

which are determined by the executive director to be not adequately served by provider pharmacies registered in New York, and in Fishers Island in the town of Southold, Suffolk county, the executive director may approve as provider pharmacies, pharmacies located in New Jersey, Connecticut, Vermont, Pennsylvania or Massachusetts. Such approvals shall be made after (a) consideration of the convenience and necessity of New York residents in the rural areas served by such pharmacies, (b) consideration of the quality of service of such pharmacies and the standing of such pharmacies with the governmental board or agency of the state in which such pharmacy is located, (c) the executive director shall give all licensed pharmacies within the county notice of his or her intention to approve such out-of-state provider pharmacies, and (d) the executive director has held a public hearing at which he or she has determined factually that the licensed pharmacies within such county are not adequately serving as provider pharmacies.

2. The executive director shall investigate and determine whether certification shall be granted within ninety days of the filing of an application for certification by the governing body of any city, town or village, within a county determined by the executive director to be not adequately served by provider pharmacies registered in New York pursuant to subdivision one of this section, claiming to be lacking adequate pharmaceutical service.

3. Every certification granted pursuant to this section shall expire not more than five years after the date of issuance.

§ 254. Cost of living adjustment

1. Within amounts appropriated, the panel shall adjust the program eligibility standards set forth in subdivision two of section two hundred forty-two of this title to account for increases in the cost of living.

2. The panel shall further adjust individual and joint income categories set forth in subdivisions two and four of section two hundred forty-eight of this title to conform to the adjustments made pursuant to subdivision one of this section.

Article III. Mature Worker Initiatives

§ 301. Mature worker task force (Repealed effective April 1, 2010 pursuant to L.2010 c.58 §§40 and 86)

1. For the purposes of this article, the term "task force" shall mean the mature worker task force established by this section.

2. (a) There is hereby established within the office a mature worker task force. The purpose of the task force shall be to coordinate the state's efforts to assist older persons who choose to work and remain self-sufficient throughout their lives, or who choose to work after retirement; to support business growth and development across the state in light of increasing aging workforce; and to combat ageism and stereotypes.

(b) The task force shall be composed of nineteen members as follows:

(1) Seven ex-officio members as follows:

- (i) the director, who shall serve as co-chair of the task force;
- (ii) the commissioner of labor, who shall serve as co-chair of the task force;
- (iii) the commissioner of education;
- (iv) the commissioner of mental health;
- (v) the president of the state civil service commission;
- (vi) the chairman of the Urban Development Corporation; and
- (vii) the commissioner of the department of economic development.

Any ex-officio member may designate a representative to act on his or her behalf;

(2) Two members appointed by the governor, who shall be representatives of not-for-profit corporations the primary purposes of which are to provide employment services to older persons and specifically serve them in their efforts to develop the requisite skills for an ever changing job market;

(3) Two members appointed by the governor, who shall be representatives of organizations representing business interests;

(4) Three members appointed by the governor upon the nomination of the temporary president of the senate, of whom one shall be a representative of organized labor, one shall be a research expert in the field of older worker employment issues and one shall be a mature worker;

(5) Three members appointed by the governor upon the nomination of the speaker of the assembly, of whom one shall be a representative of organized labor, one shall be a research expert in the field of older worker employment issues and one shall be a mature worker;

(6) One member appointed by the governor upon the nomination of the minority leader of the senate; and

(7) One member appointed by the governor upon the nomination of the minority leader of the assembly.

(c) The administrative support of the task force shall be equally provided by the office and the department of labor.

3. Powers and duties. The task force shall have the following powers and duties:

(a) to facilitate interagency planning and policy, review specific agency initiatives for their impact on mature workers and businesses, provide a continuing forum to discuss concerns and issues related to the formulation of state policy designed to help address this policy area, and develop linkages and partnerships with businesses and other appropriate entities to assist such businesses in identifying and helping them to fill their workforce needs;

(b) to identify existing statutory and regulatory provisions and business practices that limit opportunities for mature workers and develop legislative and regulatory proposals to address such limitations;

(c) to identify best practices in the private sector for hiring, retaining and retraining mature workers, and serve as a clearing house of such information;

(d) to assess the effectiveness and costs of programs that state agencies have implemented to hire, retain and retrain mature workers, and recommend cost-effective programs for all state agencies to hire, retain and retrain older workers;

(e) to meet quarterly or more frequently if its business shall require;

(f) to develop recommendations and proposals for a mature worker employment training program and a mature worker business initiative;

(g) to annually report to the governor and the legislature on or before June thirtieth, commencing in two thousand eight, its recommendations for state policy relating to mature workers, best practices in the business sector for hiring, retaining and retraining mature workers, and a review of services initiated and coordinated among public and private agencies that meet the needs of older workers who are seeking to remain active in the workforce. The report required by this subdivision shall be posted on the office's internet website; and

(h) to serve as the focal point for the development of coordinated responses by the various state agencies with regard to issues of importance to mature workers to ensure timely and appropriate responses to issues and problems.

4. Implementation. (a) The office shall collaborate with the department of labor on issues related to the development of mature worker support initiatives and enhancing access by mature workers to existing training and employment services funded through federal and state resources.

(b) The office shall utilize the data and information compiled and maintained by the task force to coordinate state funded research and employment training efforts to ensure the most efficient use of funds available for such purposes.